Priests, Providers, and Protectors
The Three Faces of the Physician

Dr. Ronald W. Pies, MD

Autonomy grew up as a street fighter, and was bloodied in some genuinely noble battles against medical paternalism. But like so many rulers . . . it has quickly forgotten its democratic roots, and grown fat and brutal in power.

—Charles Foster, Ethicist at Oxford University

“Yes, Father, I’ve been taking my medicine.”

Marie’s social worker and I had to suppress a chuckle. For a moment, Marie had been transported back 50 years to her French Catholic girlhood, and I—her psychiatrist—had momentarily become her Father Confessor.

Marie suffered from some mild cognitive deficits and a history of psychotic episodes, but her moment of role confusion was not the product of mental illness—in fact, she laughed at her faux pas and quickly corrected it. And in an important sense, Marie’s misidentification of me as a member of the clergy was quite understandable. For,

CONTINUED ON PAGE 24
A Missed Opportunity

To recognize narcolepsy symptoms in pediatric patients

Although narcolepsy is often associated with adulthood, symptom onset most commonly occurs in childhood and adolescence.1-4 Understanding how narcolepsy symptoms manifest in pediatric patients may be key to timely recognition and diagnosis.5

Visit NarcolepsyLink.com/Pediatric to learn about early signs of narcolepsy.

References
they have abandoned her to the streets and to the voices I imagine she is hearing in her head. I want to reach out to her, but I cannot speak a word of her language, and haven’t a clue.

The old man is as lean and wiry as a teenager—I know this because I see him walking quietly but purposefully through town wearing only stained shorts. His bald head glints in the tropical sunshine. As he makes his daily rounds, he carefully adjusts the rear-view mirrors on various cars and motorcycles and bikes parked by the curb. He makes random stops on the sidewalk and in the small stores and offices that line the main road . . . at each stop he kneels and makes sounds that I think must be prayers. But the words don’t sound like the local tongue to me. He has been making these daily stops for so long that his presence is no longer even noticed by the shop keepers. The locals tell me that he is an educated man . . . that he once spoke many languages, but that he suddenly stopped speaking altogether long ago. They say he is bo tem—the Lao word that translates roughly into “not full” or “mad” or “crazy person.” Many believe the spirits have infected his brain. The expats have heard he contracted dengue fever or malaria—or was it encephalitis?

A young man just past his teens whose job it is to take care of elephants—a mahout—has been acting very strangely over the past several hours. In between sudden and violent bouts of vomiting that started late in the afternoon, he has been squatting on his haunches on the jungle floor and screaming continuously. His friends carry the ailing man to a nearby hut, which is cushioned by tatami mats, where other mahouts sometimes sleep.

The hut is nestled deep in the Lao jungle. The setting is breathtaking—small groups of tourists come here to walk alongside elephants from a conservation camp and marvel at the teak trees, streams, and rich vegetation. They can hear (and sometimes see) giant wandering water buffaloes of farmers working their nearby fields that have been cleared for growing eggplant, corn, potatoes, and rice. There are giant jungle rats out here, geckos the size of your forearm, and 22 varieties of poisonous snakes. It is a place of magic.

But this mahout and his friends see and feel things that the tourists never do. When they enter this hut, they feel the presence of ghosts. The spirit house, where offerings must be made to the ghosts, is pointing in the wrong direction. The men are all deeply fearful, and they will not rest in this place. Even as their friend continues to scream, they carry him through the jungle. They watch in horror as he vomits up splinters of wood. They are afraid that spirits have caused wood poisoning. The men slowly carry their sick friend through kilometers of the dark trails they know so well and at last find transportation that will take them all to a hospital. The man’s screams alternate with vomiting on the endless ride.

The doctors examine the mahout and take blood and urine samples. All test results are normal. The patient is sent home without a medical diagnosis after the acute symptoms have subsided. He utters not a single word and lies curled in a catatonic-like state for the next 2 days.

The hut in which the mahout was “wood poisoned” is built near the burial grounds of a local village. Another group of men is gathered nearby on the day of a funeral of a villager. Out of nowhere, a chicken suddenly appears. This is the jungle—chickens don’t live here and they don’t just wander by. The men, locals, don’t think for a minute that it’s a coincidence the bird has appeared at this moment. They see not a fowl but rather a living, cackling reincarnation of the just-buried villager—and they are electrified with panic. They begin to flee in various directions from the bird, who responds in kind by running frantic zigzags to escape the men. With all the frenetic back and forth between chicken and men, there is pandemonium—a scene of high theater.

The men finally run away and disappear into the jungle. But two days later, they return to the hut—at about lunch time. The chicken seems to have taken up residence. They find it pecking around for insects. One of the men takes his machete, grabs the bird, and chops its head off. It is promptly cooked and consumed with enthusiasm by the hungry men.

A man lies in the road, moaning—his leg dangling at an odd angle, white bone like a tusk clearly visible, and blood spurting. He was minding his own business, riding his bike, when a speeding and very drunk driver broadsided him. I guess it’s a good thing the collision happened in this town—it is one of only a handful in all of Laos with an ambulance. Many of the locals will steer clear of him and will not dare to try to help, fearful that the spirits who caused his accident will turn their wrath on them.

A baby has just been born at a pediatrics hospital run by physicians trained in Western medicine. The infant—a girl—is covered with a bright red rash. The doctors diagnose thrush, and an IV is inserted into the baby’s tiny hand for delivery of medication. Three days later, the rash is disappearing and the child is well enough to be taken home by her parents. But all is not well at home. Two days later, the rash has flared and the baby is again covered with angry red welts. The parents take their child for help—this time to their village “magic lady.” The healer tells the parents that they must bring their baby to see her twice a day for the next 3 days. The healer blows on the child at each visit and rubs a paste over her red skin. At the end of the third visit, the rash has vanished.

These stories aren’t fancy tales—they were told to me by the people who lived them. I met the parents of the baby girl whose thrush was cured by the magic lady during my recent 3-month stay in a small city in northern Laos. The baby had been born in a modern pediatrics hospital—one of a very few in this lush, lovely, Buddhist country, a facility open to all children in need at no cost. The man who nearly lost his leg (and possibly his life) in the bike accident was
taken to a local hospital for adults, a place where aspirin—but not morphine—was available, care was not free, and only the cockroaches scurrying along the corridors were provided with food. After 48 hours of agonizing pain, the man was medevaced to Bangkok, where he underwent multiple surgeries that probably saved his life. “You’re crazy if you come to Laos without medical insurance,” one of the expats told me.

Few other places in Laos have a hospital, or a pharmacy (where you can purchase a variety of medications without a prescription), or an airport for emergency evacuations. Most Lao still live in small villages, where Western medical care is scarce, and perhaps not to be trusted. In these places, some still without electricity, it is the village healer or, more recently, a trained lay person, who is the go-to for help. Offers may be given to the shaman—a pig if a family is rich, or possibly a chicken if a family is less well off. (You can read the story of the “No Chicken Doctor” that appeared in Psychiatric Times in 2013.)

Animism is alive and well in Laos, and for the majority who live in this country of about 7 million people, spirits rule. To those in the many ethnic groups here, including the Lao Suong (the Lao highlanders), the Lao Theung (the midlanders), and the Lao Luom (the lowlanders), spirits are as present—and as influential—as a nuclear family. The Lao do not make decisions, small or large, without consulting these spirits. Inside and outside their homes, they erect small shrines (that could be mistaken for elaborate bird houses) for these spirit dwellers, to whom they make daily offerings of food or drink or sometimes money. They do so to pay their respects, to request help for some endeavor they are considering, or simply to keep the spirits well fed and at peace. The spirit house is a holy place—feet (the dirtiest part of the body) cannot be pointed in its direction.

Suk khaan—the call of souls—is a ceremony widely performed when someone is born, becomes ill, or dies. If it is the spirits that cause the body and mind to sicken, it is they who can restore health. If a parent has sinned, if a child has been given a name displeasing to store health. If a parent has sinned, if a child has been given a name displeasing to it is the spirits that cause the body and mind to sicken. Sandra Bode, who co-founded Reach Out Laos, told me, People who go to one of the few hospitals in the country that have psychiatric units often wind up there when their caregivers become desperate and don’t know where else to turn. Most people don’t think ‘there is something wrong with me and I need to go for help’ or they are not sure where to turn. While things are changing, especially with the young generation, and health care is improving, there is still a stigma associated with mental illness. Many young Lao have better access to information about mental health and emotional well being than older generations, and they are determined to contribute to an increased awareness and an open communication culture.”

Still, there are currently two psychiatrists in Laos. Psychiatric care does not exist at the primary care level, nor do psychiatric medications. Only one doctor at the pediatrics hospital I visited had ever seen a patient with a psychiatric illness (ie, schizophrenia), and that was years earlier at another hospital. According to a 2002 report (the most comprehensive and recent I could find), mental health care issues were described as “completely new for the country.”

The insane (ba) . . . present [with] unusual thoughts and behaviors. They might be dangerous. Madness attributed to the spirit is the major category of madness. Witchcraft and spells are still present in the minds of most people. [The] Most acknowledged of the so-called ‘mad disorders’ is epilepsy. The non-mad category Care of the mentally ill To many Lao, the concepts of mental illness and spirituality are tightly intertwined. Sandra Bode, who co-founded Reach Out Laos, told me, People with mental problems and visibly problematic behavior are often referred to as ‘open ba,’ as in visited by a ‘crazy spirit.’ ‘To many Lao, if something is wrong with me, it’s possible a spirit is playing a part in that. Of course, other narratives are also present—depending on location, ethnic group, and access to education and health care, but the spiritual world is certainly relevant for many.

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Antidepressants in Bipolar II Disorder

Experts Are Divided on the Issue, but There’s One Thing Nearly All Agree on

Chris Aiken, MD

Antidepressants are increasingly discouraged in bipolar I disorder but what about bipolar II? Here depression is the more prominent pole, and the risk of antidepressant-induced mania is smaller. On the other hand, most of what we know about treatment comes from studies on bipolar I. Research on antidepressants in bipolar II is scant, but a new textbook gives a rare glimpse into how the experts approach them in their practice.

In Bipolar II Disorder: Modelling, Measuring and Managing, Gordon Parker surveyed 18 international experts on their treatment strategies with bipolar II disorder. I’ve clustered their responses about antidepressants into 4 categories:

1. Antidepressants are helpful in bipolar II and do not cause hypomania (endorsed by 1 out of 18 experts).
2. Antidepressants are helpful in bipolar II but are best used with a mood stabilizer to avoid hypomania (endorsed by 10 out of 18 experts).
3. Antidepressants are best avoided or used with a mood stabilizer as a last resort in bipolar II (endorsed by 6 out of 18 experts).
4. Antidepressants should almost always be avoided in bipolar II because of the risk of hypomania and cycling (endorsed by 1 out of 18 experts).

That’s quite a spread, but there is one thing nearly all agreed on: antidepressants can cause hypomania, mixed states, and worsen the overall course by triggering more frequent episodes and rapid cycling. This issue has long been debated, but studies over the past decade have largely put that debate to rest. On the other hand, nearly all experts saw a role for antidepressants in bipolar II disorder. Most saw bipolar II as a more varied group than bipolar I, and within that group are some who respond to antidepressants. Even those who tended to avoid antidepressants admitted that a small minority of bipolar II patients could do well with antidepressant monotherapy.

Which antidepressants are used? SSRIs and bupropion were the favorites, as these have the lowest risk of inducing mania. The respondents were split on the SNRIs. There is evidence that these carry a higher risk of mania, but one of them—venlafaxine—also stood out for its efficacy and safety in a small, 12-week, controlled trial where it compared favorably with lithium in bipolar II depression. Nearly all agreed that the tricyclics and MAOIs carried the highest risk of mania, but several acknowledged that they had had success with these agents—particularly the MAOIs—when used as a last resort.

When are antidepressants used? In the eyes of these experts, each patient has his or her fingerprint that can guide treatment. That fingerprint is shaped by:

1. The Life Chart: a visual map of manic and depressive symptoms sketched over a timeline of the patient's life
2. Past treatment response
3. Comorbidities
4. Family history
5. Patient preference

Antidepressants were preferred if the patient responded to them in the past or got worse after stopping them. They were also seen as a viable option when depression was long-standing, and hypomanias were mild and restricted to the distant past. Features that steered these experts away from antidepressants included a history of manic symptoms, mixed states, or rapid cycling within a few months of starting an antidepressant; rapid cycling; hypomanic or mixed symptoms within the past 6 months.

In my experience, bipolar II patients rarely have classic mania on antidepressants. It seems those drugs are just not powerful enough to flip depression into euphoria, but they can sprinkle mixed features onto the depression. In that case, the patient usually says the medication “made my depression worse.”

Hypomania is difficult to measure, both in research and practice, which partly explains the inconsistencies in this poll. There’s also disagreement about how dangerous it is, with two basic positions:

1. Hypomania is a brief, mild, and partly desirable state that is far better than depression.
2. Hypomania leads to more depression, mixed states, and painful life consequences.

Many of my patients would agree with the second point. During hypomania, they feel they’ve lost control over their mind. It races with an anxious pressure, and they can’t turn it off to sleep. Research supports their experience. Anxiety tends to be even higher in hypomania than it is in depression, and the most common chief complaint during manic states is surprisingly, depression. I’m reluctant to risk that painful state with an antidepressant, especially when we have so many other options for bipolar depression. When I do use antidepressants in bipolar II, I rarely see recovery but do see some response about 25% of the time. The more difficult question is whether that response was a placebo effect and whether it came with an added cost of rapid cycling. To answer that, I’ll attempt a taper after the patient's life and moods have stabilized for about 6 months, slowly lowering the dose of the antidepressant over a 2- to 4-month period to see if it’s necessary.

Dr. Aiken is Director of the Mood Treatment Center, Editor in Chief, The Carlat Psychiatry Report, and Instructor in Clinical Psychiatry, Wake Forest University School of Medicine. He is the Bipolar Disorder Section Co-Editor for Psychiatric Times.

Dr. Aiken does not accept honoraria from pharmaceutical companies but receives honoraria from W.W. Norton & Co. for Bipolar, Not So Much, which he coauthored with Jim Phelps, MD.

References

TABLE. Expert opinion on antidepressants in bipolar II

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AN INVITATION
PSYCHIATRIC MALPRACTICE GRAND ROUNDS

With the help of Editor in Chief Emeritus, James L. Knoll IV, MD, the editors at Psychiatric Times cordially invite you to submit an article about a “what if” legal dilemma for a series of online articles about psychiatry and the law.

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Of course, we always need to be careful about confidentiality. Although the pieces are not clinical per se, authors should disguise parties and scenarios (even yourself if you prefer to remain anonymous) in order to protect privacy. Authors should be aware that if they are parties and scenarios (even yourself if you prefer to remain anonymous) in order to protect privacy. Authors should be aware that if they are parties.

Please submit your 1200-word manuscript and CV by June 1, 2019, for consideration to lmartin@MMHGroup.com, with “Malpractice Grand Rounds” in the subject line.

NOTE: This is not a contest and selection will be at the sole discretion of the editors. We cannot promise print publication, but if selected, your article will appear on our website. Only submissions by psychiatrists will be considered.

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Esketamine: Depression’s Journey From Monoamines to Glutamate

John J. Miller, MD | Editor in Chief

March 5, 2019 turned out to be an important day for psychiatric providers as well as individuals suffering from treatment resistant depression (TRD). This was the day that esketamine (Spravato) was FDA approved as an intranasal spray to combine with a traditional oral antidepressant to treat individuals that, despite aggressive and adequate traditional psychopharmacological treatments, remained severely depressed. There are many stories within this story that I would like to explore.

Ketamine’s story

Ketamine was discovered by chemist Calvin Stevens in 1962. After studies in animals demonstrated ketamine’s anesthetic effect, it was studied in human prisoners in 1964. Once ketamine proved itself to be an effective dissociative anesthetic, it was FDA approved in 1970. Unlike many anesthetics, ketamine demonstrated properties that were advantageous in acute trauma situations—specifically it did not cause respiratory depression and hypotension—and it was found to be quite useful for injured soldiers during the Vietnam War. Since that time it has continued to be used in medicine for the induction and maintenance of anesthesia, often in combination with other medications. Additionally, ketamine is commonly used in veterinary anesthesia, and is used as a first-line agent in equine surgery. In 2000, Berman and colleagues,1 at Yale University reported a significant antidepressant effect within 72 hours when 7 depressed individuals were treated with intravenous ketamine in contrast to a saline placebo.

