Viswanathan Chosen APA’s Next President-Elect

APA’s next president-elect is a nationally recognized expert in psychiatry and population health and has an extensive background in education and research. He is chair of APA’s Presidential Workgroup on a Roadmap for the Future of Psychiatry. **BY CATHERINE BROWN**

APA’s voting members have elected Ramaswamy Viswanathan, M.D., Dr.Med.Sc., of Brooklyn, N.Y., as APA’s next president-elect. He ran against Robert L. Trestman, Ph.D., M.D., of Roanoke, Va.

Viswanathan is professor, interim chair of psychiatry, director of the consultation-liaison psychiatry and fellowship, and co-chair of the Faculty Wellness Committee at SUNY Downstate Health Sciences University. His research has been in physician communication, ethics, innovations in psychotherapy and pharmacotherapy, treatment adherence in gynecologic cancers, children’s sickle cell disease, HIV, and substance use.

Viswanathan has held numerous leadership positions within APA and other national organizations. He currently serves as the Brooklyn Psychiatric Society representative in the APA Assembly and is chair of the Committee on Consultation-Liaison Psychiatry for the Group for the Advancement of Psychiatry.

“I am honored that my colleagues in psychiatry have elected me to the APA presidency,” said Viswanathan. “I look forward to working together to further develop and expand our workforce and to keeping up our momentum on research and development of cutting-edge psychopharmacologic, neuro-interventional, and psychotherapeutic treatment and preventive approaches. We will also work together to advance physician wellness, reduce practice burdens, advocate for our patients and our profession, address inequities in health care, and promote appreciation of diversity and inclusion.”

“Congratulations to Dr. Viswanathan and the other candidates on their election,” said APA President Rebecca Brendel, M.D., J.D. “I look forward to working with him and all the newly elected APA leaders to advance psychiatric practice and APA’s leadership role in increasing access to care and improving the quality of mental health care.”

APA CEO and Medical Director Saul Levin, M.D., M.P.A., echoed those sentiments. “APA members and the profession of psychiatry will be well served by Dr. Viswanathan’s leadership and commitment. I want to congratulate Dr. Viswanathan and all the newly elected APA leaders.”

The race for secretary, which has a two-year term, was up for election this cycle. Gabrielle L. Shapiro, M.D., of New York City defeated Jenny L. Boyer, M.D., Ph.D., J.D., of Norman, Okla., and C. Freeman, M.D., M.B.A., of Marina Del Rey, Calif.

In the race for minority/underrepresented representative trustee, Kamaliya Roy, M.D., M.C.R., of Seattle emerged the winner. Her opponent was Dorinda Wang, M.D., of New York City. The term for minority/underrepresented representative trustee is two years.

Two of APA’s seven geographic Areas voted for their trustee in this cycle. Area trustees hold three-year terms.

APA Election on page 41

Register Now for APA’s Annual Meeting and View Program

Register today at psychiatry.org/annualmeeting to take advantage of low advance registration rates and reserve your hotel room. The program offers more than 600 scientific sessions and 20 CME courses. Keynote speakers include actor and mental health advocate Ashley Judd (see page 22; view her greeting at https://vimeo.com/779016570) and best-selling author Heather McGhee (see page 24; https://vimeo.com/779017635). Sharpen your skills and reconnect with your colleagues in one of this country’s most vibrant cities—San Francisco. Meeting information and the scientific program as of press time begin on page 22.
FROM THE PRESIDENT

Innovation & Collaboration Will Define 2023 Annual Meeting in San Francisco

REBECCA BRENDEL, M.D., J.D.

After four years, APA is returning to San Francisco for our 2023 Annual Meeting with a world-class program featuring 800 peer-reviewed sessions and courses and more than 1,800 posters. The theme, “Innovate, Collaborate, Motivate: Charting the Future of Mental Health,” is perfect for the timing and location, capping off the cutting-edge work of my Presidential Workgroup on a Roadmap for the Future of Psychiatry in the nation’s innovation capital. Under the extraordinary leadership of Eric R. Williams, M.D., as chair, our colleagues on the Scientific Program Committee have put together an incredible program that represents the best and most groundbreaking work in the world of psychiatry and mental health care. As the integration of innovation and technology into our practice and profession continues at a rapid pace, there is no better place to explore the opportunities for the future than in San Francisco. The proximity of our meeting to Silicon Valley, the global center of technology and innovation, is the perfect backdrop for the Annual Meeting programming focused on helping participants stay on top of the ways that technology influences diagnosis, treatment, and outcomes. Examples of highlighted sessions in the Technology Track include “Technologies to Advance Access to Mental Health: Social Media, Texting, and 988” and “Leveraging Technology to Enhance Mental Health Interventions.” Back again at this year’s meeting is the Clinical Updates Track; it debuted in New Orleans and proved to be very popular. Attendees will leave prepared with new tools that can be immediately implemented to provide state-of-the-art treatment and improve patient outcomes (see page 23). The sessions will cover current standards for the treatment of anxiety, depression, psychosis, and other mental disorders encountered in everyday practice. As a top travel destination in the world, San Francisco will play host to member physicians from all over the globe who are primed to share their unique insights and experiences with their U.S.-based colleagues. The International Medical Graduate (IMG) Track is designed to support international members at all levels of their careers integrate with and thrive in the U.S. health care system. Whether you are an IMG just out of residency, just about to begin your career as a psychiatry resident, or have been in the field for decades, it is truly something for everyone in this specialized track (see page 28). Even members who are domestic medical graduates will encounter educational opportunities in the IMG track, in sessions such as “International Medical Graduates in American Psychiatry: Past, Present, and Future,” a session dedicated to the history of IMGs, their contributions to psychiatry and APA over the years, and how they will be a crucial component of psychiatry’s future.

In keeping with the spirit of San Francisco, the following pages provide a snapshot of the variety of programming and professional opportunities available throughout the week. Please enjoy the programming that will help psychiatrists create a more equitable world.
COVID-19 Public Health Emergency To End in May

The host of restrictions that were waived on the use of telehealth during the public health emergency helped patients receive services, including mental health services, without leaving their homes. With the end of the emergency, those waivers will be lifted, and several pre-pandemic regulations will be back in effect.

BY MARK MORAN AND NICK ZAGORSKI

The Biden administration announced on January 30 that the COVID-19 Public Health Emergency (PHE), first issued in March 2020, will end on May 11.

During the PHE, a host of restrictions were waived on the use of telehealth to help patients receive services, including mental health services, without leaving their homes. With the end of the emergency, those waivers will be lifted, and several pre-pandemic regulations will be back in effect. These include the following:

• With very few exceptions, health care professionals registered with the Drug Enforcement Administration (DEA) will be required to have had an in-person visit with a patient in order to prescribe controlled substances.

• Health care professionals will be required to use HIPAA-compliant messaging software for telehealth; under the PHE, physicians and other health care professionals may use popular technology, such as Skype and FaceTime, to conduct telehealth sessions.

Importantly, some states and health care plans—recognizing that telehealth has now become a permanent feature of health care—may continue certain flexibilities and coverage; commercial and Medicaid payers may vary widely in their telehealth policies.