This rapidly acting antidepressant effect of ketamine was replicated by numerous studies and led to significant excitement in the psychiatric community for the possibility of a novel mechanism of action for the treatment of depression. Up until esketamine’s FDA approval for TRD this year, all other FDA-approved antidepressants—monotherapy and augmentation agents—shared mechanisms of action that acted on the monoamine system, including the neurotransmitters serotonin, norepinephrine, and dopamine.

The monoamine hypothesis of depression dates to 1952 when both sertraline (used to treat hypertension) and imipramide (used to treat tuberculosis) were shown to increase brain levels of the monoamines serotonin, norepinephrine and dopamine, and simultaneously treated symptoms of depression. Ultimately imipramide was FDA approved as our first antidepressant medication in 1958, followed by imipramine in 1959. Although these and all subsequent antidepressants showed clinical effectiveness in the treatment of depression, it often takes 2 to 8 weeks to achieve improvement. Hence, the observation in 2000 that ketamine appeared to reduce depressive symptoms within 72 hours of the first treatment was a true and welcome paradigm shift.

An explosion of research on ketamine and its 2 isomers, esketamine and arketamine, ensued. A search on PubMed (April 12, 2019; https://www.ncbi.nlm.nih.gov/pubmed) listed 4669 articles published with the search word “ketamine” in the past 5 years. Although ketamine has been FDA approved as an anesthetic since 1970, its use in depression has been off label, greatly limiting its access to most depressed individuals. Ketamine remains off label for the treatment of TRD but is administered throughout the US by physicians of various specialties in ketamine clinics, where it is usually administered intravenously, and with no consistent protocol. Long-term studies are lacking to quantify duration of treatment, frequency of treatment, dosing, and long-term safety. A recent publication did monitor long-term tolerability in 14 patients who received from 12 to 45 IV ketamine infusions over a period of 14 to 126 weeks with no significant long-term serious side effects reported.2

Esketamine’s story: chirality and stereoisomerism

All proteins, enzymes, and receptors are constructed of a core sequence of amino acids. As life evolved on our planet, a random choice was made whenever an amino acid had at least one carbon atom with 4 unrelated groups attached—resulting in a subset of amino acids having mirror image structures, one found in living systems and the other absent. This results in the phenomena of chirality, whereby when you look at the attached groups on the carbon atom, the smallest to largest groups rotate either clockwise or counterclockwise.

Many drugs, when synthesized, contain a 50:50 mixture of these chiral compounds, and some drugs can have numerous chiral carbon sites. Depending on the arrangement of these 4 attached groups on the carbon atom, the drug is classified as either “es” or “S” for left rotating, or “ar” or “R” for right rotating. The common analogy used is “handedness.” Although the left hand and right hand look identical at first glance, they are not superimposable. Rather, they are mirror images of each other. If you had a lock that required your hand’s 3-dimensional structure to open it, only one hand would work. These basic chemical principles create the phenomena of stereoisomerism, and in most cases the “es” or the “ar” isomer of a drug binds much tighter and cleaner to its associated receptor.

Ketamine is a racemic mixture, so when it is synthesized it contains 50% esketamine and 50% arketamine. It is well established that esketamine binds approximately 4 times tighter to the NMDA-glutamate receptor than arketamine. However, both molecules have relevant and significant effects on receptors in the human brain. Each isomer is metabolized by liver enzymes, and some of the metabolites retain chirality, while others do not. An evolving research literature continues to expand our understanding of the differences between these 2 isomers, but much remains to be learned.

Janssen, the manufacturer of Spravato, chose to develop its intranasal spray with the isomer esketamine. Initial dosing studies determined the IV doses of esketamine required to achieve similar rapid onset efficacy in TRD patients to that of IV ketamine. Once these serum concentrations were established for esketamine, Janssen developed an intranasal spray delivery system to achieve these same concentrations to allow for intranasal administration. At the time of FDA approval of Spravato, Janssen had studied it for 9 years, and in over 1700 patients with TRD.

The journey to FDA approval of esketamine

After significant preclinical research on esketamine, and the successful development of an intranasal spray delivery system, five phase 3 clinical trials (three short term; two long term) were completed investigating the efficacy of esketamine in patients with TRD. The esketamine doses that demonstrated efficacy were 56 mg and 84 mg. The primary short-term, randomized, double-blind, placebo controlled 4-week clinical trial required that patients with established treatment resistant MDD, with at least 2 failed adequate antidepressant treatments in the current episode, would be started on a novel antidepressant (sertraline, escitalopram, venlafaxine XR, or duloxetine) simultaneously with the onset of treatment with either intranasal ketamine or intranasal placebo.

The subjects in this trial were quite depressed, with a mean Montgomery-Asberg Depression Rating Scale (MADRS) score of 37 at the time of randomization. Moreover, one-third of the study participants had a history of suicidal ideation. The primary endpoint of this study was the change in the total MADRS score from baseline to study end at day 28. On day 1 of the study, sub-
The most exciting parts of the ketamine story are brain structural and functional changes and increased global brain connectivity, which are observed to occur within hours and days of a single treatment dose of ketamine.

At the time of FDA approval 1-year safety data had been collected on over 800 patients, and a subset of patients were continued on open-label maintenance treatment with esketamine spray/oral antidepressant for up to 96 weeks. Janssen and the FDA established a Risk Evaluation and Mitigation Strategy (REMS) program to minimize serious adverse effects and to minimize the potential for drug diversion, as well as to provide a readily accessible database of all treatment with Spravato.

Spravato is patient administered in REMS certified clinics, and the drug is provided by REMS certified pharmacies. Patients receiving Spravato are required to remain in a supervised setting at the health care provider’s clinic for 2 hours post-nasal infusion. This allows for ongoing monitoring of patients during the period when significant adverse effects (sedation, dissociation, and elevated blood pressure) are most likely to occur. The REMS protocol requires the patient to abstain from driving or engaging in any complex tasks until the following morning, after a night’s sleep. More information is available at www.spravatohcp.com, and in the FDA-approved product insert for Spravato.

The mechanism of action (MOA) story
Ketamine, esketamine, and arketamine are all categorized as NMDA glutamate receptor antagonists, and on the surface this is an accurate description. Over the past 2 decades an impressive literature has evolved, including in vitro studies, animal studies, and studies in humans, including neuroimaging studies of subjects given ketamine or placebo. Although ketamine contains 50% esketamine and 50% arketamine, each of these 3 formulations demonstrates unique pharmacokinetic and pharmacodynamic properties, albeit with significant overlap. However, they should not be considered interchangeable. There is at least one sec-

from placebo was seen. From 24 hours post-dose through day 28 both esketamine and placebo groups continued to improve. At day 28 esketamine spray/oral antidepressant had improved the MADRS score by an average of 4 points (P = .02) compared with placebo spray/oral antidepressant.

The second study was a long-term maintenance study in patients with TRD that began with 16 weeks of open-label treatment with a new oral antidepressant along with esketamine. Esketamine was administered twice weekly for the first 4 weeks (the Induction Phase), weekly for the next 4 weeks, and then weekly or biweekly for the remaining 8 weeks (the 12-week Optimization Phase).

At week 16, two sub-groups were identified: stable remitters (a MADRS ≤ 12) or stable responders (≥ 50% reduction in the baseline MADRS score). At that point, after 16 weeks of open-label esketamine spray/oral antidepressant, remitters and responders entered into separate maintenance phases, which involved double-blind, placebo spray-controlled randomization for up to 80 weeks. All patients were treated with either flexibly dosed esketamine spray (56 mg or 84 mg) weekly or every other week, or placebo spray weekly or every other week, as well as continuing on their original open label oral antidepressant.

The stable remitters on esketamine spray/oral antidepressant relapsed 51% less than placebo spray/oral antidepressant. The stable responders on esketamine spray/oral antidepressant relapsed 70% less than placebo spray/oral antidepressant.

One way to differentiate ketamine from other antidepressants is by its rapid onset. Ketamine—wrap your brain around that! For me, the most exciting part of the ketamine story is a growing literature that demonstrates ketamine’s antidepressant activity in mice; it seems to be related to its downstream effect of increasing brain derived neurotrophic factor (BDNF). The majority of research on understanding the MOA to date has been done on racemic ketamine, which will be reviewed briefly.

A reasonable metaphor for our current understanding of ketamine’s MOA is that of the 6 blindfolded scientists who are all unknowingly placed in front of different parts of an elephant’s body and are asked to describe the object in front of them. They each accurately describe their different observations—the elephant’s back, leg, tail, trunk, ear, and tusk—and when placed in a room to discuss their conclusions each scientist was confused and perplexed by the findings of the others. Like the elephant, ketamine’s MOA remains elusive to us, but there exist significant clinical data that some day we hope to integrate into a comprehensive understanding.

A list of putative mechanisms that may contribute to ketamine’s antidepressant effect follows:

- Direct effects on the NMDA glutamate ionotropic receptor
- Effects on the AMPA glutamate ionotropic receptor
- Secondary glutamate synaptic release from interneurons in diverse circuits
- Secondary effects on GABA interneurons
- Activity of the secondary metabolite, hydroxy-nor-ketamine
- Inhibition of the phosphorylation of the eukaryotic elongation factor 2 (eEF2) kinase
- Increased expression of BDNF
- Increased expression of tropomyosin receptor kinase B (TrKB)
- Activation of the mammalian target of rapamycin (mTOR) signaling pathway
- Rapid decrease in the size of the amygdala and nucleus accumbens
- Rapid increase in the size of the hippocampus and prefrontal cortex

For me, the most exciting part of the ketamine story is a growing literature of neuroimaging studies looking at brain structural and functional changes (especially the hippocampus and prefrontal cortex) and increased global brain connectivity, which are observed in human studies to occur within hours and days of a single treatment dose of ketamine. As we untangle the mosaic of research data, it appears that ketamine ultimately improves brain connectivity with an associated rapid decrease in depressive symptoms that seems to result from a range of downstream cascades that culminates in the activation of mTOR, which plays a primary role in synaptogenesis. Remarkably, the brain’s structure appears to rewire in hours after a single dose of ketamine—wrap your brain around that!

I would be remiss not to mention a study published in 2018 that hypothesized opioid receptors played a primary role in ketamine’s antidepressant action. Williams and colleagues looked at pretreatment with naltrexone, followed by the IV administration of ketamine. Their study had a small number of participants. Of the 30 adults who were initially enrolled in this study, 12 completed the protocol to allow an interim analysis fraught with limitations. Two subsequent studies in 2019 demonstrated no interplay between the mu opioid receptor and ketamine’s rapidly acting antidepressant effect.4,5

Conclusion
So, psychiatry has finally crossed into a new paradigm in the treatment of TRD, bringing the glutamate system on board to modulate the monoamine systems. Esketamine is the first in what we hope will be a long list of non-monoamine-based treatments to help improve the lives and functioning of the many individuals suffering from TRD.

Dr Miller reports that he is on Janssen’s Advisory Board and on the Speaker’s Bureau for Spravato.

References
Cassandra or Happy Warrior: How Paradoxes of Psychiatry Can Sustain the Green New Deal

Michael A. Kalm, MD

There’s an old joke about change: How many psychiatrists does it take to change a light bulb? Just one, but the light bulb really has to want to change.

One of my teachers ruefully described working for change as a “sandwich board” concept. Poor people during the 1930s earned money as walking advertisements, wearing sandwich boards with messages on the front and back, like “Eat at Joe’s,” and “Open for Breakfast From 7-11 AM.” My teacher used to say that our patients came to us wearing sandwich boards, with the front saying, “Please help me to change,” and the back, saying, “Over my dead body.”

Our patients do come to us for help. They want to feel better. But they also come to us with fear that makes change difficult. They come to us with psychological defenses, like denial, which stop them from facing what they fear most. They also come with prejudices, beliefs, anecdotal evidence, confirmation bias—all designed for feeling better but perpetuating the same distress.

Our duty as psychiatrists is to build trust, to provide a safe environment where our patients can be open; reveal their darkest thoughts, feelings, and fears; try out new things, and use their new skills out in the world if they so wish. When we do our job right, our patients can return to, or achieve for the first time, a healthy state where they can be in the world confident, thriving, and able to sustain healthy relationships.

But this is not easy. Sometimes fear runs too deep and denial is too great. Many years ago, I had a patient with paranoid schizophrenia. With therapy and medication, she recovered from psychosis and was a full-time student heading towards a full, thriving life. However, before her illness, she had been an accomplished pilot. At the time I was treating her, the Federal Aviation Commission (FAA) had a rule that prohibited renewal of a pilot’s license as long as the person was taking prescribed medications. I appealed to the FAA on her behalf, asserting that I would trust my life flying with this patient, because, with her medication, she was completely stable and competent. But rules are rules. No license.

My patient decided to discontinue her medication. I urged her not to do so, emphasizing the risk of relapsing into psychosis, and that she would risk losing her license anyway and probably much more. But the license was too important to her. She stopped the medication, and, as predicted, relapsed into psychosis. She resisted treatment and ran away. I received a letter from her family some years later that she never finished school, couldn’t hold a job, and had become homeless.

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Treatment of Traumatic Brain Injury With Hyperbaric Oxygen Therapy

Hyperbaric oxygen therapy (HBOT) is defined as the use of oxygen at higher than atmospheric pressure for the treatment of underlying disease processes and the diseases they produce. Modern HBOT in which 100% O₂ is breathed 
diseases they produce. Modern HBOT in which 100% O₂ is breathed in a pressurized chamber dates back to the 1930s, when it was first used for treatment of decompression illness in divers. There are currently 13 FDA-approved uses for HBOT, including decompression illness, gas gangrene, air embolism, osteomyelitis, radiation necrosis, and the most recent addition—diabetic ulcers. Just as practicing physicians routinely identify off-label uses for medications, over the years HBOT physicians have identified many other conditions that respond to HBOT. A number of chronic neurological conditions including traumatic brain injury (TBI) have been shown to respond particularly well. There is published literature supporting the 13 FDA-approved uses for HBOT, but when it is “pulsed” for an hour it response and various healing responses.2-3

Pathophysiology of TBI
At each site of impact a contusion can develop—essentially a bruise that may involve local bleeding and neuronal death. Over hours to days an area of inflammation will develop around the contusion, just as inflammation will occur around an injury anywhere in the body. Since the brain is encased in the skull swelling is strictly limited, resulting in increased pressure in the affected area. The increased pressure results in reduced blood flow, damaging a much larger area of cortex than was initially injured. Within this penumbra, neurons may be injured and unable to carry out their prime function of transmitting neuronal impulses, yet they can survive in this stunned or “idling” state indefinitely.2

This understanding of the pathophysiology of TBI explains the typical evolution of symptoms after a concussion. The patient may lose consciousness or may just feel stunned for some time. There may be an initial headache and some degree of confusion, which often improve over the next few hours. However, as the inflammatory process evolves more severe symptoms develop, usually peaking within 1 to 2 weeks. These include headache, “brain fog,” nausea, photophobia, hyperacusis, difficulty with focus and multitasking, impaired memory, difficulty with visual processing with prominent difficulty looking at screens, and profound fatigue. The symptoms eventually stabilize, then begin a slow recovery over several months.
This type of injury is referred to as "mild" TBI, since there is no gross destruction of brain matter. The absence of gross damage is reflected in the typical finding of unremarkable CT and MRI scans even in the presence of disabling symptoms. However, in many cases a brain perfusion (SPECT) scan can image macroscopic areas of reduced perfusion of the cortex.

Treatment protocol for TBI
HBOT is regulated by the FDA as a drug, and like a drug, the appropriate dose can vary with the condition being treated. Dose is determined by the pressure in the chamber and the total hours of treatment. HBOT for FDA-approved indications is most commonly delivered in hospital settings, usually in large multipurpose chambers at a pressure of 2.0 ATM or higher. High pressure treatment is superior for infections and for other acute severe problems.

It took several decades to determine that, due to excessive oxidative stress, high pressure HBOT carries a significant risk of further damage in chronic diffuse neurological conditions. Treatment at lower pressures in conjunction with limits on the number of sessions has been shown to be safer and more effective for these conditions, including TBI.

The recommended protocol for TBI is currently one or more blocks of 40, 1-hour HBOT sessions delivered at 1.3 to 1.5 ATM. Treatment can be conveniently delivered in "mild" hyperbaric chambers, soft vinyl chambers limited to 1.3 ATM that are inflated by a small compressor using room air (eliminating the risk of fire). Oxygen is extracted from ambient air by a portable oxygen concentrator, removing the need for oxygen tanks. Oxygen is fed into the chamber through a tube and delivered to the patient via an ordinary hospital oxygen mask.

These chambers are available, simple to assemble, simple to operate, and can be used in the outpatient setting. They are considered class II medical devices similar to a continuous positive airway pressure machine, requiring a doctor’s prescription but usable at home without direct medical supervision.

CASE VIGNETTE
RP is a 55-year-old man who originally entered treatment with a 20-year history of bipolar disorder. His life had been chaotic because of lack of treatment adherence. He was stabilized on a modest dose of lithium and has been in a stable relationship and successfully self-employed for the past 10 years. When it occurred to me to ask him about concussions, it emerged that there were several significant sports-related concussions during adolescence and at least a half-dozen serious concussions in early adulthood, possibly related to recklessness during manic episodes. His last concussion occurred 30 years before this history was obtained. He was unable to describe any specific post-concussion symptoms, possibly because he had so many concussions starting in adolescence, and could not remember what his functioning was like prior to his concussions. A brain-perfusion SPECT scan showed extensive perfusion defects consistent with TBI, which is a strong predictor of clinical benefit with HBOT. Accordingly, he was offered treatment even in the absence of a clear history of acquired symptoms.

The patient rented a mild-HBOT chamber and did the treatment at home. He completed two blocks of 40 one-hour sessions of mild HBOT (1.3 ATM, 100% O2) over the course of 4 months. A post-treatment SPECT scan was obtained about 56 months after he completed the treatment protocol.

Following is the summary section of the radiologist report for each scan. Note that a normal SPECT scan should show homogeneous perfusion, whereas areas of reduced perfusion or heterogeneous (spotty) perfusion indicate cortical areas of reduced blood flow.

Pre-treatment SPECT scan, Aug. 29, 2016
"Findings: Decreased tracer perfusion is seen in the right temporal lobe and also there is heterogeneous perfusion in the bilateral parietal and posterior frontal lobes. The cerebellar hemispheres are symmetrically perfused in the correct clinical settings, this may reflect sequelae of traumatic brain injury."

Post-treatment SPECT scan, Dec. 27, 2017
"Findings: Brain SPECT images demonstrate homogeneous perfusion of the cerebral hemispheres. There are no asymmetric perfusion defects, with interval resolution of previously seen asymmetrically decreased radiotracer uptake in the right temporal lobe. Similarly, previously seen decreased perfusion in bilateral parietal and posterior frontal lobes has resolved. Impression: Normal brain perfusion SPECT with interval resolution of previously seen areas of decreased perfusion."

After completing treatment he reported improvement in focus, improved ability to multitask, and generally more stable emotional functioning. He noted that he was using vocabulary that he had not used since he was a teenager, which was readily observable on interview. He found that he was communicating with people in a much more direct way, in contrast to his usual tendency to be tangential with difficulty getting to the point. He stopped using an appointment book for his business, finding that he could keep track of appointments with his clients for several weeks ahead by memory.

Discussion
This case is not ideal as a teaching vehicle because of the lack of clear documentation of changes in post-concussion symptoms or neuropsychological testing results. However, the normalization of a grossly abnormal SPECT scan is clear indication that HBOT can repair neurological damage even decades after an injury, bringing macroscopic areas of cortex back “on-line.” The changes in the patient’s functioning and demeanor were striking, and clinically there was no doubt about the magnitude of the response. A controlled trial in a series of similar patients including pre-and post-neuropsychological testing, rating scales, and serial SPECT scans was published in 2012.

Cerebral palsy (CP) can be considered to be perinatal TBI and patients with CP have been shown to respond significantly to HBOT. Benefits brought about by HBOT in TBI and CP are generally permanent, although patients may be more vulnerable to reinjury. Clinical experience and compelling case reports suggests that Alzheimer disease and multiple sclerosis can be improved to some extent by HBOT. Benefits in patients with progressive illnesses such as multiple sclerosis will tend to deteriorate over time. A maintenance schedule of perhaps a few sessions per week can slow down and, in some cases, appears to prevent progression.

Conclusion
HBOT can bring about dramatic improvement in many neurological conditions for which we have had very little to offer other than palliative care. Considering the high incidence of many of these neurological conditions, the safety of treatment, and the simplicity and relatively low cost of mild-HBOT, it is unfortunate that it is not more widely available.

Dr Gómez is a psychopharmacologist and integrative medicine practitioner in private practice. He offers hyperbaric oxygen therapy for traumatic brain injury and other neuropsychiatric conditions including dementia and radiation necrosis.

References
Should We Prescribe Different Dosages of Psychotropic Medications to Men and Women?

Brynn S. Chavira, Anita S. Kablinger MD, and Elham Rahmani MD, MPH

The human cytochrome P450 (CYP450) enzyme system operates primarily in the liver and is found in large amounts in the intestines. These enzymes are responsible for metabolizing a wide array of compounds from various classes, including many psychoactive medications. Variability in the performance of CYP450 enzymes is common and strongly affects how a person will react to medication. Pharmacogenomic tests can reveal the efficiency with which a patient’s CYP450 enzymes operate, providing classifications into metabolizer types: poor, intermediate, extensive, and ultrarapid. A person’s metabolizer type for an enzyme affects how he or she will respond to pharmacologic agents processed by that particular enzyme. Dosages inconsistent with a patient’s metabolizer type can be ineffective and/or increase the risk of adverse events.

Multiple recent studies suggest that there is a correlation between gender and metabolizer type for several of the most medically relevant CYP450 enzymes. When patients have above-average metabolism for a certain CYP450 enzyme they may need to take a higher dose of medication to achieve therapeutic efficacy. Similarly, patients who are slow enzyme metabolizers, and are prescribed too high a dose of medication, run the risk of experiencing significant adverse effects.

For many medications, dosage does not take gender into account with women and men receiving similar dosages relative to their size. Pharmacogenomic testing is (currently) primarily used on medically complex patients or those with treatment-resistant conditions and failed previous trials. Its utility and cost-effectiveness as a first step rather than a last resort has yet to be demonstrated.

Evidence exists to suggest that there may be a correlation between sex and metabolizer type for certain CYP450 enzymes. This knowledge can be used to inform the prescription of medications metabolized by these enzymes. Taking information about the expression of each metabolizer type by sex into account can increase the likelihood of initiating an effective dose of medication earlier in the course of illness without needing to conduct genetic testing on individual patients.

Psychotropic tests

Psychotropic tests analyze roughly 16 genes to determine how they affect a person’s metabolism of psychoactive medications. Six of the genes encode CYP450 enzymes. There is significantly less evidence for sex differences in the metabolism of CYP2B6, CYP2C19, and CYP2C9 compared with the CYP450 enzymes discussed at length in this review. A 2003 study of CYP2B6 suggested that women have higher metabolic activity than men.

Evidence suggests that women have higher metabolic activity than men.

CYP1A2: The CYP1A2 gene encodes a protein that metabolizes a large variety of antidepressants, antipsychotics, and sedative/hypnotics. It is one of the more frequently studied CYP450 enzymes and demonstrates large variability in populations tested. In general, extensive metabolism is considered normal enzyme activity and would be expected to be detected in a majority of the population. However, in a retrospective analysis of data gathered from a neuropsychiatric clinic, Ramsey and colleagues found that 86.4% of patients displayed altered function in the form of enhanced induction of the CYP1A2 enzyme.

In the US, 49% of the general population is classified as ultrarapid or poor metabolizers of CYP1A2. The results regarding sex differences in CYP1A2 metabolism are mixed, with some studies failing to establish a statistically significant difference. However, a study conducted in 2000 by Ou-Yang and colleagues demonstrated that CYP1A2 activity was generally higher in men than women. A study by Karjalainen and colleagues in 2008 supported these findings by demonstrating that certain oral contraceptives and female sex hormones are inhibitors of CYP1A2 activity.

Thus, women are likely to have slower CYP1A2 metabolism than men. Because above-average metabolizers more quickly process CYP1A2 substrates, men may require higher doses of certain medications to achieve response.

Although on average, men may have faster CYP1A2 metabolism than women, individual differences should be taken into account. Many women may have faster than typical metabolism. With this knowledge, physicians may decide to start women on slightly lower dosages of medications metabolized by CYP1A2, hopefully limiting the risk of adverse effects but keeping in mind the possibility of a need to increase the dose. Similarly, physicians may decide to start men on a slightly higher dosage, limiting the number of adjustments before the patient starts responding to treatment.

CYP2D6: Although there are more than 50 different CYP450 enzymes, just six metabolize 90% of drugs. The two most significant enzymes of this class are CYP2D6 and CYP3A4. Studies on the effect of sex on CYP2D6 metabolism have yielded mixed results, but there is evidence to suggest that activity is slightly higher in females. A study conducted by Labbé and colleagues in 2000 involved men who were phenotyped monthly over the course of a year and women phenotyped every other day over the course of one complete menstrual cycle. The results showed high variability in CYP2D6 activity regardless of sex and phenotype. The study reported that about 80% of observed variability was explained by urinary pH variations. Due to weight-based dosing, men are frequently prescribed higher doses of medication than women. Such dosing practices may be ineffective; the findings from Haag and colleagues suggest that women may actually need higher dosages of medications metabolized by CYP2D6 than men.

CYP3A4: As explained above, the CYP3A4 enzyme is one of the two most medically significant CYP450 enzymes.

| TABLE. CYP450 enzyme activity differences between men and women |
|--------------------------|-----------------|
| CYP450 enzyme | Gender differences |
| 1A2 | Men may be slightly faster metabolizers on average |
| 2D6 | Women may be slightly faster metabolizers on average |
| 3A4 | Women may be slightly faster metabolizers on average |
| 2B6 | Women may be slightly faster metabolizers on average |
| 2C9 | No sex-related difference established |
| 2C19 | No sex-related difference established |

(Continued on page 13)
The Grief Monster

M y husband can hear me sob incoherently as I muffle my screams into my pillow. It is so soaked in tears and sweat that I have no choice but to raise my burning eyes and, invariably, stare at the framed picture of my mother standing on my bedside table. I have been baptized by “the grief monster.” With empty desperation, I drown in a sea of darkness. I am 30 years old—an only child. I gave birth to twin girls 2 months ago, and I lost my mother a month later. I wondered what the golden secret was to new motherhood as a grieving daughter.

On the evening of Friday, January 5, I rang the obstetrician’s office to confirm my test results. The secretary took what felt like an eternity to read them over. “It is positive,” she said, “but I am not sure what it means.” I was effectiveness pregnant. Less than 2 weeks later, I was leaving my new post in psychiatry, my husband, my pets, and my life in Ireland to hop on a plane to Buenos Aires. “We saw something in your mother’s colon in the ultrasound,” the doctor had said on the phone, “and the liver seems highly compromised, too.” I can still hear the words resounding in my head, like a dagger piercing all my senses. It was denial that got me through the 14-hour flight—the feeble conviction that they had found an abscess that explained the fever, and maybe the liver had abscesses too, or benign cysts. It was, in fact, stage IV colon cancer with liver metastases, and although I never told anyone (not even my mother), her chance of survival was only 10%.

An emotional ride
The surgeon summoned me. His voice was grave. At that point, I was certain that my mum had died in surgery. “We couldn’t remove the tumor,” he explained nonchalantly. He then began to get excited, as if reciting a novel case in an international surgical conference. “The size of the tumor was massive, and the smallest metastasis is the size of lemon.” I don’t exactly remember falling, only the jolt of my aunt’s arms supporting my back as I hit a nearby column. “This lady will be killed by the lymph nodes in the peritoneum though,” the surgeon continued, directing his gaze to my uncle, as if he was the most interested participant of his case exposition. “At least we managed to bypass the bowels to avoid obstruction.”

Being empathic comes with overwhelming emotions. I still fear now that the twins will absorb my sadness during the days I can barely breathe, or that they will be confused by my sudden mood swings given my denial and shock. Reading, talking, and consulting with my obstetrician and even my former boss helped me navigate these uncertain waters. I began to question if it would be right for me to jump straight back into work after my mother’s passing. I wondered, “What if having a gap in my CV will affect my career?” “What if being around the babies with such heavy emotions will make them neurotic and unhappy?” So began a vicious cycle of worry and sadness, until my very wise, very understanding and experienced former boss, who also happens to be a perinatal psychiatrist, said, “You should not go back to work any time soon. You are not galvanizing around and traveling the world. For now, having twins and losing your mother are your full-time duties.” It will take months to recover, maybe longer—but that is okay.

Conflicts of the self
Grief has the effect of shaking core beliefs and certainly provokes a whirlwind of emotions. That was certainly the case with me, but it is the loneliness and guilt that scared me the most. The on-call doctor asked me if I wanted an anxiolytic. As a psychiatrist, all my reasoning fought against it. I considered the adverse effects of benzodiazepines to the babies, their half-life, effectiveness, and interactions. But my instincts stopped me, and for the first time, I put myself before everything else and accepted the prescription. Not only that, but I requested a referral to a perinatal psychiatrist, who came to see me right before we were discharged after the twins’ birth.

Even with all our theoretical knowledge and clinical experience, when loss touches us, we discover that we, too, are human. Even with all our theoretical knowledge and clinical experience, when loss touches us, we discover that we, too, are human. I try to remind myself that I play many roles—mother, daughter, doctor, patient, woman, and wife. I am, and will always be, scared by this loss. At times, the grief monster seems to build an igloo so thick around the heart that it isolates me in guilt and impossible sadness. My mother was the victim of cancer; she lived through it with nobility and died by its dreadful hands even more dignified. I, too, was a victim of it all, and I still am—there should be no shame or guilt in admitting this. I still remember the dread I felt as I entered her hospital room, heart pounding madly in my chest, fearing I would collapse from sadness. I felt a sense of pride, tinged with a pinch of guilt, naturally, when I finished closing the suitcases and caressing the walls goodbye. The linens on my mother’s bed were flooded by tears—but I did it. I survived, all on my own. It was the proper goodbye—the slap in the face that I needed to be shaken out of shock and denial to progress into deep sadness and acceptance now. And acceptance may lead to letting go one day.

The dream of resilience
One morning, as I changed one of my twin’s nappies, she stared at me as if wondering why I was the one crying desperately and not she. Grief almost knocked me to the floor. It is not only pain that defines my grief, for that emotion can be easy to override. It is the explosive mixture of despair and emptiness that is much more striking.

Even with all our theoretical knowledge and clinical experience, when loss touches us [psychiatrists], we discover that we, too, are human. It is not the even the presence of the images of my mother’s last days that torture me, with her almost unrecognizable face and her delirious thoughts; rather it is the absence of the memories that we will never make. I will never hear her soft voice again, see her dancing ridiculously to 80s music, watch her basking for hours on end under the sun, or admire her endlessly in all her flaws and imperfections.

My mother dazzled with the strength of her light and grace; she was elegant as she was sharp and proud as she was generous. Not even her departure managed to break a love so infinite, so strong, so eternal. I relish now in the hungry yelps of my babies, in the tiny sighs they make when they are bursting with milk. In the unconscious smiles they draw on their perfect faces when they’re dreaming. It is in the sparkle of one of the twin’s curious eyes that I find my mother’s vivacity, in the other’s cleverness I tease out my mother’s. I feel my mother’s empathy in my husband’s embrace. They are the epitome of love, desire, passion, and life that one day will expel the grief.
My story could be anyone’s story—and it is a story of lessons. 1 I openly share this fragment of my life with my fellow psychiatrists. From mourning comes resilience; from loss, we can rethinks our place in the world, and ultimately, a light can be shed on the end of one thing and the beginning of another. Even now, with a seemingly forever missing compass, I find the courage to disclose my raw grief and see that strength can be mustered even in the darkest of times. Motivation will continue to feed my existence and strengthen my profession, but above all, love and time will lighten my way—as it will yours.

**Dr. Giacalone** is a general adult psychiatrist and a psychotherapist specialized in CBT. She was a lecturer in Psychiatry at the University College Dublin, Republic of Ireland, and currently works in clinical psychiatry in Dublin. She reports no conflicts of interest regarding the subject matter of this article.

References

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**Book Review**

**Left to Our Own Devices: Outsmarting Smart Technology to Reclaim Our Relationships, Health, and Focus**

Reviewed by John Torous, MD, MBI and Jane Gould, PhD

As interest in digital mental health grows, so do questions about its risks and benefits. The ubiquity of smartphones and a plethora of apps has created a new digital culture that puts a wealth of on-demand tools and resources into the palm of one’s hand. In *Left to Our Own Devices*, Margaret Morris, PhD,2 explores whether technology can extend and advance patient care outside the office and be scaled for mental health. She suggests that while technology can help users manage their moods and mental states, they question whether it is beneficial for well-being and mental health, given that it may present fewer emotional demands on users than face-to-face therapy.