Additionally, the Consolidated Appropriations Act of 2023 (HR 2617), the federal spending bill signed by President Joe Biden in late December, extends some telehealth flexibilities for physicians treating Medicare patients: Any in-person requirements for billing Medicare are suspended through at least the end of 2024. Audio-only visits are a permanently allowable telehealth modality in Medicare.

For psychiatrists who transitioned from an office-based to a hybrid or fully virtual role, the ambiguity and uncertainty of the next few months could be stressful. APA has several resources to help make sense of the expected changes to come:

• “Best Practices in Synchronous Videoconferencing-Based Telemental Health”: This document provides guidance on addressing the key administrative, technical, and clinical considerations when using a telehealth platform. The document—which covers such topics as legal and regulatory issues as well as telehealth platforms—was created by a joint writing committee drawn from the APA Committee on Telemental Health and the American Telemedicine Association Telemental Health Special Interest Group.

• “What Happens When the Public Health Emergency Ends? Telespsychiatry and Hybrid Practice Post-PHE”: This webinar—featuring a 60-minute presentation exploring some of the regulations to change when the PHE lifts followed by a Q&A—was recorded on January 11. It was hosted by Shabana Khan, M.D., the director of the child and adolescent telepsychiatry program at NYU Langone Health, and John Torous, M.D., director of digital psychiatry at Beth Israel Deaconess Medical Center. Khan is the chair of APA’s Committee on Telespsychiatry, and Torous is the chair of APA’s Committee on Mental Health Information Technology.

APA is now working to update and create additional materials about some of the changes to expect in May when the PHE lifts. APA members can expect additional webinars, podcasts, blog posts, FAQ documents, and more in the near future.

“Even if most of the pre-pandemic regulations come back, telepsychiatry will still be an integral part of mental health care, as will other digital tools like mobile apps and patient monitoring,” Torous said. “But as we saw with the rapid uptick of telepsychiatry services over the past two years, this is also a fast-moving field. It’s imperative we do what we can to keep our members educated and informed.”

The PHE was originally set to expire on April 11, and Republicans in the House of Representatives had submitted two pieces of legislation calling for an immediate end to the emergency. In a statement from the White House Office of Management and Budget on January 30, the administration extended the expiration date to May 11, saying an immediate end to the PHE “would create wide-ranging chaos and uncertainty throughout the health care system—for states, for hospitals and doctors’ offices, and most importantly, for tens of millions of Americans.”

While the end of the federal public health emergency marks a turning point, many policies are based on state, local, or private actions. APA members are urged to contact the APA Practice Management Helpline, their APA district branch, state medical board, or other trusted resource for information about the status of relevant telehealth policies.

More information on these resources is posted at https://www.psychiatry.org/psychiatrists/practice/telepsychiatry.
Mental Health: Potential Bipartisan Oasis In a Partisan Congress

APA has worked very hard to educate Congress about the need for action on a number of issues related to mental health, and public recognition that such action is needed is greater than it’s ever been. The scales may finally be tipping toward progress. **BY CRAIG OBEY**

How will the stars align for mental health policy nationally over the next two years? Good question, since much work remains after Congress took some important steps last year and the Biden administration announced the COVID-19 Public Health Emergency (PHE) will expire on May 11 (see page 3). It is apparent to all that greater access to quality mental health care is necessary, with too few psychiatrists, social workers, psychologists, and other clinicians, as well as a multitude of other needs.

Psychiatry made notable progress in the 117th Congress, which concluded on January 3—an unprecedented 100 new Medicare residency slots specific to psychiatry, enactment of new grants that APA proposed to boost access to care through the Collaborative Care Model, new grants and resources to enforce mental health parity, a guarantee two additional years of Medicare telehealth flexibilities, $500 million to implement the 988 Suicide and Crisis Lifeline, and more. The APA members whose advocacy contributed to these achievements can be proud of those results.

Congress responded to APA and our allies, in part, because the pandemic’s massive negative impact on Americans’ mental health is undeniable. But much was also left on the table. The need for additional action is significant, with increasing numbers of Americans rating their mental health as only fair or poor, drug overdose rates continuing to increase, and suicide the second leading cause of death for people aged 10 to 34. Unlike days past, when lawmakers often sought to change the subject when asked about mental health, today it’s hard to find a lawmaker who doesn’t hear regularly from constituents about it. In fact, 4 in 5 Americans agree on the need for greater access to mental health care. Mental illness affects legislators and voters regardless of their politics.

So, will partisanship and divided government in Washington, D.C., allow for further progress? Despite the drag, Congress responded to APA and our allies, in part, because the pandemic’s massive negative impact on Americans’ mental health is undeniable. But much was also left on the table. The need for additional action is significant, with increasing numbers of Americans rating their mental health as only fair or poor, drug overdose rates continuing to increase, and suicide the second leading cause of death for people aged 10 to 34. Unlike days past, when lawmakers often sought to change the subject when asked about mental health, today it’s hard to find a lawmaker who doesn’t hear regularly from constituents about it. In fact, 4 in 5 Americans agree on the need for greater access to mental health care. Mental illness affects legislators and voters regardless of their politics.

APA’s Government, Policy, and Advocacy Update

APA Expresses Support for Efforts to Increase Naloxone Access

In a letter to the Food and Drug Administration (FDA), APA expressed its support for the FDA’s preliminary assessment that naloxone nasal spray and autoinjector formulations are safe and effective for over-the-counter use. The letter, signed by APA CEO and Medical Director Saul Levin, M.D., M.P.A., was written in response to the FDA’s request for comments on the use of naloxone for nonprescription use.

In the letter, APA encouraged the FDA to add naloxone nasal spray to the list of FDA Essential Medications. “This would open federal resources and prioritize investment in long-term domestic manufacturing,” further, APA emphasized the importance of education on the use of naloxone so individuals can appropriately identify and respond to an overdose. Finally, APA addressed the cost barriers associated with naloxone, noting that some forms of nicotine replacement therapy are not covered by Medicare because they are over the counter. APA encouraged the FDA to work with the Centers for Medicare and Medicaid Services and other payers to keep costs down for the most vulnerable populations.

APA’s letter is posted at http://apapsy.ch/naloxone_cost.

Mental Health Liaison Group Provides Feedback On CONNECT for Health Act

APA and its partner organizations, members of the Mental Health Liaison Group Telehealth Work Group, sent a letter Sen. Brian Schatz (D-Hawaii) and Rep. Mike Thompson (D-Calif.) providing suggestions for the reintroduction of the Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act.

The groups wrote that any reintroduction of the CONNECT Act should eliminate the in-person requirement for telemental health services under Medicare as a prerequisite for coverage of a telehealth service, which was included in the Consolidated Appropriations Act of 2021. This provision is “iniquitous for individuals with mental health conditions,” the letter stated. The letter emphasized the groups’ support for in-person care when clinically appropriate or desired by the patient.