When Morris began to write, her perspective was at odds with academic research by Sherry Turkle, PhD, as well as other mainstream researchers. Turkle, a noted social scientist at MIT, called out the Internet for accelerating a host of maladies, including alienation, loneliness, and a flight from conversation.2 In the spirit of academic debate, Turkle agreed to write the foreword to *Left to Our Own Devices*. She poses this vital question to readers: “If you are working with a technology that might close down important conversations, can it be repurposed to open them up?”

Morris is a skillful storyteller and takes this challenge to task. Across eight easy-to-read chapters, she illustrates how people, most likely younger users, “hack” technologies to foster connection, mindfulness, and well-being. The chapters are centered around a collection of personal narratives from people who personalized their digital devices and experience positive results. Morris records these stories with a gentle, engaging, and upbeat tone that requires no formal background in either mental health or technology.

The narratives in the book underscore the idea that technology can provide enhanced connection and treatment. The people described in the book have modified many different technologies from smart lights, to mood trackers, to game playing. It is important to note that the author is intent on describing the positive virtues of technology. Hence, like her counterpart, Sherry Turkle, who reported on more negative effects, Morris features case studies that provide ethnographic substance and context to support her thesis. Although the book does not promise to cover all ground and it does not seek to focus on vital issues surrounding data privacy, tracking, and the commercialization of personal data or health records, it does provide references for the reader to explore these issues in more depth.

This book is a good read for today’s digital health initiatives and for clinicians hoping to keep up to date in current trends in mental health technology. It reminds us that putting a device in a patient’s hands will often lead to outcomes that we could never have imagined. It also pokes holes in the once reigning view that robotics and chatbots are dehumanizing and antisocial. If anything, the narratives suggest that technology can help patients monitor their emotional states and improve sharing and connections. The book underscores how useful it is to study how patients use apps in real-world settings and to learn from their lived experiences.4

Hopefully, Dr. Morris will continue the conversation in a follow-up book as the field advances. There are social topics that need to be woven into future dialog. What is the emotional toll of using social media and the evolving debate on how much screen time is too much? What about potential attentional deficits that may result from being online nearly all the time. What are the concerns around safety and suicide that continue to evolve in terms of clinical knowledge and popular perception?4

We do not know how younger generations, who are more savvy with smartphones and future technologies, will make therapeutic modifications. We also know that we are in the early stages of gathering observations and data. From where we stand today, the well-annotated references in the book provide a useful compendium of topical inquiries on smartphones and apps.

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enzymes. Multiple studies have found that CYP3A4 is predominantly expressed by women. Waxman explains that the temporal pattern of plasma growth hormone regulates genes expressed in the liver. Sex differences are seen in plasma growth hormone released by the pituitary gland, contributing to the difference in CYP450 expression by sex. Waxman and Holloway established that these three have the most extensive research base suggesting gender differences in their expression.

Conclusion
Thought should be granted to the sexually dimorphic expression of CYP450 enzymes when prescribing medication.

Men have been found to more highly express the CYP1A2 enzyme, but the majority of people of either sex have above-average metabolism for CYP1A2. Paying attention to CYP450 enzyme activity differences between men and women may help physicians to prescribe accurate dosages of certain medications more quickly and with less trial and error (Table). Arguments for early pharmacogenomic testing are thus noteworthy.

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Most variability in the metabolism of medications between men and women results from the uneven expression of CYP3A4 and the frequency of medications reacting with this enzyme. The CYP3A4 enzyme has arguably the most research to suggest sexually dimorphic expression of any CYP450 enzyme. Substrates of CYP3A4 have been found to have higher clearance levels in women than men. In 2003, Wolbold and colleagues found that surgical liver samples from women contained levels of CYP3A4 that were double those of men on average. The study showed that the findings were not due to higher drug exposure resulting in preferential induction.

References


Looking for America
Elizabeth A. Varas, MD

Winter had not yet fallen
A crimson tide of red leaves
Rained down from the heavens
Mixed with the crisp blue of the fall sky.
I heard them before they came into view
The power and the glory of roaring thunder
Harley Davidsons as big as the wide
Open horizons of this great country.
They rode two by two with a majestic grace
The torchbearer bore an American flag tied to its pole.
I could hear it whistling in the wind.
The black flag of the POW brought up the rear.
I was suddenly moved to tears
A distant mourner behind a funeral procession
Transported to the far-off neighborhood of my youth.
I paused to show my respect
For all these young warriors buried like a time capsule
Beneath the dark soil of a distant land.
As my reverie receded
I was left to contemplate this bond of brotherhood.
How will we remember these warriors of our past?
How long will the Harleys last?

Dr Varas has been in solo private practice in Westwood, NJ since 2007. She is a veteran in the US Navy Reserve, having recently completed her 8-year commitment as an officer in the medical corps as a critical wartime specialist in the field of psychiatry. Before starting her private practice, she was the Medical Director of a mental health center in Paramus, NJ for more than 10 years and served as the director of the PACT program for patients with chronic psychiatric illness. Upon completion of her fellowship in consultation/liaison psychiatry she was an attending psychiatrist at Bronx Lebanon Hospital in New York City in the consultation/liaison service.
As physicians, we learn from our patients, textbooks, and experience. “Cure sometimes, treat often, comfort always,” these words from Hippocrates remain at the core of our values when interfacing with patients.

Psychiatrists have a unique therapeutic relationship—we gain access to a patient’s innermost private thoughts, fears and hopes. We come to know our patients on a profound and intimate level. As we are present through the highs and lows of our patients, we also navigate our own personal life demands. It is critically important, therefore, that we engage in a practice model that meets our individual professional and personal goals.

There are a multitude of ways to structure a practice model. And done correctly, most come with ample opportunities for work-life balance, entrepreneurship, and positive patient impact.

This Special Report on practice management helps serve as a tool for developing and structuring your own rewarding practice. One of the great benefits of our field is having options. With a variety of ways to practice—including virtual encounters, office appointments, locums, and consultancy—opportunities for the earnest psychiatrist are endless. There is no perfect pathway to achieving a sustainable practice model, which is why we need to support camaraderie in our field and learn from each other.

In this Special Report, a variety of topics are discussed and sound candid advice is provided. The Special Report serves as a guideline for dealing with a range of issues, from social media to burnout to office design to locums. Highlights include learning in detail how an office design can support a positive doctor-patient alliance. For those looking for even more freedom and flexibility in their day-to-day work, you will hear about one doctor’s experience doing locums in psychiatry. Specifics are shared about both the challenges and rewards of such work, as we hear from the author about the overall benefits of a practice with inherent flexibility. Another section focuses on the pros and cons of social media integration into practice—along with tips about how to overcome the “sting of negative reviews.” Readers will also become aware of the risk of burnout and learn how to foster resilience.

The goal remains to create exciting careers that will have us practicing for a long time. By building a practice model that we enjoy, it enhances our ability to “cure sometimes, treat often, and comfort always.”

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Dr Farrell reports no conflicts of interest concerning the subject matter of this Special Report.
Locum Psychiatric Practice Unexpected, Unheralded Benefits

Lawrence H. Climo, MD

At the age of retirement, I was unceremoniously and discourteously given 2-weeks’ notice. I was medical director of a struggling community mental health center stealthily down-sizing to show profit to then find a buyer, and I’d been deliberately kept out of that loop. I never saw it coming. Embarrassed and angry I impulsively signed up with a temp agency and became a locum tenens, a first for me, to get away and forget what had just happened, block it out of my mind. I joined our medical “Foreign Legion,” as it were—home for misfits and adventurers as I’d imagined this practice—to disappear and not have to deal with my shame, pain, and loss.

I took my first assignment in another state. Once I began seeing patients, I couldn’t help but view them as having been thrown under a bus just like me. They were stuck there and coming to me for help getting unstuck and back on course; I began keeping a journal. I had to. The familiar issue of boundaries was not only germane, it was a minefield.

Many months and several assignments later when I began to process what had happened to me, I discovered I didn’t want to stop this locum work. It wasn’t the novelty, salary, or perks. It was the renewal I’d begun experiencing as a physician and mental healer. But how is that possible for someone who is always a stranger, outsider, and about to leave, three obvious psychiatric liabilities? The answer, I realized, lay in my attitude. Would I see myself as there to hold down a fort until help arrives or would I be the help they’d have to make—were usually met with relief and support. When cases flounder and staff are demoralized, simply validating that reality can restore hope and boost morale.

For patients, too. Temporal lobe epilepsy (TLE) mimics neurotic symptoms, psychotic symptoms, behavior disorders, and personality disorders. It can destroy a life and ruin a family. It is easy to diagnose, easy to treat, the prognosis is often good for relief and improved functioning, but you have to think of it. Once I started thinking of it, I started finding it. And I started thinking of it because so many of my patients came from poor families that featured frequent childhood ear infections and inadequate access to pediatric care, well-known TLE antecedents.

Distraction relief Workplace culture
As a locum physician, you get to play a variety of different roles—admission officer, stopper of run-away-trains, de-frocker of sacred cows. Here are just a few roles I played during different scenarios I encountered during my 5 years as an outsider psychiatrist.

Anticipated complaints
A hostage-taking scenario is suddenly and rapidly unfolding. A nurse is about to be trapped inside her office with a rageful intruder who has barged in and is now closing her door to lock the two of them inside. You are first on the scene, drawn by his shouting, and immediately push back to keep that door from closing. The situation is tense but fluid and you see an opportunity. You direct people who are gathering to do something they’ve never done and are afraid to do, namely not only help keep that door open but squeeze inside as well. The room quickly fills with bodies that soon press against the now rattled and distracted intruder until he can’t move, let alone notice his captive has, on my signal, squeezed her way out of that office. All ends well. The nurse is unharmed, the intruder taken away in handcuffs, and the two security guards he’d assaulted when he’d invaded the clinic are back on their feet, uninjured. I ignore the complaints about me.

Runaway-train baggage
A patient finally finds the courage to share with her young, inexperienced social worker therapist—who knows her history of mental, physical, and emotional abuse by the violent alcoholic man she’d lived with and the helplessness, fear, and despair that had led 20 years ago to overdoses that never required treatment—that her intermittent suicide thoughts had never stopped. She still has them. She’s finally found the courage to take that long-delayed step forward in her treatment and talk about them. Her rattled therapist calls the police and signs an involuntary commitment form.

The police arrive and the startled patient, a black woman in her 50s, refuses to get in their cruiser. She’d never been inside a mental hospital let alone a police cruiser. She is put in shackles, forced into the cruiser, and brought to the state hospital. I am the Admissions Officer.

My mental status exam and assessment for risk-of-harm convince me she’s been railroaded. But commitment forms, once signed, can take on a life of their own, gathering steam with endorsements and justification until the train is barreling down a track towards a locked ward of a mental hospital.

SIGNIFICANCE FOR PRACTICING PSYCHIATRISTS

Contrary to what we’re taught and how we’re trained, locum psychiatrists need not feel at a disadvantage as mental healers, as there are actual advantages to being an outsider and stranger who is always leaving—advantages to both doctor and patient.
This is a woman who lives with her sister and is completing medical records training. This polite, cooperative, and deeply humiliated caregiver who smiles as she illustrates her craft abilities is a woman betrayed. I am the only one who can stop this runaway train. Retirement age may be no time to stick my neck out, but it may be the last time I get to stick my neck out. I stop that train.

**An outside-the-box perspective**

**New card to play**

Low expectations can be disarming. Patients sometimes forgo a power struggle with a locum whom they view as, like themselves, powerless. And it’s as if, by prefacing any treatment suggestion with the disarming, “Where I come from . . .” as deferentially confessing you’ve only one foot in this door, any power struggle may be rendered pointless.

I’m helping out on an Admissions Unit. They’re short-handed. The admission last night, a young man with bipolar disorder in relapse, was assigned a doctor who didn’t have time to see him let alone write a note. I’m told this patient denies he has bipolar illness or any problem, won’t take meds, and never has. In the community he uses cocaine and alcohol. Then, when he can’t come down from his mania, he causes trouble, authorities are called, and he is re-hospitalized. Like now.

I introduce myself. He’s still manic and refusing meds. I tell him I’m from out of town and here only temporarily when he interrupts with this challenge, “So, do YOU think I am bipolar?!”

It’s time to play my “hapless stranger” card. “Where I come from,” I begin quietly, “we don’t bother with whether or not someone’s bipolar. All we care to know is whether or not they have a chemical imbalance in their brain because, if they do, there is a salt, an old-time table salt, that can take away stressed-out feelings.”

No response, I continue. “No one knows how it works so, if a patient asks if he can have some, we just give him a prescription and . . .”

“You can try it.”

I pause. “You’ll have to ask your doctor.”

“Would you ask her for me?”

Later that day I do just that. “Do what you want,” the doctor murmurs as if she’s been around the block with this kid one time too many. I discontinue the antipsychotic meds he’s refusing, order lithium salt, and return to my assigned post. He takes the lithium, soon asks for higher strength, doesn’t miss a dose, and is ultimately discharged to the community, illness in remission. In the community he remains sober and continues the lithium.

**Sacred cows defrocked**

The state hospital Patient-at-Risk Committee has determined that this seriously regressed and “out-of-control” woman, the most difficult patient on the locked unit I’m told, will likely kill herself should she be discharged. On one-to-one supervision (she threatens suicide daily) she resists all treatment. She has no hospital privileges, a reality that fuels ever more antisocial behavior; an irresistible force meeting an unmovable object.

I’ve just arrived as their locum psychiatrist, her care is transferred to me, and I immediately see a way to break this impasse.

I introduce myself to the woman and express horror at the way she’s being treated. I encourage her to continue demanding privileges and assure her the hospital is in violation of her rights. I express my determination to fix this and get her out. Not surprisingly, the more I assume command of her control issue and make it my issue the more she loosens her grip on it. The more I manifest outrage and indignation the more composed and appropriate she becomes. Finally, I’m rushing back and forth in a feigned dither trying to “force the hospital” to relax their controls while, unsupervised, she is calmly earning privileges until, one day, she is deemed “clinically stable and optimally functioning” and discharged unconditionally by that same Committee. Her transformation took just 2 weeks. It seems my staff splitting and patient manipulation, two professional no-nos, were the ticket. Over the ensuing months in the community there is neither re-hospitalization nor calls for police intervention.

**The Role of Social Media in Private Practice**

**Kaustubh G. Joshi, MD, and Marie E. Gehle, PsyD**

More than half of the world’s population now uses the Internet. Many of these users access social media sites on a regular basis. Social media can be classified in a plethora of ways to reflect the diverse range of social media platforms, such as collaborative projects (eg, Wikipedia), content communities (eg, YouTube), and social networking sites (eg, Facebook). A recent Pew Research Center survey of US adults reports that social media use in early 2018 was characterized by a combination of “long-standing trends and newly emerging narratives”; 73% of US adults reported using YouTube and 68% reported using Facebook. At the same time, younger Americans (especially those aged 18 to 24 years) are embracing a variety of platforms (eg, Snapchat, Instagram, Twitter) and using them frequently.

Psychiatrists are increasingly using social media to educate the general public, existing patients, and potential patients about various conditions. With their many applications, social media platforms are useful for professional networking, patient and provider education, research collaboration, personal and professional support, and academic dialogues. Social media adds a new dimension to health care because it offers a medium for physicians and patients to communicate about medical issues with the potential to improve health outcomes.

**SIGNIFICANCE FOR PRACTICING PSYCHIATRISTS**

Psychiatrists are increasingly using social media as part of their private practice. Using social media in private practice comes with benefits and challenges.

- Social media provides communication in real time and is inexpensive.
- Information in user-generated form is largely unregulated.

**Benefits of using social media in private practice**

Using social media in private practice has many benefits. It provides avenues for us to market ourselves and our services. The most popular social media sites for physicians are those where we can participate in online communities, listen to experts in their fields, read news articles, network, and communicate with colleagues regarding patient issues. These sites allow us to acquire and read relevant information related to our patients and practice. Social media allows us to engage with other psychiatrists and mental health professionals by commenting on posts and participating in group discussions or online chats. By identifying and sharing useful information or links with followers or other members of an online community, these interactions can increase the acquisition of salient information.