Given the immense need for mental health services combined with acute behavioral health workforce shortages, the in-person telemental health provision is counter to the intent of ensuring more Americans receive life-changing care and, in fact, could further exacerbate our nation’s growing mental health crisis,” the letter stated.

The letter is posted at http://apapsy.ch/CONNECT.

APA Provides Comments on SUD Patient Records

In a letter to the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Office of Civil Rights, APA provided input to the proposed changes to the Confidentiality of Substance Use Disorder (SUD) Patient Records under 42 CFR Part 2 (referred to as Part 2), which protects patients’ privacy and records concerning treatment related to SUD. The goals of the proposed changes are to improve coordination among professionals and increase protections for patients concerning records disclosure to avoid discrimination in treatment, according to a SAMHSA news release.

However, APA cautioned that the proposed rule, as written, does not do enough to mitigate data segregation and segmentation, which challenge care coordination efforts. For example, the regulation does not ease the burden of data management in integrated and collaborative care settings. At best, psychiatrists and other specialists may have significant administrative burden added to manage and maintain patient data in separate platforms, all without the intended outcome of coordination with colleagues to support shared patients,” APA’s letter stated.

APA offered numerous recommendations, including that SAMHSA should provide one-on-one technical assistance to clinicians or facilities wanting to ensure compliance with the rule, delay the rule’s finalization, and implement public education around SUD data to empower patients when consenting to data disclosures.

APA’s letter is posted at http://apapsy.ch/Part_2.
It’s 10 O’clock: Do You Know Where Your State Legislature Is?

This article is part of a series by APA’s Council on Advocacy and Government Relations, by Katherine G. Kennedy, M.D.

Some readers may recall the classic public service announcement when the announcer ominously intoned: “It’s 10 o’clock. Do you know where your children are?”

This popular PSA, which ran on radio and TV stations from the 1960s to the 1980s, warned clueless parents to double check their children’s whereabouts, implying that delay could spell trouble—or worse.

Perhaps we need a similar PSA today? Not for modern parents, who can monitor their kids via smartphones, but for us, psychiatrists, to alert us to the timely happenings in our own state backyards.

We need to be aware because, while the foibles of federal officials are served up daily as media fodder, the actions of our own state legislative bodies are often hidden in plain sight. Yet, every day, in statehouses across the country, decisions are being made about issues that will shape the access, quality, and scope of the health care that we provide to our patients.

For example, these are some current issues that your state legislature may be working on:

• Prior authorization reform: Most of us know patients who have not received treatments they need because of burdensome preauthorization requirements. APAs model legislation is being taken up by several states, including Maryland, Massachusetts, Montana, Nevada, and New Jersey, and APA is working in coalition with other physician specialties to advance this issue.

• Implementing the Collaborative Care Model: This evidence-based method safely increases access to quality psychiatric care. At least six states have signed collaborative care laws, while other states, including Arizona, Arkansas, South Dakota, and Wyoming, are working on these legislative initiatives.

• Addressing psychiatric workforce shortages: While passage last December of the Consolidated Appropriations Act of 2023 (HR 2617) offered our field future relief from a medical education docket, you can advocate in coalition with other physician specialties to advance this issue.

• Telehealth access and reimbursement: Many states still lack payment, coverage parity, and audio-only laws for telehealth services. Now that the end of the Public Health Emergency has been announced (see page 3), new state laws are needed.

• Implementation of Mental Health Parity: Despite the 2008 federal law, mental health parity has not been fully implemented in most states; new state laws are needed to achieve true parity.

• Safe Prescribing: Patients deserve access to mental health care by qualified prescribers with quality medical training. We need to help stop the expansion of prescribing to practitioners with no medical training.

• Opposing the criminalization of the practice of medicine: Some states have bills that criminalize the practice of medicine or prevent patient access to care. Is your state considering such a bill?

Now that you’re aware of some of the critical issues that your state legislature may be addressing, explore these issues more deeply on APA’s website, www.psych.org. Then consider engaging in state advocacy by following these simple next steps:

• Do you know the names of your state legislators? Go to https://www.psychiatry.org/psychiatrists/advocacy.

https://psychnews.scihiatryonline.org/do/10.1176/appi.n.202302.2.43)

• After identifying your state legislators, look them up online and on social media. Learn what they think about the issues you care about. For ideas about how to reach out and introduce yourself, go to https://votervoice.net/AmericanPsych/Campaigns/97931/Respond.

• Learn which issues your state legislature is working on. One easy way? Connect with your district branch (DB). Most DBs stay on top of the hot-button bills before their state legislatures. What’s more, DBs need your help with state advocacy. For example, you can help DBs by sharing a clinical vignette that illustrates why a bill is needed. (Of course, make sure to de-identify any patient stories before sharing.)

• Once you know a bill is on the docket, you can advocate in several ways: Email or call your state legislator and ask your representative to vote for or against the bill, email your colleagues to raise awareness, offer testimony at public hearings, and consider writing an op-ed for your local paper.

• Finally, stay on top of “all-things-advocacy” by signing up for APA Advocacy Alerts at https://votervoice.net/AmericanPsych/ Register.

• Need help or advice? Reach out to APA staff by emailing advocacy@psych.org.

Let’s work together to make a difference for our patients and our profession. Now is the perfect time to know where your state legislature is!
Psychedelics Legislation Gains Momentum

Bills that would decriminalize the use of psychedelics are popping up faster than magic mushrooms, but the field of psychedelics research has yet to yield supporting evidence about psychedelics’ safety and efficacy. BY TERRI D’ARRIGO

Legislative reform regarding psychedelics is gaining ground, a study in JAMA Psychiatry has found. From January 1, 2019, to September 28, 2022, 25 states considered 74 bills that proposed to reform existing laws restricting access to psychedelic drugs or proposed further research into reform legislation, and 10 of those bills had been signed into law by seven states.

The vast majority of the bills—90%—specifically referred to psilocybin, and 36% of the bills also included 3,4-methylenedioxy-methamphetamine (MDMA). Less than 20% of the bills included peyote/mescaline, ibogaine, LSD, and/or DMT/ayahuasca.

Among all bills, 58% proposed decriminalization, and 42% proposed policy research to explore paths to decriminalization. The focus of those that proposed decriminalization varied widely, as follows:

- 51% called for legalization of possession of at least one psychedelic drug for therapeutic or recreational purposes.
- 35% indicated that some training or licensure would be provided to prescribe psychedelics or to provide psychedelic-assisted psychotherapy.
- 23% mandated that access to psychedelics be restricted to some type of medical environment, such as a registered treatment center.
- 12% explicitly mandated physician involvement in prescribing psychedelics or making qualifying diagnoses.

“As the analysis results came in, I don’t think any of us were expecting the sheer heterogeneity of bills being considered, and that a majority of decriminalization bills did not call for medical oversight or licensure,” said lead author Joshua S. Siegel, M.D., see Psychedelics on page 12
Resident Evaluations May Be Biased Toward Whites

**Milestone scores are used by programs to assess residents’ knowledge, skills, attitudes, and more. Lower ratings given to residents of color compared with White residents may hinder residents of color as they embark on their careers.**

BY TERRI D’ARRIGO

Internal medicine residents who are Asian or belong to racial groups that are underrepresented in medicine often receive lower ratings on performance assessments than their White peers in the first and second years of postgraduate training, a study in JAMA Network Open has found. The findings suggest a racial and ethnic bias in trainee assessment that may have a far-reaching impact.

“This disparity in assessment may limit opportunities for physicians from minoritized racial and ethnic groups and hinder workforce diversity,” wrote Dowin Boartright, M.D., M.B.A., M.H.S., the vice chair for research at the Ronald O. Perelman Department of Emergency Medicine and an associate professor of emergency medicine and population health at the New York University Grossman School of Medicine, and colleagues. For example, trainee assessments are often considered in decisions regarding promotion, chief resident selection, readiness for unsupervised practice, and entry into competitive subspecialty graduate medical education programs.

The researchers examined data from the performance assessments of 9,026 internal medicine residents from the graduating classes of 2016 and 2017 who were in internal medicine residency programs accredited by the Accreditation Council for Graduate Medical Education (ACGME). Among the residents, 50.4% were White, 36.1% were Asian, and 13.5% belonged to groups that are underrepresented in medicine — defined as Latinx only; non-Latinx Native American, Alaska Native, or Native Hawaiian/Pacific Islander only; or non-Latinx Black. The researchers focused on scoring for the midyear and year-end ACGME Milestones. These Milestones are used by residency programs’ Clinical Competency Committees to assess residents’ knowledge, skills, attitudes, and other attributes in clinical competency domains such as medical knowledge, patient care, professionalism, and others.

The researchers separated Asian residents from other residents of color partially because Asians are overrepresented in medicine relative to their representation in the general population and partially because of variability in racist biases, Boartright explained.

“Studies have demonstrated that there are differences in the type of discrimination people experience based on race, and there is an idea that Asians are the ‘model minority’ where biases toward them may operate differently,” Boartright told Psychiatric News.

Yet the results suggest that Asian residents may experience more discrimination in their first postgraduate year (PGY-1) assessment than other people of color: midyear total Milestone scores were a median of 1.27 points higher for White residents compared with Asian residents, whereas there was no significant difference in PGY-1 midyear total Milestone scores between White residents and residents from groups underrepresented in medicine. From the midyear PGY-1 assessment onward, White residents began to receive increasingly higher scores compared with Asian residents and residents from groups underrepresented in medicine. These disparities peaked in PGY-2, when White residents’ total scores were a mean of 2.54 points higher than those of residents from groups underrepresented in medicine and 1.9 points higher than Asian residents. However, the gap in scores narrowed by the PGY-3 year-end assessment, when the researchers found no racial and ethnic differences in the total Milestone scores.

The researchers also found differences in the ratings for individual clinical competency domains between White residents and Asian residents and residents from groups that are underrepresented in medicine, with White residents scoring higher than the other groups.

“The findings suggest, representation alone cannot solve racism,” said study researcher Nientara Anderson, M.D., M.H.S., a psychiatry resident in the Neuroscience Research Training Program at Yale University School of Medicine. “Recruiting people and not ensuring that they are assessed fairly makes the environment hostile to them. As long as there are racist attitudes and structures..." said Anderson.

The researchers also conducted routine investigations of disparities in assessments evaluating resident competence, says Boartright. For example, trainees and residents from groups that are underrepresented in medicine relative to their peers in the first and second years of training were assessed fairly makes their working environment hostile to them, says Nientara Anderson, M.D., M.H.S.

### Likelihood of PGY-3 Residents Being Rated Ready for Independent Practice

At the PGY-3 midyear assessment, trainees from minoritized racial and ethnic groups were less likely than White residents to be considered ready for unsupervised practice in all Milestone competency domains. By the year-end assessment, the differences between these groups narrowed, but Asian residents were deemed less ready based on interpersonal and communication skills.

<table>
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<th>Group</th>
<th>Patient Care</th>
<th>Medical Knowledge</th>
<th>Systems-Based Practice</th>
<th>Practice-Based Learning and Improvement</th>
<th>Professionalism</th>
<th>Interpersonal and Communications Skills</th>
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Not ensuring that residents are assessed fairly makes their working environment hostile to them, says Nientara Anderson, M.D., M.H.S.

Boartright encourages hospitals and academic medical centers to assess themselves for bias in evaluating resident competence.

“What I fear is that some programs will see our data and assume that it’s only about other programs and not theirs,” Boartright said.

This study was supported by the National Institute on Minority Health and Health Disparities. PN

"Racial and Ethnic Differences in Internal Medicine Residency Assessments" is posted at https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2799972.
Iowa Funds Expansion of Rural Psychiatry Training, Services for Underserved Populations

In the face of a vast pandemic of mental illness and a severe shortage of mental health professionals, some institutions, such as the University of Iowa, are expanding services in underserved areas and their residency programs. BY MARK MORAN

Growing up with two physician parents in Hannibal, Mo., the boyhood home of Mark Twain, Katie Meidl, M.D., saw firsthand the enormous health care needs of rural communities—especially for psychiatric care.

“There was only one psychiatrist at the time for a very wide area and so much need,” she recalled. “My parents talked about it. My own experience and background were what led me to want to seek out training in rural psychiatry. I wanted to bring track, begun in 2020, is the fruit of a 2019 competitive grant from the state that provided $800,000 for the University of Iowa to train two extra residents a year in rural psychiatry, increasing the training slots offered by the University from seven to nine. And that was just the beginning of what now appears to be a remarkable growth of the university’s training program, a product of advocacy and a recognition on the part of the state’s legislators that the shortage of mental health professionals is a crisis.

Ensuring Capacity for Training

The expansion of the University of Iowa’s residency program is an example of how some states are addressing the severe shortage of mental health professionals and ways in which some institutions are making creative use of state funds to expand their training programs. Five-hundred and fifty miles to the east, Cleveland’s MetroHealth University Hospital—the safety-net hospital for Ohio’s Cuyahoga County—opened a behavioral health hospital last year on Cleveland’s east side that will add a total of 112 psychiatric beds and expanded the hospital’s psychiatry training program from 20 residents for all four classes to 32 (see facing page).

New York Gov. Kathy Hochul announced, as part of the 2023 State of the State, a comprehensive plan to overhaul New York’s continuum of mental health care including a phased increase of 1,000 inpatient beds. Several years previously, the New York State Office of Mental (OMH) had begun paying for additional psychiatry training slots with the agreement that residents taking those slots would commit to working in an OMH hospital setting following completion of training.

But growing a residency is not just a matter of finding the money; it means meeting stringent ACGME requirements regarding faculty capacity and time spent by residents meeting specific learning requirements. The ACGME recently formed the Medically Underserved Advisory (MUA) Group to provide consultation specifically to institutions serving medically underserved areas and populations.

Tate said a principal obstacle to building training capacity in a rural community is ensuring there are faculty to provide supervision—in this case, at the five sites where the new trainees will be rotating. “We also have to think about housing in these remote areas—where will our residents live when they are doing monthlong rotations at these sites?”