We can create blogs, forums, videos, and information-sharing websites that provide information to the general public, patients, and other mental health professionals on mental illness, treatments available, and wellness; these efforts can help reduce stigma associated with mental illness and promote psychiatry. Our use of social media can expand access to individuals who may not easily access health information via traditional methods. Social media can provide peer, social, and
emotional support for patients, the general public, and other mental health providers. It can allow the general public to discuss sensitive topics and complex information with us and provide opportunities for us to provide online consultations.

Social media provides communication in real time and is inexpensive, although potentially time consuming. We can quickly monitor public response to mental health issues, identify misinformation of mental health information, and disseminate pertinent mental health information to targeted communities. We can compile data about patient experiences from blogs, collect data from patients, and gather opinions regarding our performance (e.g., via customer satisfaction surveys). We can use social media to disseminate personalized messages immediately.

**Challenges of using social media in private practice**

The challenges of using social media can be as numerous as the benefits. Information on the Internet, especially in user-generated forums, is largely unregulated and its accuracy cannot be guaranteed. Authors of medical information found on social media sites are often unknown or are identified by limited information, and the medical information may be unverified, incomplete, or informal. Social media tends to emphasize anecdotal reports while evidence-based medicine tends to de-emphasize it. Using social media may make us susceptible to both known and unknown conflicts of interest that we may be unable to decipher.

Social media conveys information about a person’s personality and values, and the first impression generated by this content (e.g., photos, posts) can be lasting. Posting inappropriate content or unfavorable comments can reflect negatively upon us and can be viewed as unprofessional.

We can view our patients’ social media profile to obtain information about them. Their “digital footprints” may help us understand the context of their lives, reconcile discrepancies with what they have told us, or allow us to confront denial and address incomplete reporting. However, perusing our patients’ online profiles could negatively impact treatment and adherence. Patients may choose to portray themselves differently on their online profiles, and their identities often cannot be confirmed. Even if some information is accurate, we might discover things that we did not expect to learn about our patients, including important information that they did not share. Significant problems they are currently experiencing, or even something they lied about. This can create ethical dilemmas of what to do with the information and whether it should be addressed immediately or at a future session.

Despite their online activities being displayed for the world to see, our patients may not expect us to access their online information. They might perceive such perusal as a breach of trust, which can lead patients to view the doctor-patient relationship as adversarial. Accessing this information could also create a more intimate relationship than intended. Even if we acquire their consent to perform a search, our patients may still feel coerced into allowing it because they might feel that declining to grant permission would make us suspect that they have something to hide, or that we would search without their consent. In addition, if our patients are aware that we are monitoring them, they might change their behavior. For example, they may delete certain data, add additional information that may not be accurate, or censor future social media posts. Knowing that we could be paying attention to them online might motivate patients to act out or become withdrawn.

Breaches of patient privacy can occur when posting information, photos, videos, or comments concerning our patients to a social media platform. These breaches can lead to legal action against us as well as adversely affect our credentials and licensure. There is a vast amount of information that is available for us to peruse; however, perusing that information might require excessive time and effort, or divert attention from more productive therapeutic interventions.

**7 PRACTICAL TIPS AND GUIDANCE**

We would like to offer evidence-based objective guidance; however, this guidance is not available. Various medical organizations, such as the American Medical Association, have released guidelines regarding the professional use of social media. However, because these are guidelines, they are not requirements and are subjective. The following is based on our subjective personal experience as well as synopses of existing guidelines.

1. **Determine your purpose.** Determining the purpose for your social media presence is an important step in focusing your efforts. Who do you want to reach? What topics are important to you? From daily affirmations to starting conversations about public policy, tailor the information and use platforms that reach your target audience. Make sure anyone who will be posting for the practice understands the purpose and conveys that same message.

2. **Brand your practice.** Maintaining consistency in the look and feel of your social media accounts helps your brand become recognizable. From the use of a logo, colors, font, and the overall tone of messages, match your brand to your purpose.

3. **Post relevant content at regular intervals.** Regularly post content that serves your purpose. Keep it positive, respectful, and professional (and spelled correctly). Ensure information is accurate. Avoid complaining, using casual language, referencing patients, and oversharing personal information.

4. **Separate personal from professional accounts.** Do not post personal information on professional practice accounts. Consider using a pseudonym for personal accounts. Set personal accounts to the highest privacy settings. Do not link/sync personal accounts with professional accounts. Be aware that posting your activities, whereabouts, etc., in real time may jeopardize your privacy and safety. Be aware that posts may automatically include your location information.

5. **Maintain confidentiality and privacy.** All social media interactions should comply with federal Health Insurance Portability and Accountability Act (HIPAA) and state privacy laws. Develop a social media policy to share with patients that includes how the practice uses social media and how privacy is maintained. At a minimum, the policy should inform patients that the practice and its employees will not accept friend requests from them nor will the practice and its employees follow them on social media platforms. Do not post patient information, pictures, or videos of patients without their written consent. Remember that de-identifying patient information may not be sufficient to remain compliant with HIPAA and/or state privacy laws.

6. **Develop and maintain boundaries.** Do not engage in conversations about specific medical issues with patients or non-patients on social media platforms. Do not search your patients’ social media profiles unless it is discussed beforehand and part of the overall treatment plan. Do not reach out to patients via social media platforms. Remember that any information you post is a reflection of you and your practice and can have unintended consequences on your reputation and career.

7. **Deal with negativity in a consistent and professional manner.** Before addressing negative comments or responding to cyberbullying, gather all relevant information. Respond in a kind and compassionate manner or ignore the comments altogether. Make sure all staff posting to the practice’s social media accounts understands how to handle negative comments and cyberbullying. Review comments before they are visible to the public or consider turning off comments entirely. Support others publicly and privately when they are the victims of cyberbullying.
Turning a Negative Into a Positive
Ways to Avoid and Overcome Negative Reviews

John Luo, MD

The Internet has transformed the way we get information. No one uses the telephone book anymore to find a phone number or a physical map to determine traveling directions. Smartphones and tablets have even supplanted laptop and desktop computers as the portal to the vast amount of information available online. Typing is not necessary — calling out “Hey Siri” and “Hey Google” have become the preferred method of finding information on these devices. Perhaps librarians are at risk of becoming an endangered profession as the public has become more dependent on digital assistants to find the information that they need.

Online information has been transformed
Thirty years ago, websites were mostly about distribution of information, usually curated by someone who may have been an authority in that arena but not necessarily so. The concept Web 2.0 may be largely forgotten, but it highlighted how the Internet and software have changed to harness collective intelligence or knowledge of the masses as well as how the web has become a platform.1 Blogs are a great example of the web as a platform. Technology has enabled everyone to put their opinion and other comments online and made them easier to find. Amazon has changed the retail industry as a platform for commerce, helped in part by its presentation of customer reviews and ratings as well as questions and answers that facilitate purchase decision making.

Physician rating sites
It is no surprise that finding health information online is a common activity. Google Trends has shown that since 2004, 70% of queries on average are health-related.2 Insurance companies use the web to provide information about health plan benefits as well as providers in their network. Searching for psychiatrists is even easier by entering the terms “psychiatrist,” “desired city,” and “appropriate state,” in any Internet search engine. This search also reveals a new web resource — the physician rating site.

Physician rating sites are just what you would imagine. The sites allow individuals to review their physician and add their opinion. Many of these websites list information such as where the physician trained (eg, medical school, hospital affiliations, board certifications), and what insurance plans he or she accepts. Some of this information comes from the American Medical Association while other information comes from partner websites such as Doximity.com. Healthgrades will conduct a background check that includes disciplinary actions, malpractice claims, and board actions.3

The majority of these sites use metrics to rate the psychiatrist, such as how easy it is to make an appointment, the friendliness of the staff, promptness of the physician, and how much time he or she spends with the patient. A typical rating scale ranges from zero to five stars. More significantly, an open comments section provides a platform for patients to state whatever they wish. Some sites allow anyone to rate and remain anonymous, while for other sites a valid email address is necessary to post reviews.

The implications of reviews are straightforward. Positive reviews help the online reputation of the physician, potentially increasing the number of patients who will contact the office to set up an appointment. Negative reviews will do the opposite. Many of these physician rating sites suggest several physicians with higher ratings for the prospective patient.

Implications of negative reviews
Given the impact on both reputation and referrals, what can physicians do to address this situation when negative reviews appear? One strategy is to hire a lawyer and sue the patient, which a New York gynecologist did when a patient posted negative reviews on Yelp.4 The patient took down the negative reviews, but the lawsuit persisted because the doctor stated that he suffered defamation, libel, and emotional stress. While this strategy may sound just and appropriate, in the field of mental health, some would consider this approach to be a bit draconian.

Hiring a professional firm such as Reputation Defender might also make sense.5 This firm says that they can help with search engine optimization so that positive reviews stay at the top search result and negative reviews are found on the last pages of the search. They accomplish this approach by creating new content and using metadata and link content on these pages to increase the presence of this content. However, this service comes at a cost of $3,000 to $25,000 per year depending on the number of personalized websites, professional content, and unique direct website desired. Keep in mind, they do not delete negative reviews, but help physicians to “bury” them.

Similarly, many of these physician rating sites offer premium accounts in addition to the free ones. Besides providing higher search result placement, they offer additional tools that may mitigate the negative review. They do not allow for negative reviews to be deleted as that practice would impact the integrity of the review platform. Instead, they improve attention to the profile by eliminating advertising and competitor ads. Healthgrades Advanced is $65 per month and Healthgrades Premium is $780 per month. Healthgrades Premium also provides the ability to promote your practice profile on other physician profile pages as well as to be featured on the website. Patient testimonials are utilized to combat anonymous negative reviews.

What you can do
The solutions discussed above involve a significant investment of time, energy, and capital. There are other options available with a little effort. While it may appear to be colluding with the enemy, physicians should claim their profile on the various physician rating sites. One reason to do so is that there may be erroneous information about your practice that may impact how patients perceive your practice.

Another reason is that a more accurate site will be higher on search engine hits. It sounds counter intuitive to help a site with negative reviews appear higher in search findings, but it is better exposure for your practice online. One thing to consider regarding negative reviews is that if the comments are full of vitriol, then many rating sites will consider removing these posts because they don’t wish to be perceived as a platform that enables scathing comments because it will...
diminish their reputation as well. They believe that a negative review should be factual such as “the psychiatrist was a jerk and didn’t give me the time of day.” It is common knowledge that most patients who post reviews are those who are dissatisfied with the service. Often, the psychiatrist knows exactly which patient wrote the anonymous post because of an identifying feature. For example, the patient didn’t get the medication he or she was seeking.

While it sounds like making lemonade out of lemons, it is important to keep in mind that prospective patients who read a negative review regarding denial of medications and decide to not make an appointment are likely patients whom you may not want as a patient anyway. A savvier prospective patient may choose to make an appointment with you because he or she understands that the person who wrote the negative review may have an ulterior motive such as drug seeking and find that the you were correct in declining to participate in the abuse.

You may be tempted to ask patients that you know appreciate your care to post reviews to drown out the negative ones. This strategy sounds appropriate, but it is risky because asking patients for reviews may be a boundary crossing in the psychiatrist-patient relationship. It is better to have a card or sign in the office waiting room with a link to a physician review site for all reviews, not just positive ones. Likewise, office staff should not prompt or remind patients to review the practice, which will appear to be coercion.

Staff and other colleagues could technically post positive reviews as well, but that would be disingenuous. Unlike retailers who often respond to negative reviews online, it is recommended that physicians and staff do not respond to reviews online because a response may lead to a HIPAA privacy breach because of the public nature of such communications. Instead, if a physician can ascertain the identity of the patient who posted a negative review, it is reasonable to engage with the patient in person with an open and nonconfrontational manner to better understand the patient’s concerns.

**Conclusion**

It is easy to create your own content online without spending extravagant amounts of money. A blog that highlights your professional activities or articles that you find interesting to read is easy to create on services such as WordPress. Registering a URL is fairly inexpensive, and today’s technology has made website creation easy without any programming skills.

By creating a website with links to physician rating sites that have more positive reviews as well as other social media such Twitter or LinkedIn, these sites will be placed higher on search engine hits over time. These “homemade” tactics will work just like hiring a professional service, no different from deciding to change the oil in the car yourself versus going to an automotive service shop.

The sting of negative reviews online hurts both professionally and personally. Feelings such as betrayed, shame, or disgust will certainly be evoked by negative online reviews. It is all too easy and understandable to fall into the void of negativity. However, you must remain objective and process your feelings. It is helpful to commiserate with trusted colleagues, especially those who have experienced the same situation. The challenge is to take that leap of faith that your colleagues won’t judge you but have empathy for your negative experience. Stay positive and well-balanced, understand that there are many patients who have benefited from your care and typically the disgruntled few use the physician rating forum to vent and bully you.

Given that social media can be taken out of context, it is better to share in person than to vent online with your peers. The court of social media is often too quick to judge before all the facts are available. For that reason, while it may be tempting to be open and share your feelings and experiences on all your posts, it may be wise to stay professional and neutral to political and social issues. Unfortunately, it comes down to the perception—not the intent of your post, which you have little control over.

Damage to your online reputation is unfair and much too easy to accomplish with the easy to use tools that the Internet has today. It is important to be resilient and keep in mind that it is a new climate to which we must adapt. Bullying hasn’t gone away but has found a new avenue on the Internet. We can take some comfort in that physician rating sites today have an Achilles’ heel. There are too many of them and most practices and physicians have a paltry number of reviews.

**Conflict of Interest Form**

Richard M. Berlin, MD

They ask me to sign
the moment before
my poetry reading
and I comply,
though I don’t let on
my conflicts are
my greatest interest—
how I profit from sickness,
the way I can be both
detached and concerned,
that my most inspired device
is to marry psychiatry’s science,
without conflict,
to the poetry of healing.

Dr Berlin is Instructor in Psychiatry, University of Massachusetts Medical School, Worcester, MA.
Disability: Overview of Concepts Psychiatrists Need to Know

Barbara Long, MD, PhD, Andrew O. Brown, MD, Sean Sassano-Higgins, MD, and David “Daven” E. Morrison, MD, for the Committee on Work and Organizations, Group for the Advancement of Psychiatry

As in the case of “Bob,” whom you met in our previous article in the April 2019 issue, patients frequently ask psychiatrists to be “put on disability.” Such requests typically require that the psychiatrist complete documents confirming the patient’s inability to work. While patients claim work incapacity for a variety of reasons, in claiming disability patients are separating themselves from a situation, event, or demand at the workplace. The patient may have difficulty completing work-related tasks or may feel the need to avoid the workplace for some other reason.

Although patients are typically self-directed in their decision to seek disability, it is not uncommon for patients to lack an understanding of the intent and purpose of “disability” programs. It is also common for human resources personnel to advise employees to claim disability when a workplace problem is brought to their attention. This article discusses the risks of supporting versus withholding support for a patient’s disability claim and six key definitions psychiatrists need to understand when they are asked by patients to support such a claim.

**Responding to the patient who claims disability**

Requests for disability may induce a range of reactions in psychiatrists. Positive feelings arise when the request impresses the psychiatrist as reasonable or indicated, or when such requests gratify the psychiatrist’s inclination to advocate for a patient in need. Negative feelings can also occur if treaters feel that their services are being used inappropriately, or if they feel the request is opportunistic, counter-productive, or counter-therapeutic. Because countertransference reactions can be intense, best practices involve psychiatrists’ being aware of the emotions that arise when a patient asserts disability.

**Disability**

Disability is a legal and administrative construct that refers to an individual’s eligibility to receive benefits from an institution, government, or society at large. Because one’s eligibility to receive benefits is contingent upon the terms of specific contracts, laws, and policies, disability is not a medical or clinical concept. Government agencies (such as the Social Security Administration), insurance companies, or the courts—rather than physicians—determine whether an individual is disabled.

**Functional impairment.**

Functional impairment is present when a pathological condition has weakened or damaged an individual’s capacity to execute a mental function. A delusion, for example, can impair an individual’s judgment and ability to make sensible decisions, while mania can impair behavior and impulse control.

Although functional impairment can be attributed to a psychiatric diagnosis, functional impairment does not in itself constitute a diagnosis. Moreover, a psychiatric diagnosis does not necessarily result in a functional impairment that precludes employment. For example, the vast majority of patients seen in a typical outpatient psychiatric practice have a diagnosis of a psychiatric disorder, but only a very small percentage have symptoms that would preclude the ability to engage in gainful employment.

**Restriction.**

Restriction is a type of activity that an individual should not perform because performance of such activity can be reasonably expected to worsen an illness or disease. It may be reasonable to restrict an individual with bipolar I disorder from performing irregular work shifts, for example, because disruption of the patient’s sleep–wake cycle can be reasonably expected to exacerbate the disorder.

**Limitation.**

A person with a limitation has a compromised capacity to perform an activity due to the presence of a specific functional impairment. For example, an individual who manifests profound levels of psychomotor retardation attributable to severe Major Depressive Disorder may be limited in his or her capacity to arrive on time for their scheduled work hours.

**Impairment versus disability.**

An individual may manifest impairment, restrictions, and limitations and yet not be prevented from performing the duties of his occupation. For an individual to manifest disability as a result of impairment, the identified impairment would need to be considered occupationally relevant. For example, individuals with functionally impairing levels of social anxiety disorder may be limited in their capacity to give presentations, but if their occupation does not require that they give presentations, such impairment and limitations would not preclude them from performing the duties of the job. When adjudicating such claims would probably acknowledge that these individuals are “impaired” but would not consider them “disabled.”

**SIX KEY DISABILITY-RELATED DEFINITIONS**

1. **Disability.** Disability is a legal and administrative construct that refers to an individual’s eligibility to receive benefits from an institution, government, or society at large. Because one’s eligibility to receive benefits is contingent upon the terms of specific contracts, laws, and policies, disability is not a medical or clinical concept.

2. **Functional impairment.** Functional impairment is present when a pathological condition has weakened or damaged an individual’s capacity to execute a mental function. A delusion, for example, can impair an individual’s judgment and ability to make sensible decisions, while mania can impair behavior and impulse control.

3. **Restriction.** Restriction is a type of activity that an individual should not perform because performance of such activity can be reasonably expected to worsen an illness or disease. It may be reasonable to restrict an individual with bipolar I disorder from performing irregular work shifts, for example, because disruption of the patient’s sleep–wake cycle can be reasonably expected to exacerbate the disorder.

4. **Limitation.** A person with a limitation has a compromised capacity to perform an activity due to the presence of a specific functional impairment.

5. **Impairment versus disability.** An individual may manifest impairment, restrictions, and limitations and yet not be prevented from performing the duties of his occupation. For an individual to manifest disability as a result of impairment, the identified impairment would need to be considered occupationally relevant. For example, individuals with functionally impairing levels of social anxiety disorder may be limited in their capacity to give presentations, but if their occupation does not require that they give presentations, such impairment and limitations would not preclude them from performing the duties of the job. When adjudicating such claims would probably acknowledge that these individuals are “impaired” but would not consider them “disabled.”

6. **Short-term versus long-term disability.** Patients may have a condition that prevents them from working at a current job but that does not prevent them from working in a different position (such as for a different manager, boss, or employer). Short-term disability is often used when individuals experience a problem that prevents them from performing their job duties under their current employer but not necessarily under a different one. Two problems typically ensue when an individual transitions from “short-term” to “long-term” disability status. First, the likelihood that the patient will ever return to work in his or her occupation (or gainful employment in general) is sharply reduced. Second, the terms governing the patient’s disability status change. For example, the patient’s claims may be adjudicated based on whether the patient can perform the duties of an occupation anywhere or whether he or she can complete the duties of the occupation and/or the specific job under a specific employer.
Meet & greet.

Come meet the editor-in-chief of *Psychiatric Times* at the APA Annual Meeting! **John J. Miller, MD** will be available on Sunday, May 19, 2019, from 11 AM to 1 PM in our booth, #1424.
Introduction to Immunotherapy of Malignancies for Psychiatrists

Janet Charoensook, MD and Susan Turkel, MD

The immune system has an essential underlying role in both physiological and pathological conditions. The immune response is the result of the complex interaction of inflammatory cells and circulating humoral factors, which trigger immune surveillance, immune defenses, and the healing processes that are crucial for survival.

In recent years, immunotherapies have become increasingly effective options for cancer treatment, but they can also lead to abnormal immune reactions and adverse effects ranging from minor to severe toxicities against crucial organ systems, including the brain. Cancer immunotherapy was first attempted with nonspecific immune stimulation using Bacillus Calmette-Guérin (BCG) or vaccination against other infectious agents with limited success. Treatment with immune modulating cytokines such as interleukin and interferon proved effective, and identification of tumor specific antigens led to attempts at active immunization of the patient with better results. The newer methods of adoptive cell transfer and blockade of immune checkpoints show additional promise.

Traditional cytotoxic chemotherapy is the most commonly used and generally most effective class of antineoplastic agents. It acts by targeting rapidly dividing malignant cells. The adverse effects of chemotherapy are related to antimitotic effects on normal cells while simultaneously targeting the malignant cells. Immunotherapy can often bypass these toxicity problems and may be more effective in selected patients, but it can also result in its own toxicity, including adverse neuropsychiatric consequences.

The immune system normally detects cancer by recognizing antigens expressed by cancer cells but not by normal cells. These tumor-associated antigens may be neoantigens unique to the tumor. As it became easier to sequence cancer genomes, it was hoped that vaccines that target them could be developed to generate a more robust immune response to the tumor antigens. It is important for psychiatrists to be aware of potential neuropsychiatric toxicities and complications to be able to distinguish them from primary psychiatric disorders.

It is important for psychiatrists to be aware of potential neuropsychiatric toxicities and complications to be able to distinguish them from primary psychiatric disorders.

Cytokines

Many of the functions of the immune system are mediated through the production of small proteins called cytokines. These proteins include interleukins, interferons, and tumor necrosis factor. Cytokines modulate the highly complex, interconnected inflammatory response depending on clinical, physiological, and immune factors. Chemokines are locally acting cytokines that enhance the migration of inflammatory cells, and lymphokines are mediators that are produced transiently during an immune response.

Cytokines have major effects on cerebral function and affect sleep patterns, mood, behavior, cognition, and memory. Cytokines can inhibit acetylcholinergic pathways, resulting in delirium. Interleukins 1 and 2 (IL-1, IL-2), interferon (IFN), and tumor necrosis factor (TNF) can trigger excitatory CNS effects including agitation, delirium, delusions, hallucinations, and seizures. Patients receiving IL-2 or IFN-α for cancer treatment have experienced hypotension, multiorgan failure, and severe neurotoxicity with cognitive, behavioral, and mood symptoms.

IFN-α has been used for over 30 years to treat myeloproliferative disorders. It can induce cell differentiation and cell death, and it can inhibit cell proliferation and angiogenesis required for tumor growth. IFN-α therapy for cancer has been associated with autoimmune disorders of vitiligo and diabetes and can aggravate preexisting autoimmune disease. Although IFN-α can be an effective antitumor agent, its use has been limited by its toxicities.

IL-2 is a cytokine that plays a major role in the growth and proliferation of immune cells. Trials of high dose IL-2 to treat a variety of disorders, including malignancy, began in 1985 and IL-2 has proved to be an important immunotherapy cytokine for the treatment of cancer. IL-2 induces activation of lymphocytes and their differentiation into lymphokine-activated killer cells, which can recognize and eliminate tumor cells. By inducing systemic inflammation, IL-2 can exacerbate autoimmunity or trigger it de novo.
aerosolized IL-2 has enabled localized delivery directly to the lungs resulting in less systemic effects, higher local immune cell activation, and greater antitumor effect in patients with primary lung cancer and pulmonary metastases.6

The use of IL-2 has been limited by systemic toxicities, including the capillary leak syndrome (CLS). It can occur following administration of cancer drugs, bone marrow transplant, and IL-2.7 In patients with CLS, fluid from the circulatory system leaks into the interstitial space and results in edema, hypotension, hypoalbuminemia, hemococoncentration, dyspnea, circulatory shock, cardiopulmonary collapse, and multiple organ failure. Prophylactic pretreatment with intravenous immunoglobulin and supportive therapy with careful fluid management are of clinical benefit when CLS occurs.

Adaptive cell therapy
Adaptive cell therapy is based on infusions of autologous T cells to mediate an antitumor response. Chimeric Antigen Receptors (CARs) are synthetic receptors for T-cell antigens that redirect the specificity and repurpose the function of the T cells onto which they are genetically introduced. Chimeric antigen receptor T cells (CAR-T) are the patient’s own T cells modified using viral vectors to express these CARs.

CAR-T cells were first made in 1993 and represent a form of adoptive cell therapy. To make CAR-T cells, lymphocytes are harvested from a tumor biopsy or a resected tumor. These lymphocytes are then grown in vitro with IL-2 and reinfused into the patient after the patient’s T-regulatory cells are eliminated. The infused CAR-T cells retain their cytotoxic activity and recognizing tumor antigens, eliminate the malignant cells.

Currently, CAR-T cells are usually CD19 specific, and they target and lyse CD19 positive cells in both normal and malignant B cell lineages. CD19 is a cell surface antigen unique to B-cells, thus specifically targeting CD19 is effective for B-cell leukemias and lymphomas even in patients with a high tumor burden. Moreover, treatment with CAR-T cells has yielded high remission rates in patients with other refractory, relapsed disease, including acute lymphoblastic leukemia, chronic lymphocytic leukemia, and non-Hodgkin lymphoma.8

Adverse events following infusion of CAR-T cells are reversible in most instances, although they often require specific medical intervention and transfer to intensive care for support and management. The most common adverse effect is cytokine release syndrome (CRS). It typically begins within the first week after T-cell infusion and follows the in vivo proliferation of the infused CAR-T cells.

CRS occurs in 13% to 43% of patients and is characterized by high fever, cardiac dysfunction, hypotension, dyspnea, respiratory compromise, hypoxia, and multiorgan failure. The severity of CRS may range from mild to severe life-threatening multiorgan failure. Corticosteroids are considered the main treatment for CRS, but they are toxic to infused CAR-T cells, which limits the outcome of CAR-T treatment as well as the efficacy of corticostereoid treatment itself.

Rarely, severe CRS can evolve into fulminant hemophagocytic lymphohistiocytosis. It is related to tumor burden and cell lysis and is associated with elevated levels of inflammatory markers such as ferritin, C-reactive protein, lactate dehydrogenase, IFN-γ, soluble IL-2 receptor, and IL-6.

Neurologic toxicity is the second most common toxicity associated with CAR-T therapy. It is distinct from CRS and has been termed “CAR-T-cell–related encephalopathy syndrome (CRES).” It appears to result from endothelial dysfunction and increased blood brain barrier permeability, and is associated with headache, seizures, confusion, agitation, delirium, hallucinations, aphasia, and myoclonus, and may require hospitalization in an intensive care unit. The management of CRES neurotoxicity has been non-specific, generally emphasizing supportive care. Antipsychotics are effective for agitation, delirium, and psychotic symptoms associated with CRES.

New engineering modalities may further enhance the efficacy and safety of CAR-T cells. Modifications in the way CARs are made to allow destruction of CAR-T cells when serious toxicity occurs have been suggested, but they have increased the risk of graft-versus-host disease.9 Recent FDA approval of CD19 CAR-T cells for acute lymphoblastic leukemia and non-Hodgkin lymphoma will likely lead to expanded use of these therapies to physicians without prior experience in managing toxicities, increasing risks of adverse consequences and problems in management.

Melanoma antigen gene (MAGE) proteins are a large group of proteins expressed in reproductive tissue and a wide variety of cancers. These proteins are associated with aggressive cancers, a worse clinical prognosis, increased tumor growth, and increased metastases.10 Adoptive cell therapy using autologous anti-MAGE-A3 engineered T cells has been attempted. The patients experienced clinical regression of their cancers, but Parkinson-like symptoms and mental status changes were noted, and a few patients lapsed into coma and subsequently died. MRI showed perivascular leukomalacia, and autopsy showed necrotizing leukencephalopathy with extensive white matter defects, widespread neuronal cell destruction and lymphocyte infiltration in the brain parenchyma.7

Immune checkpoint inhibitors
Immune checkpoint inhibitors are normal inhibitory signals in the immune system that maintain self-tolerance and modulate immune response. Cancer cells can bypass immune checkpoints and immune surveillance, which interferes with the patient’s normal immunologic ability to recognize and destroy cancer cells. Checkpoint inhibitors are monoclonal antibodies that block specific immune checkpoint molecules that antagonize immune inhibitory pathways and promote immune activation by removing or blocking the inhibitory signals. Immune checkpoint inhibition has been effective and safe in patients with solid tumors and some hematologic malignancies, resulting in both long-lasting tumor responses and adverse effects.11

The most prominent checkpoint blocking target is cytotoxic T-lymphocyte-associated protein-4 (CTLA-4).12 CTLA-4 is a potent inhibitor of T-cell activation that helps maintain self-tolerance. Anti-CTLA-4 antibodies result in activation of T-cells and initiate an anti-tumor response. While the therapeutic blockade of CTLA-4 enhances anti-tumor immunity, it may also inadvertently increase the likelihood of paraneoplastic neurologic disorders due to antibodies against tumor associated antigens that cross react with neurologic cells.

Endocrinopathies associated with CTLA-4 blockade occur with either hormone excess or deficiency, and one or more endocrine glands can be affected sequentially or simultaneously.
Most adverse effects of CTLA-4 blockade usually resolve after several weeks. Mild liver and gastrointestinal effects respond to steroids, and mild dermatitis is usually managed by antihistamines, but more severe intestinal perforation and toxic epidermal necrolysis have been described. Endocrinopathies associated with CTLA-4 blockade occur with either hormone excess or deficiency, and one or more endocrine glands can be affected sequentially or simultaneously. They are mostly irreversible and require long-term hormone therapy.

Programmed cell death protein 1 (PD-1) is an immune checkpoint regulator that helps prevent autoimmunity and uncontrolled inflammation in chronic infections. Inhibition of PD-1 has been used to treat melanoma, lung cancer, and renal cell carcinoma. Adverse effects include fatigue, pruritis, rash, diarrhea, colitis, and pneumonitis.

Checkpoint inhibitors are associated with a unique group of autoimmune conditions called “immune-related adverse events.” These include neutropenia, thrombocytopenia, red cell aplasia, hemophilia A, orbital inflammation, uveitis, keratitis, lupus nephritis as well as a range of potentially severe neurologic toxicities the affect the central and peripheral nervous system, including myositis, myasthenia gravis, Guillain-Barre, and encephalitis with altered mental status. These conditions are usually responsive to corticosteroids, plasmapheresis, and IV immunoglobulin.

**Conclusion**

There has been significant improvement in the outcome of many malignancies from increased understanding and application of the anti-tumor immune system and subsequent development of new immunotherapy approaches, which have required balancing anti-tumor immunity and immune toxicity.

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Priests, Providers, Protectors

*Continued from cover*

once upon a time, the role of physician and priest were intimately connected. I use the term “priest” in the broadest sense, without reference to a particular religion, to denote “...one authorized to perform the sacred rites of a religion, especially as a mediatory agent between humans and God.”

In this essay, I contrast the physician’s priestly role with that of the modern-day, medical “provider.” I then develop a third way of seeing the physician that preserves the gravity, dignity, and authority of the medical profession while recognizing that the patient’s autonomy is an increasingly important medical ethical value.

**The physician as priest**

According to the Encyclopaedia Judaica, medicine and religion were closely connected for Jews in ancient times. Priests were “the custodians of public health,” and Jews in biblical times regarded the physician as “the instrument through whom God could effect the cure.” Accordingly, “Jewish physicians ... considered their vocation as spiritually endowed and not merely an ordinary profession.” Moreover, Jewish history is replete with a “...long line of rabbi-physicians that started during the Talmudic period [ca. 2nd to 6th century BCE] and continued until comparatively recently.”

Hippocrates—the “Father of Medicine”—also practiced in a context that fused medical and priestly roles. Indeed, Hippocrates “...learned through a network of physicians belonging to an established guild...in a master-apprentice relationship among a cadre of priest-physicians known as the Asclepiads. The cult of Asclepius, the hero-god of medicine and healing, would eventually gain widespread acceptance in Greek and Roman culture, with devotion to this deity lasting well into the fourth century.”

The intertwined medical and spiritual functions of the physician are also found in the writings of the early Christian Church. Thus, St. Basil (ca. 329-379 CE), in a letter to the physician Eustathius, describes the “ambidexterous” role of the physician: “...your profession is the supply vein of health. But in your case, especially, the science is ambidextrous, and you set yourself higher standards of humanity, not limiting the benefit of your profession to bodily, but also contriving the correction of spiritual ills.”