Shea Jorgensen, M.D., director of the Public and Rural Psychiatry Training Track at the University of Iowa, is photographed with her son, Finn. “A major appeal of this work is the difference you can make, because there is such a lack of services.”

In June 2022, Iowa Gov. Kim Reynolds signed a multimillion-dollar public health bill that included $100,000 in funding for up to 12 additional positions for each residency class at the university to work at five designated state facilities, pending approval by the Accreditation Council for Graduate Medical Education (ACGME).

Once it is approved, participating residents will complete a portion of their training at State Mental Health Institutes in Cherokee and Independence, Iowa, serving people with serious mental illness; the Iowa State Resource Center in Woodward, serving individuals with intellectual disabilities; the Iowa Medical and Classification Center at Oakdale, serving inmates in a medium security correctional facility; and the Iowa State Training Center in Eldora, serving adolescents with a history of criminal justice involvement.

Jodi Tate, M.D., a professor of psychiatry and vice chair for education at the University, credited Iowa state Rep. Ann Meyer and Iowa state Sen. Jeff Edler for championing the investment in expanding Iowa’s psychiatric workforce. “We are always advocating for better mental health for Iowans, but this really came from our legislators,” she said. “They are the ones who pushed this through.”

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She said the university will add more residents incrementally as capacity for training and supervision grows, first developing elective rotations at the five sites that will be launched by spring of this year, while collaborating with two institutions in Des Moines to train child and adolescent psychiatrists who will work at the State Training School in Eldora and the State Resource Center in Woodward. In July, the university will launch a public psychiatry fellowship, whose graduates will be able to provide faculty supervision at the five sites.

Over time, the program will work toward accommodating the 12 new residents the state has funded. “What we hope to do is create a culture of excitement about serving in underserved areas and working with underserved populations,” Tate said.

Training director Erin Crocker, M.D., said past graduates of the university’s training program who have dispersed around the state have helped provide supervision for new residents in the Public and Rural Psychiatry Track. “This has been a great opportunity to partner with our own University of Iowa graduates who have stationed themselves around the state and are passionate about serving these rural areas.”

Second-year trainees in the rural track have the option of working four-week rotations at several sites throughout the state, one of which is Prairie Ridge Integrated Behavioral Healthcare in Mason City, Iowa. Katie Meidl, M.D., did her four-week rotation there, under the supervision of medical director Shea Jorgensen, M.D., a graduate of the University’s residency program and director of the Public and Rural Psychiatry Track.

Jorgensen told Psychiatric News that working as a psychiatrist in a rural region means being able to treat patients with a range of needs who might in a more urban region be farmed out to subspecialists.

“I wear many hats,” she said. “I work continued on next page
Cleveland’s Safety Net Hospital Builds 112-Bed Psychiatric Facility

The Cleveland MetroHealth Behavioral Health Hospital opened last October and will eventually have 112 inpatient beds, cutting the region’s inpatient deficit by more than 50%.

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MetroHealth Hospital in Ohio, founded in 1837, is the safety net hospital for Cleveland and Cuyahoga County, serving more than 300,000 patients, two-thirds of whom are uninsured or covered by Medicare or Medicaid. Last October, the hospital opened the MetroHealth Behavioral Health Hospital to replace the 20-bed psychiatric unit in the old hospital.

The psychiatry residency training program at MetroHealth received approval from the Accreditation Council for Graduate Medical Education to add three new training slots a year, which will increase the total number of residents from 20 to 32. Like the state-funded expansion of the training program at the University of Iowa (see facing page), the developments at MetroHealth are evidence that states and municipalities are responding to the shortage of mental health professionals and the need to invest in expanding the psychiatric workforce.

Last November, the Cuyahoga County Council approved the use of $5 million from its Opioid Mitigation Fund to construct the $42 million hospital. The council’s $124 million fund is derived from settlements with opioid manufacturers. According to the U.S. District Attorney’s Office for Northeastern Ohio, the county saw a 1,000% increase in opioid deaths between 2007 and 2016. There were 653 overdose deaths in the county in 2022, an 112-Bed Psychiatric Facility

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Cheryl Wills, M.D., director of child and adolescent psychiatry at MetroHealth, said the new hospital and the expansion of the training program are a result, in part, of a 2018 needs assessment conducted by the hospital’s strategic team. Taking into account existing resources in the region, the assessment showed that Cuyahoga County was short 200 inpatient psychiatric beds.

“MetroHealth has a rich history of serving all people, regardless of ability to pay,” said Wills, who is also APA’s Area 4 trustee. “But we were consistently referring people out for mental health treatment because we had only 20 beds. By expanding with the new hospital to 112 beds, we are addressing 50% of the deficit, a huge step.”

Raman Marwaha, M.D., the residency training director at MetroHealth, said the developments there mark the largest expansion of behavioral health services in northeast Ohio in 30 years. “When I joined MetroHealth eight years ago, I had a waiting list of 18 months,” said Marwaha, who is president of the APA Caucus of International Medical Graduates.

He said the new hospital is moving incrementally toward reaching the total of 112 beds—40 adult beds became available when the hospital opened last October, and at press time a psychiatric-medical unit and a four-bed psychiatric intensive care unit were expected to open. “The plan is in the next six months to open more beds—a 20-bed adolescent unit, a 20-bed addiction unit, and a 20-bed geriatric unit.”

Marwaha said that residents in the expanded program, which will be located at the new hospital, will have training rotations in schools, integrated group practices, and the county correctional facility.

Attracting residents and, importantly, faculty to help supervise residents is critical. Wills did some detective work and discovered an Ohio state loan repayment program for which physicians who work at MetroHealth would qualify—a lesson, Wills said, for other institutions and localities.

“It’s important to think creatively and strategically and to learn about existing available resources,” she said. “When I started at MetroHealth in March last year, one of my concerns was recruitment of the best faculty possible. I felt we had to have something to offer people, to make it attractive to work here. We are hoping to attract psychiatrists invested in working with underserved and safety net populations who will be involved for the long haul.”


PSYCHNEWS.ORG
Gender-Affirming Clinics Subject To Onslaught of Threats, Harassment

Clinics and clinicians that provide gender-affirming care to transgender youth have seen a rise in harassment over the last year, including bomb and death threats. The threats echo the hostility that patients very often experience, which experts say is detrimental to their mental health. **BY KATIE O’CONNOR**

Over the last three years, there has been an escalation of organized, political hostility toward the transgender community from people with agendas to restrict access to gender-affirming care for everyone, but particularly for transgender and gender-diverse youth, said Alex Keuroghlian, M.D., M.P.H. This past year, particularly, has been very alarming.

Keuroghlian is the director of the Division of Education and Training at The Fenway Institute and the Michele and Howard J. Kessler Chair and director of the Division of Public and Community Psychiatry at Massachusetts General Hospital. Keuroghlian is also prime mode of suicide in the United States: The Centers for Disease Control and Prevention reports that over half of deaths by suicide in this country involve the use of firearms. As a result, psychiatrists are trained to routinely ask patients about access to firearms in psychiatric assessments, especially patients who have depression or other relevant mental illnesses. In fact, not asking about guns in those circumstances could be considered unethical and could open up the possibility that the psychiatrist could be sued for malpractice. Therein lies the conflict.

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When Laws Collide With Responsible Patient Care

**ETHICS CORNER**

**When Laws Collide With Responsible Patient Care**

**BY CHARLES C. DIKE, M.D., M.P.H.**

very so often physicians are confronted with the serious dilemma of navigating medical situations in which ethical practice is deemed unlawful.

Florida’s physician “gag” law, the Firearm Owners’ Privacy Act (FOPA) of 2011, required health care practitioners to “respect a patient’s right to privacy” and to “refrain from making a written inquiry or asking questions concerning the ownership of a firearm or ammunition by the patient or by a family member of the patient or the presence of a firearm in a private home or other domicile of the patient or a family member of the patient.” Psychiatrists who broke this law faced the risk of suspension, outright loss of their medical license, and/or significant financial penalties.

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The threats have prompted many clinics to remove information about their staff from their websites in order to protect them, which advocates fear could make it even more difficult for patients to access care, according to an article in STAT. Last October, the American Academy of Pediatrics, the AMA, and the Children’s Hospital Association sent a joint letter to Attorney General Merrick Garland, urging him to investigate the organizations, individuals, and entities that are coordinating and carrying out the attacks.

“Attacks against health care institutions that threaten violence, intimidation, and physical harm have left hospitals, staff, and their communities shaken,” the organizations wrote in the letter. “Families seeking care at these institutions as well as those providing their care fear for their personal safety in the wake of these attacks.”

“People working in the field are now more vigilant and intentional about protecting the safety of patients and the communities we serve,” Keuroghlian said. “I have been heartened by the dedication, determination, and resolve of providers of gender-affirming care to continue to do this work.”

‘Our Patients Are Very, Very Afraid’
The attacks have had a significant impact on those who provide care to transgender youth, but especially on the patients, Keuroghlian said.

The Trevor Project conducted a survey from September 20 to December 31, 2021, that included nearly 34,000 LGBTQ youth aged 13 to 24. Of the respondents, 37% of transgender and nonbinary youth reported that they had been physically threatened or harmed due to their gender identity, and 71% reported that they had experienced discrimination based on their gender identity. Further, LGBTQ youth who experienced threat or harm due to their sexual orientation or gender identity reported attempting suicide in the past year nearly three times as much as those who did not experience threat or harm.

The hostility toward gender-affirming care clinics reflects the direct violence that individuals in the transgender and gender-diverse community regularly experience, Keuroghlian said. “This has been personally distressing for health care professionals, but I find it helpful and grounding to focus entirely on the impact it has on the communities we serve, who often don’t have the privilege that health care professionals and clinicians have had in our country and in society at large.”

Kate Thomas, Ph.D., director of mental health services at the Johns Hopkins Center for Transgender Health, has been working with the transgender community for nearly 40 years. She has never seen so much widespread, national hostility toward her patients, she said, in part because the transgender and gender-expansive community was not as high on the national radar as it has become in recent years.

The gender-affirming care community was excited when more transgender people gained prominence in the media and in Hollywood, and members of the transgender community saw themselves represented on the big screen, Thomas said. But that greater visibility also created a backlash. In recent years there has been a flood of new legislation aimed at restricting access to gender-affirming care, especially for youth (Psychiatric News, https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2021.6.10).

“Our patients are very, very afraid,” Thomas said. “I can’t think of one of my patients lately who hasn’t brought up the political climate and what it means for them.”

Psychiatrists as citizens and medical organizations, including APA, can band together with interested community organizations and advocacy groups to vigorously challenge laws that negatively impact patients’ dignity and respect, autonomy, and care. This fight should not be left to patients alone, some of whom are too vulnerable and/ or lack the resources to defend themselves. Our commitment to individually and collectively stand with them is the least we can do.

Creating Inclusive Health Care Environments
The current climate of hostility aimed at the transgender community and its impact on patients and families highlight the urgent need to create inclusive, affirming, and welcoming health care environments, ensuring that gender-affirming care is incorporated into primary pediatric and medical care, Keuroghlian said.

“Patients regularly express distress about the threats they are personally experiencing and threats to the community at large,” Keuroghlian said. “This manifests as increases in depressive, anxiety, and posttraumatic stress symptoms, as well as decreased engagement in care. There is well-founded mistrust of the health care system in transgender and gender-diverse communities, who have experienced their basic human right to access care being used as a political issue. It erodes the sense of safety people feel when engaging in health services.”

Jonah DeChants, Ph.D., a research scientist with The Trevor Project, said that the first and most important thing that transgender youth need is safety. “They need to feel safe at home and in their communities,” he said. He noted that having at least one affirming adult in a transgender youth’s life is associated with one-third lower odds of attempting suicide.

“Doctors working with young people can be that adult who tries to understand their LGBTQ identity from a place of openness and understanding,” he said. “That can be incredibly impactful.”


The attacks on clinics that provide gender-affirming care underscore the importance of creating inclusive, welcoming, and safe health care spaces for transgender and gender-diverse patients, who regularly experience hostility and threats themselves, says Alex Keuroghlian, M.D., M.P.H.
Post-Residency Life: How to Build a Successful Career

Graduating residents face a plethora of decisions regarding their future, but taking the time to look inward at professional goals and connect with the right advisors will pay off.

By DIONNE HART, M.D., and EILEEN MCGEE, M.D.

The psychiatry residents who are completing their residency this year face a number of colliding challenges: They are beginning their careers at a time of an unprecedented demand for mental health services in the wake of the global pandemic and a severe psychiatric workforce shortage. They also have what seems to be an endless number of career paths.

Last December, the Area 4 Council of the APA Assembly hosted a virtual presentation titled “Residency Is Over, So What Now?” Residents and fellows throughout the nation listened to a panel of young physicians representing diverse practice types and an experienced attorney and financial planner who shared their wisdom and experience.

The program began with a discussion of important financial matters including tax liability, retirement planning, and tools to finance personal priorities. Two key takeaways were to plan early for retirement and plan for emergencies. Our guest financial advisor recommended a familiar salary allocation known as the 50/30/20 rule: 50% is earmarked for necessities and obligations; 30% for discretionary purchases; and 20% for retirement planning, debt repayment, and savings.

After a discussion of how to protect one’s hard-earned income, the discussion turned to recognizing the limits of one’s legal knowledge—it is imperative to seek professional advice prior to signing employment contracts and taking out personal, home, and practice loans; and to build an advisory team consisting of an attorney, accountant, tax advisor, banker, insurance agent, and consulting specialists such as an information technologist. A team of professional advisors will offer protection while new physicians focus on building a practice, interacting with patients, understanding legal obligations, and protecting assets.