Although the priestly functions of the physician have largely disappeared in modern times—with some justification, as discussed below—the religious and spiritual needs of patients have received increasing attention in the recent literature. As one review concluded,

> For many patients confronted with chronic diseases, spirituality/religiosity is an important resource for coping. Patients often report unmet spiritual and existential needs, and spiritual support is also associated with better quality of life. Caring for spiritual, existential and psychosocial needs is not only relevant to patients at the end of their life but also to those suffering from long-term chronic illnesses.

**The physician as provider**

As internist and Harvard professor Allan H. Golrell, MD, explained in a recent editorial, “...the term ‘provider’ first appeared in the modern health care lexicon as a shorthand referring to delivery entities such as group practices, hospitals, and networks. More recently, its use has expanded to encompass physicians, nurse practitioners (NPs), physician assistants (PAs), and perhaps others, especially those engaged in delivery of primary care.”

Dr Golrell notes that, on one level, this expansion “...is both logical and convenient, as it reflects the importance of a multidisciplinary approach to modern primary care delivery, extending beyond the traditional dyad of patient and physician.” But Golrell goes on to note that “...the term ‘provider’ has the potential for adverse consequences for primary care, calling into question the wisdom of its expanded use.” Specifically, he argues, “Designating all as ‘providers’ blurs important distinctions and creates confusion among team members as to roles, responsibilities, and specific contributions, compromising effective team functioning."

I agree with Dr. Golrell. But there are even more troubling problems with the term “provider,” as applied to physicians. As internist Suned Dhand, MD, and William J. Carbone (chief executive officer, American Board of Physician Specialties) argued in a letter to the American Medical Journal, the word “doctor” is over 2000 years old, aptly derived from the Latin docens, meaning to teach or instruct. “...In almost every country in the world, a medical doctor is considered to be among the most noble and prestigious professions, the title only conferred after one of the most rigorous university courses in existence. It is a privilege and honor to be one."

The word “provider” is a non-specific and non-descriptive term that conveys little meaning.

—Dr Dhand and Dr Carbone call for restoration of the “courtesy and respect that is due to a hardworking and dedicated profession.” That the term “provider” shows neither courtesy nor respect to physicians is revealed in a little-known but telling example from the history of Nazi Germany (for which I thank my colleague, Dr Mark Komrad). As related by pediatric professor Paul Saenger, MD: “In the 1937 issue of the Reichs MediZinal Kalender, a directory of doctors, the remaining Jewish doctors in Germany were stigmatized by a colon placed before their names.

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Their medical licenses were finally revoked in 1938. They could no longer call themselves ‘Arzt’ or ‘doctor.’ They were degraded to the term ‘Behandler,’ or, freely translated, ‘provider.’”

I am certainly not comparing the status of US physicians to that of Jewish physicians in Nazi Germany. However, I am comparing two usages of the term “provider,” and suggesting that, in both cases, there is a “degrading” of the physician’s status and stature. It is not merely that the ancient priestly mantle is stripped from the physician’s persona, which some might argue is a change long overdue. Rather, the term “provider” renders the physician little more than a functionary—a specialized and obedient drone who carries out the wishes and instructions of others.

The origin of the term “provider” (as applied to physicians) is roughly contemporaneous with the later years of the consumer movement, which began in the early 1960s and continues to this day. As I have argued elsewhere, this movement—notwithstanding its notable merits—has attempted to replace the term “patient” with the terms, “client” or “consumer.” Specifically, “...contemporary with the rise of the term “consumer,” the term “provider” has become a substitute in many settings for the terms “doctor” or “physician.” By labeling physicians as mere providers of services, the consumer movement—abetted by insurance companies, and sometimes by physicians themselves—may have undermined the historical role of physicians as teachers and healers who have answered a calling.

The great frustration engendered by these consumer-driven trends is summed up in these comments by family medicine physician Dr Stephen Zimmer:

[Patients] often just call in and actually TELL me what I’m SUPPOSED to call in for them. The physician’s role is to call the insurance company and ask permission to order a test... or to start a medication.... I have been a physician for several years and have seen the system change such that the doctor is actually a “Provider” and no longer a physician. And if I do actually suggest a treatment, medication, or procedure (which again, contrary to popular belief, does not benefit me in a financial way) I am often told by the insurance company that this cannot be done unless I can prove the benefit [emphasis is Dr Zimmer’s].

The physician as protector

I believe there is a “third way” of viewing the role of the physician—one that neither elevates the physician to the exalted (grandiose) position of “priest” nor denounces us to the level of mere “providers.” In the role I call the protector, the physician’s chief obligation is the safeguarding of the patient’s physical, emotional, and spiritual well-being.

As the patient’s protector, the physician does not embrace a false equality between his or her medical knowledge and that of the patient: the physician as protector is still the medical expert. However, the patient’s views, wishes, and perspectives are always treated with the utmost respect, and are never dismissed on the pretense of the physician’s “priestly” authority. Indeed, respect for the patient’s autonomy is a foundational value in the physician’s role as protector. As Surgeon C. Ronald MacKenzie, MD notes, “...the notion of the respect for autonomy of the patient has come to lie at the heart of Western medical practice and its ethics, replacing the legacy of medical paternalism of the physician.”

And yet, Marie’s addressing me as “Father” suggests that some older patients may find it difficult to relinquish medical paternalism. As Dr Mark Komrad has noted, “The priest-like status of doctors historically encouraged paternalism to which patients readily acquiesced.”

We are not priests, yet we are not simply providers of services.

Someday between the extremes of priest and provider beats the protective heart of medical healing.

To be sure, there are good reasons for abjuring the “priestly” role and affirming the patient’s autonomy as a central principle of medical ethics. On the other hand, some medical ethicists believe that the principle of autonomy has been carried too far in modern medical practice, sometimes compromising the other three foundational principles of medical ethics: beneficence, nonmaleficence, and justice. Komrad has observed that “...all illness represents a state of diminished autonomy. The ill are dependent on others such as physicians, if not for outright therapeutic ministrations then for their expert legitimation of their illness.”

Komrad goes on to argue that “...some paternalism is not only justified but is required in all therapeutic relationships due to the nature of illness and the sick role...[furthermore] Paternalism is not always incompatible with the principle of autonomy.” Komrad notes that medical paternalism may actually serve the justifiable goal of restoring the patient’s autonomy—and that this restorative function is medical paternalism’s sole justification. Indeed, a degree of benign paternalism toward, say, an acutely psychotic patient may be the only feasible means of restoring the patient’s autonomy.

Other medical ethicists have observed that autonomy is susceptible to over-valuation by some physicians. This privileging of autonomy runs the risk of ignoring the ethical constraints that have defined Hippocratic medicine for centuries, i.e., ignoring the deontological duty-based nature of medical ethics. For example, we would never tolerate a physician’s engaging in sex with a patient under active treatment, on the theory that the patient “autonomously” consented to, or sought out, a sexual relationship with the physician. On the contrary, we would view the physician as having committed a serious boundary violation, based on the principle of non-maleficence. In short: the patient’s autonomy must sometimes stop at the border of the physician’s fiduciary duties as protector.

Indeed, some ethicists have applied this argument to the very controversial issue of physician-assisted suicide. Thus, as Yang and Curlin put it:

If physicians were solely service providers who accommodated the self-determining choices of patients, then physician-assisted suicide would be logical if assisted suicide were justified. But the heart of the medical profession is not providing services. Rather, the physician’s constitutive professional role is to attend to those who are sick and debilitated, seeking to preserve the measure of health that can be preserved, and to help them bear the pain and progressive loss of autonomy and bodily function that illness often brings.

Conclusion

The professional role described by Yang and Curlin is at the core of the “third way” I have described—the role of the physician as protector. We are not priests, and we should not lay claim to the “God-given” power or authority of priests—which, as we well know, may be subject to abuse and exploitation. On the other hand, we are not simply providers of services, bowing obediently to an overvalued notion of the patient’s autonomy. In Dr Leon Kass’s pungent phrase, the physician is not merely “a highly competently hired syringe.”

Somewhere between the extremes of priest and provider beats the protective heart of medical healing.

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References

Spirit Chicken

Continued from page 2

refers to several pathologies, including depression, Down syndrome, and psychological/ intellectual dysfunction . . . including mental retardation. Causes are primarily attributed to organic problems . . . an external spell or spirit attack-possession, people breaking a taboo, defective family care and education, food deficiency, and use of contraceptives.

The report also offers insights into the care of the mentally ill—particularly those in remote villages.

Patients . . . were well treated . . . but they were not stimulated as families are not aware of potential improvements. Others were found chained but were washed, fed, and receiving some visits from former friends. Mal-treatment . . . occurs during some rituals that are supposed to expel bad spirits (eg, biting the patient). Mental [illness] is . . . an economic and familial burden, difficult to bear for some impoverished families.

Since that report was written, Laos has made significant improvements to its health care system. Between 1990 and 2015, for example, the maternal death rate plunged by 78%. Health units, staffed by villagers trained in basic care, have been established in most villages. And, a number of organizations have become a source of help—and hope—for those in need.

Among these is Reach Out Laos, the country’s first mental health, crisis, and suicide prevention helpline. Phone lines and a 24/7 Facebook chat provide a listening service staffed by trained volunteers who speak English and Lao and who make referrals when appropriate for people with a range of problems, from depression to drug and alcohol abuse or domestic issues.

BasicNeeds is a UK-based non-governmental organization that works with people with mental illness and/or epilepsy. Its Mental Health Innovation Network is a multidisciplinary group that promotes mental health and provides care for those with neurological and substance use disorders.

There are also at least two agencies dedicated to helping those who have lost loved ones or who have been mauled by bombs dropped on Laos during the Vietnam War (Sidebar). These agencies provide prosperous and other rehabilitation services to help heal the physical wounds.

Acknowledgement— I wrote this piece to honor the Lao and their beliefs, and I thank the people who told me their stories. I do not mean to imply that Western medicine is better or has all the answers. But as practitioners of Western medicine make inroads in that country, I hope these narratives offer insights into another way of thinking. I also want to thank Sandra Bode for her extraordinary input, and I share her hope that this piece might contribute to culturally sensitive approaches to spreading knowledge about mental health, and to combat stigma in a way that the Lao can adopt without feeling patronized.

World traveler, Susan Kweskin is the former Editorial Director of Psychiatric Times. She wrote this article at the invitation of Natalie Timoshin, Executive Editor.

References

Disability

Continued from page 20

litigation ensues, and the patient or attorney asks the treater to provide forensic expert opinions on diagnosis, causality, and “permanence of disability.”

Legal and licensure entanglements may ensue, eg, the psychiatrist may be asked on a disability application to swear findings are accurate under penalty of perjury.

Risks of Withholding Support

1. The patient may decide to sue.
2. The patient may decide to complain to the state medical board.
3. The patient may write negative online reviews.
4. Your decision may result in anger and possible violence on the patient’s part.
5. You may become a victim of countertransference with feeling of guilt: “I am a bad doctor for not supporting my patient;” “My patient won’t like me, he may decide to stop treatment.”

Psychiatrists must utilize specific concepts when they assess patients who claim work incapacity. Adequate understanding of the six key definitions on the previous page is critically important as such concepts guide assessment and treatment of the patient and will ultimately inform adjudication of the patient’s disability claim.

Approach to a functional assessment of claimed disability

The determination of disability requires an understanding of the specific tasks that an individual must complete to perform his or her occupational duties as well as an assessment of whether there is any functional impairment that would preclude the individual’s capacity to complete such tasks. Because psychiatric training is focused on establishing an accurate DSM diagnosis and on providing appropriate treatment, most psychiatrists lack adequate skills, training, and education necessary to perform an assessment of functional impairment (also known as a functional assessment). While DSM 5 is a useful means of categorizing mental disorders and can be used to guide appropriate treatment, it is far less useful as a guide to functional assessment.

Endorsement of disability by a physician has many consequences. Some of these consequences can be beneficial, but there are also negative unintended consequences that can ensue.

Unintended negative consequences of disability:
- Decline of mental health and mental functioning
- Social isolation and marginalization
- Negative economic, psychological, and social effects of unemployment
- Role duality resulting in ethical and legal risks for the treater supporting disability rather than recovery and health
- Loss of identity as working individual
- Loss of life structure conferred by regular participation in work activity
- Loss of sense of meaning and purpose
- Disruption of the connection between work and reward
- Mental and physical deconditioning due to inactivity

Dr Long is Committee Chair, Work and Disability Consultant Private Industry, the Courts, and the Legal Profession; Dr Brown is Department Psychiatrist, Boston Police Department, Consulting Psychiatrist, Boston Fire Department, Work and Disability Consultant, Private Industry and Government; Dr Sassano-Higgins is Adjunct Professor, Department of Psychiatry, University of Southern California; Dr Morrison is Clinical Assistant Professor of Psychiatry and Behavioral Sciences, Chicago Medical School.

Reference
Negative Symptoms in Schizophrenia
Etiology, Hypotheses, and Treatment Implications

Susana Da Silva, MSc, Sarah Saperia, Gary Remington, MD, PhD, and George Foussias, MD, PhD

The historical evolution of negative symptoms
The recognition of negative symptoms in schizophrenia dates back to the early works of Kraepelin and Bleuler, with clinical descriptions of emotional disturbance and volitional deterioration as central features of the illness. Although for much of the 20th century emphasis was placed on the assessment and treatment of positive symptoms, the 1980s saw a renewed interest in understanding and conceptualizing negative symptoms. While definitions are highly prevalent in individuals with schizophrenia. Typically emerging long before the onset of psychosis, these symptoms often persist throughout the course of the illness. Despite their importance in driving functional outcomes, however, effective treatment of negative symptoms remains elusive.

ACTIVITY GOAL
The goal of this activity is to provide a comprehensive understanding of the etiology, hypotheses, and treatment implications of negative symptoms in schizophrenia.

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

- Explain the historical bases for the understanding of negative symptoms
- Distinguish primary negative symptoms from secondary negative symptoms
- Identify the central feature of negative symptoms
- Understand the multi-faceted constructs of motivation deficits
- Discuss the current treatments for negative symptoms

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

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have varied over time, consensus from a National Institute of Mental Health (NIMH) Negative Symptom Initiative identified five core negative symptoms: affective flattening, alogia, avolition, asociality, and anhedonia. Recent efforts using factor and component analyses have allowed for an even more refined classification of negative symptoms as two separate, yet interrelated subdomains consisting of diminished emotional expression (ie, affective flattening, alogia) and amotivation (ie, anhedonia, asociality, avolition) reflected in the diagnostic criteria for schizophrenia in DSM-5.

The etiology of negative symptoms

Although many hypotheses have been proposed over the years, the etiology of negative symptoms in schizophrenia remains poorly understood. Neurobiological hypotheses of negative symptoms have focused on the role of dopamine, with evidence of hypodopaminergic dysfunction as well as structural and functional abnormalities in the frontal cortical regions of the brain. Specifically, studies have revealed relationships between negative symptom severity and volume reductions in the prefrontal cortex, temporal cortex, corpus callosum, and limbic structures as well as compromised white matter tract integrity. Negative symptoms have also been linked to ventral striatal reward system dysfunction, with more severe negative symptoms associated with reduced activation in the nucleus accumbens, orbitofrontal cortex, anterior cingulate cortex, and the dorsolateral prefrontal cortex.

The cognitive model of negative symptoms presents an alternate biopsychosocial approach that emphasizes the role of maladaptive cognitions in the development and maintenance of negative symptoms in schizophrenia. This model relies on a diathesis-stress hypothesis, which posits that individuals predisposed to the illness are more vulnerable to negative life experiences, and to the subsequent development of dysfunctional attitudes and beliefs.

Specifically, psychological attributes such as defeatist beliefs about performance as well as low expectancies for pleasure and success may lead to reductions in goal-directed behavior, which in turn permeate the affective and motivational impairments that are often experienced by individuals with schizophrenia. While these hypotheses, along with many others, have contributed to our understanding of the multitude of factors associated with the expression of negative symptoms, there has not emerged a definitive cause for their development in schizophrenia.

Primary versus secondary negative symptoms: a clinical conundrum

One of the challenges in uncovering the underlying etiology of negative symptoms in schizophrenia stems from the difficulty in distinguishing between primary and secondary negative symptoms. This distinction has its origins in the early works of Carpenter and colleagues in the 1980s. They defined primary negative symptoms as idiopathic features of the disorder that in a subset of individuals with schizophrenia represent an enduring characteristic of their illness (ie, the “deficit” syndrome), and secondary negative symptoms as iatrogenic, environmental, or illness-related phenomena (eg, extrapyramidal symptoms, neuroleptic dysphoria, positive symptoms, depression).