After discussing these fundamental, a panel of early career physicians shared their practice and planning experiences, along with their successes and failures. Although their career pathways were different, the panelists agreed that networking and mentoring are important. Valuable takeaways included Dr. Kyle LeMasters’ advice to “know your value,” while Dr. Erica Steinbrenner advised residents to “create exactly the practice you want.” Dr. Matt Kruse urged participants to take a personal inventory of their interests and goals before accepting a position. Dr. Erika Larson echoed this advice when she counseled participants to build a practice that reflects their goals and needs. For example, those who enjoy traveling and new challenges might find that a locum tenens position is a good fit, but for structure and predictability, a government practice or employed position may be optimal.

Many new physicians find that their first position is not an optimal fit. In fact, 47% of physicians change positions in the first five years of practice. The early career panelists agreed that practice preferences may change as priorities and life circumstances evolve, so it is important that newly practicing physicians give themselves the grace to explore or create new professional opportunities and maintain that openness throughout their professional life. In summary, as Dr. John Korpics advised, “Define your own future.”

“A team of professional advisors will offer protection while new physicians focus on building a practice, interacting with patients, understanding legal obligations, and protecting assets.”

Psychedelics

continued from page 6

Ph.D., a neuroscientist and psychiatrist at Washington University School of Medicine in St. Louis. “I think there needs to be a public conversation—not necessarily led by the Food and Drug Administration, Drug Enforcement Administration, or the corporations looking to get rich from psychedelics—about how we want to incorporate these drugs into American society.”

Jonathan E. Alpert, M.D., Ph.D., chair of APA’s Council on Research, expressed concern that such a small proportion of bills would require training or licensure for psychedelic prescribing and psychedelic-assisted psychotherapy or mandate physician involvement.

“We don’t have a lot of knowledge about the risks and safety of psychedelics use, any drug interactions they may have, or their long-term effects, particularly in those who might be vulnerable to their effects by virtue of having a family history or prior symptoms of psychotic disorders,” said Alpert, who was not involved with the study. He is the Dorothy and Marty Silverman University Chair of the Department of Psychiatry and Behavioral Sciences at Montefiore Medical Center and the Albert Einstein College of Medicine.

“From the perspective of state legislatures and the ballot box, the idea of decriminalization is one thing. It is within the purview of states to make those decisions. But there is already an appropriate framework in place for decisions about the therapeutic use of psychedelics or other substances,” Alpert added, referring to the FDA’s pathway for approval. “If we really care about their potential for therapeutic benefit, short-circuiting the process doesn’t serve that goal.”

Alpert’s sentiments echo those of an APA position statement he co-wrote on the use of psychedelic and empathogenic agents for mental health conditions. The position statement, released last year, is explicit about APA’s stance: “There is currently inadequate scientific evidence for endorsing the use of psychedelics to treat any psychiatric disorder except within the context of approved investigational studies. APA supports continued research and therapeutic continued on facing page
ew technologies have opened limitless doors of possibility for new generations of medical clinicians and researchers. Whether it is an automated text app that augments clinical care or a virtual reality (VR) headset that implements therapy, next-generation technology has made it possible to maximize the accessibility, quality, and efficiency of mental illness prevention, treatment, and management. But how do passionate new clinicians with bright ideas begin their journey into this exciting technological world?

At APA’s 2022 Mental Health Innovation Exchange, like-minded panelists noted that there is a Catch-22 if you’re a sprouting clinician interested in creating a digital platform. Armen Arevian, M.D., a psychiatrist and creator of the Chorus digital platform, expressed that to start a digital platform, clinicians need funds, but to get funds, clinicians need a working digital platform. The paradox of needing funds for production but currently needing production for funds causes ideas to get lost along the way.

This Catch-22 makes it almost impossible for new clinicians to implement their inventions into their patients’ care management. Rather, Arevian explained, what ends up happening is that technologies are created by tech companies that do not have clinical expertise but do have resources. Those new technologies benefit the tech companies and provide more resources, allowing companies to create more technologies, and so on. So those with funds gather more funds, and those with expertise do not launch their high-quality products.

Arevian continued, “Who gets to create and control technologies and who gets to benefit from technologies are often very uneven. And there is definitely a cycle where people who are winning continue to win and win more.” —Armen Arevian, M.D.

"Who gets to create and control technologies and who gets to benefit from technologies are often very uneven. And there is definitely a cycle where people who are winning continue to win and win more." —Armen Arevian, M.D.

To that end, psychiatrists should be prepared to answer their patients’ questions about psychedelics, said Alpert.

“It’s critical for psychiatrists to talk with patients about the current status of psychedelic drugs as promising therapies that at this time are almost exclusively investigational and need to be subjected to the same rigorous study and regulatory approvals as other drug therapies,” Alpert said.

As Psychiatric News went to press, at least five states had introduced new bills regarding psychedelics since January 1. This study was supported by the Taylor Family Institute Fund for Innovative Psychiatric Research, the National Institute of Mental Health, the National Center for Advancing Translational Sciences, and the National Institute on Drug Abuse.


Number of Psychedelic Drug Bills on Rise
The number of new psychedelic bills introduced each year has steadily increased from five in January 2019 to 36 by late September 2022. The bills varied in their contents, ranging from requests for research funding to proposals for decriminalization.

“Things unfolded fairly quickly, and it caused a lot of confusion with respect to the differences between decriminalization, legalization for medical use, legalization for recreational use, [FDA] approval for treating recognized medical conditions, and Drug Enforcement Administration scheduling.”

"We’re not reinventing the wheel. There’s decades of work on CBT, meditation, mindfulness, breathing. We’re just taking that foundational knowledge and building really high quality VR content.”

In his opinion, the ones who should be creating patient care apps should be the clinicians themselves. Although many barriers remain when competing with tech giants, it is through small pots of funding and expansion of existing technology that new clinicians can become successful players in the world of digital startups.

Source: Joshua S. Siegel, M.D., Ph.D., et al., JAMA Psychiatry, December 2022.
TREND Watch

BY GLORIA UMALI, R.N., M.S., C.P.H.R.M.

Being a medical director as well as a treating psychiatrist may be an exciting career move, but it raises a number of liability issues that you need to think through before accepting the position. BY GLORIA UMALI, R.N., M.S., C.P.H.R.M.

It is not uncommon to hear of psychiatrists taking on a medical directorship role while providing direct care to their own patients. Psychiatrists have many reasons for assuming this role; however, the passion to serve, loyalty to and a strong connection with an organization, and financial freedom are often cited as the main motivators.

While being a medical director is undoubtedly rewarding, there are aspects of the role that psychiatrists need to consider from a medical malpractice standpoint. It is imperative that psychiatrists understand the legal, regulatory, and professional liability coverage issues associated with being a medical director. Although the role of a treatment psychiatrist and the role of a medical director both fundamentally require clinical training and competency, each role may differ. Psychiatrists performing a dual role may believe that the coverage from the existing professional liability insurance policy automatically extends to their role as a medical director without realizing that certain arrangements compound their liability exposures and therefore leave an unintended gap in coverage.

Furthermore, what it means to be a medical director and how to acceptably stay within the agreed-upon scope of responsibilities can be confusing and tricky to navigate. To decrease the risk of practicing outside of scope, psychiatrists need to understand the usual responsibilities of a medical director and take the time to thoroughly review the scope of responsibilities outlined in their specific contract.