From a clinical perspective such a distinction is imperative because the differentiation between primary and secondary negative symptoms has important implications for treatment. Specifically, primary negative symptoms are more resistant to pharmacological interventions, whereas secondary negative symptoms are typically responsive to treatment targeting the underlying cause. For example, negative symptoms resulting from antipsychotic-induced extrapyramidal symptoms or dysphoria may be improved with a change in medication type or dosage. Similarly, affective or depressive symptoms—commonly mistaken for negative symptoms—may be effectively treated with an antidepressant medication. The clinical presentation of primary and secondary negative symptoms is often indistinguishable, thus, ascertaining the root cause of these symptoms typically requires thorough knowledge of the longitudinal course of the patient’s illness and treatment history.

Motivation deficits: the central link to functioning

In addition to differentiating between primary and secondary negative symptoms, it is necessary to keep in mind that the construct of negative symptoms consists of two distinct subdomains: diminished expression and amotivation. While both are important from a phenomenological perspective, it is amotivation that has been shown to represent the most critical feature of negative symptoms, with research consistently pointing to motivation deficits as the driving force linking negative symptoms to poor treatment and functional outcomes in schizophrenia. Moreover, compared with diminished expression, symptoms within the amotivation subdomain have been shown to be more prevalent and persistent in persons with schizophrenia.

The following is a typical case of an individual who endorses prominent negative symptoms, and in particular, motivation deficits.

**CASE VIGNETTE**

Mr A is a 21-year-old patient with schizophrenia diagnosed 3 years ago. He initially presented to the emergency department at the local psychiatric hospital with a 1-year history of functional decline that began in the summer after graduating high school. At that time, his parents noted that he became more withdrawn and isolated with gradually deteriorating self-care. This was followed by the emergence of auditory hallucinations and persecutory delusions that prompted his family to bring him for psychiatric assessment.

Mr A subsequently received treatment in a local early psychosis intervention program, where he experienced a good response to low-dose treatment with a second-generation antipsychotic. He has maintained treatment adherence and with no evidence of treatment-emergent adverse effects and has experienced full remission of psychotic symptoms. Despite this, however, Mr A has not been able to return to his premorbid level of functioning and continues to struggle with ongoing negative symptoms.

This case illustrates the clinical presentation of negative symptoms in schizophrenia, and the nature by which these expressive and motivational deficits pervade the lives of affected individuals. In particular, Mr A’s lack of interest and motivation to initiate and sustain goal-directed behaviors translate into poor functional outcomes across a number of domains including interpersonal relations and institutional role functioning. In the absence of mood symptoms, co-occurring substance use, or extrapyramidal symptoms, it would appear that he is experiencing primary negative symptoms.

Motivation deficits: a multi-faceted construct

The identification of motivation as a fundamental construct by the NIMH Research Domain Criteria (RDoC) further underscores the importance of this symptom domain, and the critical need to advance our understanding of the behavioral and neurobiological underpinnings of motivation deficits.

Current conceptualizations of motivation outline a multifaceted construct of inter-related reward processes, whereby reward responsiveness (ie, “liking”) and reward expectancy (ie, “wanting”) interact to inform both reward valuation and effort valuation. This is followed by decision-making and action selection to achieve a final motivated outcome. The following summarizes the behavioral and neurobiological findings that have emerged from examinations of isolated facets of motivation in schizophrenia.

Regarding reward responsiveness (ie, “liking”) in schizophrenia, there has existed a long-standing belief that the illness is characterized by anhedonia. However, this notion has been challenged by recent case-control studies revealing that patients with schizophrenia and healthy controls demonstrate statistically comparable levels of reward responsiveness or “in-the-moment” experience of
pleasure, along with evidence from neuroimaging studies suggesting intact ventral striatal responses to reward. Similarly, neurobiological investigations of reward expectancy (ie, “wanting”) in schizophrenia have demonstrated reduced ventral striatal activation in response to reward-predicting cues. Behavioral studies utilizing reinforcement-related speeding paradigms extend these findings, such that patients fail to modulate their behavior in response to reward cues. Given the inherent learning component involved in the prediction and anticipation of rewards, there have also been numerous investigations into reward learning processes in schizophrenia. These studies have revealed that patients exhibit intact gradual or procedural learning but impaired rapid reward learning in the face of changing feedback. In terms of reward valuation, or the appraisal of reward value, studies have shown that in the context of delay discounting paradigms, individuals with schizophrenia discount the value of future rewards more rapidly than healthy controls, particularly for longer-term delays.

Closely related to reward valuation is effort valuation, which refers to one’s willingness to exert effort in the context of cost-benefit computations. Studies using effort-based decision-making paradigms have shown that patients with schizophrenia demonstrate impairments in the ability to efficiently allocate effortful choices across different probability and reward levels. Lastly, action selection and/or preference-based decision making, as it relates to the planning and implementation of a desired goal, has also been examined with performance on gambling-based decision-making tasks suggesting impairments in schizophrenia. Neuroimaging studies have similarly demonstrated that individuals with schizophrenia exhibit reduced activation in the dorsolateral prefrontal cortex during these gambling tasks. Taken together, these findings underscore the importance of recognizing the mechanistic heterogeneity of amotivation, with different underlying impairments in one or more facets leading to similar clinical presentations of motivation deficits across individuals with schizophrenia. Thus, delineating the differential profiles of amotivation is an important step towards identifying specific targets for the treatment of negative symptoms in schizophrenia.

Current treatments for negative symptoms in schizophrenia

Antipsychotic medications have represented the cornerstone of treatment for schizophrenia since the discovery of chlorpromazine in the 1950s. Acting as D2-receptor antagonists, these antipsychotic medications have proven effective at treating positive symptoms, but unfortunately, have offered little benefit for improving the negative symptoms of the disorder. While the introduction of newer second-generation antipsychotics initially generated considerable optimism, ensuing clinical trials have offered little evidence for their efficacy in treating primary negative symptoms, with clinical improvements typically attributed to the amelioration of positive symptoms and/or secondary negative symptoms. Given the clinical parallels between depressive and negative symptoms in schizophrenia, the use of antidepressants has also been explored as a potential adjunctive therapy to antipsychotics; although evidence for their efficacy has generally been inconclusive, with findings suggestive of some small positive effects unlikely to translate into meaningful clinical improvements. The use of stimulant, glutamatergic, and cholinergic augmentation has similarly failed to demonstrate consistent benefits for treating negative symptoms in schizophrenia. Beyond pharmacological interventions, psychosocial strategies have been examined as potential treatments for negative symptoms. In light of the promising findings of cognitive-behavioral therapy (CBT) for depression and anxiety, there has been increasing interest in the potential of CBT interventions that target negative symptoms in schizophrenia, with recent meta-analyses revealing potential benefits for negative symptoms, albeit with small effect sizes. Moreover, cognitive remediation, although primarily designed to target the cognitive deficits of the disorder, has also been shown to have some moderate associations with negative symptom reduction. Lastly, non-invasive brain stimulation therapies including repetitive transcranial magnetic stimulation (rTMS) and transcranial direct current stimulation (tDCS) has gained momentum in the past decade as potential treatments for negative symptoms. rTMS has been extensively investigated in schizophrenia, with a number of studies and meta-analyses revealing small to large improvements, though not consistently. Research on the application of tDCS is still in its nascent stages, although early findings suggest that tDCS may offer some benefit for negative symptoms.

Conclusion

Negative symptoms—of which motivation deficits are a core feature—are prominent and pervasive in schizophrenia and currently represent an unmet therapeutic need. While several treatment modalities have been explored, their lack of broad efficacy to date may be attributed to a number of factors.

1. Most studies evaluating treatments for negative symptoms have relied on overall symptom severity scores as their primary outcome; however, this may be too crude a method to capture meaningful differences in specific symptom domains. That is, negative symptoms are not a unitary construct, but rather, a broad cluster of multi-faceted symptoms, and must therefore be examined and treated as such.

2. We continue to face with the challenge in distinguishing between primary and secondary negative symptoms. Moreover, our limited understanding of the pathophysiological underpinnings of negative symptoms inevitably restricts our ability to develop treatments targeting the specific underlying etiologies.

3. It is important to acknowledge the possibility that negative symptoms may be caused by a complex interaction of biological and environmental factors, and as a result, no single treatment may act as a panacea for negative symptoms.

4. Complementing symptom-targeted pharmacological therapy with psychosocial interventions may offer the most effective treatment strategy for ameliorating negative symptoms, and ultimately improving functional outcomes for individuals with schizophrenia.

References

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- **Modesto/Ceres, CA:** Schedule: Weekends (Saturday/Sunday). Pay Rate: $3,200 per weekend!
- **Oakland, CA:** Schedule: 20 hours per week Pay Rate: $140 - $187 per hour
- **Stockton, CA:** Schedule: 16 hours per week Pay Rate: $182- $205 per hour

For additional listings, please visit: [www.telecarecorp.com/physician-jobs/](http://www.telecarecorp.com/physician-jobs/)

You will work as part of a multidisciplinary team. The staff is all very friendly and it is a supportive working environment.

Please email your resume to tlcrecruiting@telecarecorp.com

EOE M/F/V/Disability

**The University of Miami Miller School of Medicine Department of Psychiatry and Behavioral Sciences**

The University of Miami also provides a moving bonus and faculty stipend. The UM Department of Psychiatry is ranked 29th in the nation in NIH funding and there are extraordinary opportunities to participate in research, resident education and medical school teaching. Position Requirements:

- **Medical transcription**
- **Computer Software**
- **Practice management**
- **Marketing**
- **Medical billing**
- **Internet Services**

For details call (203) 523-7026
To be considered for a position, please send a copy of your CV to Barbara J. Coffey, M.D., Professor and Chief of Child and Adolescent Psychiatry, UM Department of Psychiatry and Behavioral Sciences at psychiatry@med.umich.edu

Hackensack Meridian Health is a leading not-for-profit health care network in New Jersey offering a complete range of medical services, innovative research, and life enhancing care aiming to serve as a national model for changing and simplifying health care delivery through partnerships with innovative companies and focusing on quality and safety.

Through a partnership between Hackensack Meridian Health and Seton Hall University, the School of Medicine will re-define graduate medical education, research, and clinical practice; reverse the critical physician shortage in both the New York/New Jersey metropolitan area and the nation; and stimulate economic development in northern New Jersey.

The University of Michigan is an affirmative action/equal opportunity employer and believes that diversity, broadly defined, is integral to institutional excellence. Interested applicants should submit a letter of interest and CV to:

Sagar V. Parikh, MD, FRCPC at parikhsa@med.umich.edu

The University of Michigan is an affirmative action/equal opportunity employer and believes that diversity, broadly defined, is integral to institutional excellence. Interested applicants should submit a letter of interest and CV to:

Sagar V. Parikh, MD, FRCPC at parikhsa@med.umich.edu

Hackensack Meridian Health is seeking a Board Certified/Board Eligible Child and Adolescent Psychiatrist to join this growing team. With 4 hospitals in the top 10 ranking in New Jersey, this is an outstanding opportunity to join the area’s largest healthcare network.

Highlights:
• Academic Affiliations with the new Hackensack Meridian Health School of Medicine at Seton Hall University.
• Collaborations among multiple sites (statewide).
• Call is not required.
• Outpatient/Consultative setting.
• Competitive Salary.
• Comprehensive Benefits Package.

In addition to our collegial work environment, we offer a highly competitive compensation package which includes: medical/dental plans, 403(b) retirement plan, and relocation assistance.

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

HackensackMeridianHealth.org

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Chief Medical Officer – Community Healthlink
Worcester, MA

UMass Memorial Health Care’s Department of Psychiatry and its Community Healthlink (CHL) member institution is looking for a chief medical officer to help lead the largest provider of mental health services in Central Massachusetts.

The position involves supervision of a large group of professionals and participation in the executive team’s strategic, program and organizational development efforts. The ideal candidate will have a demonstrated commitment and passion for community psychiatry and an interest in a leadership role in advocating and promoting the wellbeing of traditionally underserved populations.

CHL has a long tradition of bringing excellent mental health and substance use disorder services to our city and region, from its inception as a community mental health agency to its current role as a key member organization at UMMHC. Its 1300 employees serve over 22,000 individuals each year and its programs assist patients across the life span. Medical staff are faculty members of the UMass Department of Psychiatry and employees of the medical group practice—they are vital contributors to the department’s missions of training, research, and clinical excellence. We believe this position will be a terrific opportunity for individuals committed to serving their community through the provision of high quality psychiatric care as part of mission driven teams.

To learn more about our Community Healthlink locations, please visit our website http://www.communityhealthlink.org/chl/

Interested applicants should submit a letter of interest and curriculum vitae addressed to:

Alan P. Brown, MD
Vice Chairman of UMMS Department of Psychiatry for BH Integration and Population Health
Clinical Professor of Psychiatry, Family Medicine and Community Health
c/o: Jessica Saintelus, Physician Recruiter
Jessica.Saintelus@umassmemorial.org

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

Private Practice Opportunity

Portland Oregon
A longstanding group of psychiatrists who share a philosophy of comprehensive treatment that includes psychotherapy is seeking colleagues to join us in our overhead and billing services cooperative. Offices are immediately available in a historic house as well as group health insurance is. Reduced rent while practice is built and a sharing of new patient referrals is available.

If interested, please contact our Office Manager, Deanne Gomez at 503-228-5909

 PENNSYLVANIA

The Penn State Hershey Medical Center Department of Psychiatry is currently recruiting board eligible/certified psychiatrists for inpatient and outpatient positions in both adult and child psychiatry. We are a growing, vibrant department in a strong academic medical center. We host specialty clinical and research programs, including research that crosses the translational spectrum. Our educational programs include adult psychiatry residency, child fellowship, psychology internship, externship and postdoctoral fellows. We have a strong collaboration with basic and clinical science in other neuroscience disciplines across several Penn State campuses. With our clinical partner, the Pennsylvanian Psychiatric Institute, the Department staffs several outpatient and partial hospital programs for children and adults, 89 inpatient beds, ECT and other neuromodulation services, specialty sleep and eating disorders programs, and expanding psychiatric consultation and integrated care programs for Hershey Medical Center. Successful candidates should have strong teaching as well as clinical skills and, optimally, potential for scientific and scholarly achievement. We offer an attractive compensation package commensurate with qualifications. Tenure-track positions are possible.

For consideration, send your CV to: Jenna Spangler Physician Recruiter Phone: 717-531-4271 Email: jspangler2@pennstatehealth.psu.edu

The Penn State Milton S. Hershey Medical Center is committed to affirmative action, equal opportunity and the diversity of its workforce. Equal Opportunity Employer – M/F/W/V/D

TENNESSEE

EAST TENNESSEE STATE UNIVERSITY

Quillen College of Medicine Department of Psychiatry & Behavioral Sciences

ADULT PSYCHIATRISTS, CHILD PSYCHIATRISTS

Two full-time positions available for Adult Psychiatrists who are BE/BC at time of hire, and/or Child Psychiatrists who are BE/BC at the time of hire in the subspecialty of Child and Adolescent Psychiatry. Positions may include inpatient and/or outpatient. Program activities include clinical care of patients combined with teaching and supervision of residents and medical students. Research and academic activities are encouraged. Salary and academic rank are commensurate with experience and qualifications. Salary is competitive with funding available through the Medical School and other sources.

ETSU is located in Johnson City, TN, which has the perfect blend of four mild and beautiful seasons, gentle mountains, a local theater, and a symphony orchestra. Come explore this idea family location with college/urban sophistication surrounded by national forests and beautiful parks. No state income tax, low cost-of-living, low crime rate, golf courses, and lakes.

Apply to the position at https://jobs.etsu.edu. Telephone inquiries should be made at (423) 439-2235 or e-mail at loveeaye@etsu.edu. AA/EOE.

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512-330-9507

VIRGINIA

Psychiatrist Opportunity

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

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

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

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

For more information, please visit:

www.swvmhi.dbhds.virginia.gov;
www.smythcounty.org;
www.abingdon-va.gov

WASHINGTON

Psychiatry Medical Director Opportunity Tacoma WA

• Available opportunities for medical director leadership, outpatient positions and consultative liaison.
• Part-time and full-time positions with competitive compensation package and the added benefit of no state income tax.
• Tacoma/Seattle is one of the most sought-after metro areas for relocation.
• 2019/2020 start dates

Arleen Richardson, MBA
RM Medical Search
5340 S. Quebec, Suite 320 S
Greenwood Village, CO 80111
rmmedicalsearch.com
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