A medical director’s typical responsibilities include administrative duties such as management of medical staff matters, development of organizational policies, oversight of clinical operations and compliance with regulatory requirements, and quality improvement activities. Depending on the arrangement, it may not be easy to discern that a medical director might also be held accountable for everything that happens in the facility.

If you are thinking about taking on a medical directorship role, here are some points for your consideration:

- Identify duties and responsibilities not covered under your basic professional liability coverage agreement to delineate the coverage necessary for the medical directorship role.
- Do not assume that your medical professional liability insurance policy covers your actions as a medical director. Notify your medical malpractice carrier if considering a medical directorship position to review possible changes in the current coverage.
- Confirm that the duties and responsibilities outlined in the contract are within your scope of practice and expertise.
- Delegate and oversee only those medical tasks and clinical operations that are consistent with your scope of practice and specialty.
- Verify that your contractual arrangements do not violate state or federal laws.
- Conduct proper due diligence by performing research on the facility’s quality rating, care standards, and performance before accepting the position.
- Ensure resources are available to adequately fulfill and execute your assigned duties and responsibilities.

Being a medical director is both an honor and a privilege. It gives psychiatrists the perfect opportunity to satisfy the passion for serving their patients while fulfilling civil community responsibilities. However, performing the dual role as a psychiatrist and a medical director requires due diligence to avoid needless risk and liability exposures. PN

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TREND Watch

BY EZRA E.H. GRIFFITH, M.D.

There are many published stories of international medical graduates settling in the United States. A good collective example is described by Daniel José Gaztambide in his A People’s History of Psychoanalysis (Lexington Books, 2019). He discusses the early psychoanalysts fleeing persecution in Europe and seeking safety on this side of the pond. The account is grand by design, signaling the historicity of psychoanalysis. However, there are quieter tales of this search for refuge, like the one I recount here about the Nigerian Dr. Joel Akande Idowu. His story is about being caught in the mundane pressures of life in a developing country that offers minimal opportunities to bloom and flourish. The local conditions often just favor migration, one of the most common outlets for releasing social and economic pressure in one’s homeland. A subsequent life focus is to explore the possibility of putting down roots in a foreign land.

Joel Idowu was the youngest of five siblings born to a farmer father and trader mother in Arigbawonwo (pronounced Aree-ba-won-wó), a hamlet of about 200 citizens located in Ogun State in western Nigeria. There were no formal birth certificates issued there, although Joel’s father kept a ledger that recorded important birth events. Growing up in that village made Joel noticeable because of his innate curiosity and cheerful disposition that collectively suggested a youngster with academic promise. He also had older cousins who were schoolteachers. They kept an eye on him and obtained his father’s permission to take responsibility for Joel’s education. The schoolteachers moved around the region from one job to another to improve their professional status. So, they soon realized that maintaining continuity in Joel’s education would require his placement in a boarding school. That happened in 1973, and Joel became a boarding student at age 12. When his father died in 1975, an older relative took over defraying the cost of Joel’s education.

The boarding school had its advantages, and Joel flourished in the new context. The students, all boys, came from a wider community and from families that were Muslim, Catholic, or Protestant. English was the language of instruction, but Yoruba remained the medium of discourse at home. He was also exposed to Islamic religious instruction and to the Arabic language. He enjoyed being the best student in class and became more outgoing in the comfortable school environment. The long vacations were for spending time with his mother. This divided life was pleasurable and suited his disposition.

Joel’s solid academic performance justified his relatives’ financial support and reassured him that he was not wasting the generous outlay of money spent on him. When he was ultimately admitted to the University of Lagos in 1982 as a medical student, he saw himself moving among future doctors from families accustomed to privilege. He had no stories to tell about the benefits.
APA Library & Archives Receives Grant To Preserve Unique Collection

The APA Foundation’s Melvin Sabshin, M.D. Library & Archives boasts a unique collection of items, and a grant from the National Endowment for the Humanities represents a major step to enabling the preservation of these treasures for generations to come.

BY KATIE O’CONNOR

There are approximately 1,800 volumes in the APA Foundation’s (APAF) Melvin Sabshin, M.D. Library & Archives. The collection chronicles the history of the profession of psychiatry, the creation and advancement of APA, and the key figures that have shaped the field. To help preserve that history, the library has been awarded a $10,000 Preservation Assistance Grant from the National Endowment for the Humanities.

“Our collection is incredibly valuable,” said Librarian and Archivist Deena Gorland, M.S.L.I.S. “This grant will allow us to understand what we need to do to preserve our volumes, which offer a unique window into the history of our understanding of mental illness over the centuries.”

The grant allowed APAF to hire a conservator, Bexx Caswell-Olson, M.S.L.I.S., to assess the condition of the library’s collection and make preservation and conservation recommendations. Caswell-Olson is the director of book conservation at the Northeast Document Conservation Center in Andover, Mass. She visited the library in late January and selected titles to evaluate with an emphasis on the library’s oldest and rarest volumes.

“I’m looking at a wide variety of elements, including the temperature, the humidity, the lighting conditions, and just generally the environment that the books are being stored and used in,” Caswell-Olson explained. “The quality of materials they used was not particularly good,” Caswell-Olson explained. “The industrial era was all about trying to make things faster and cheaper, and those books tend to fall apart as they age.”

Gorland said her hope is that Caswell-Olson’s assessment will provide a roadmap that APAF can follow to protect and preserve the collection for generations to come. APAF’s Adopt-a-Book program for APA members was developed with that same goal in mind—to support the preservation of specific volumes while providing funds for the library to maintain and conserve its collection.

Caswell-Olson pointed to the frequently used adage “preservation is access.” Without preserving the volumes in collections like APAF’s, future generations will lose access to a wealth of knowledge and irreplaceable items.

“This library is part of this organization’s history and cultural heritage,” she said. “Preserving these works and making them available for continuing use, not just for the present but for the future as well, is hugely important.”

To learn more about APAF’s library and archives, schedule a visit, or view virtual galleries, visit legacy.psychiatry.org.

Joel Idowu, M.D., a native of western Nigeria, is chair of the Department of Psychiatry at Richmond University Medical Center, Staten Island, N.Y.
Fighting for Psychotherapy by Psychiatrists: Join Us!

BY JOHN C. MARKOWITZ, M.D.

Since Freud first invented it in the late 19th century, psychotherapy has been part of psychiatrists’ treatment armamentarium and professional identity. It was once their primary treatment intervention.

Psychiatrists long defined themselves by embracing the biopsychosocial model, with psychotherapy an implicit part of that outlook and practice. Unfortunately, however, psychotherapy by psychiatrists has been and remains under siege on several fronts. Research has documented a marked decline in psychotherapy practiced by psychiatrists, from 44.4% in 1996-1997 to 21.6% in 2015-2016 (Psychiatric News, https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2022.2.15). That’s an alarming drop.

Why are psychiatrists no longer doing psychotherapy? Several factors probably play a role, including the following:

• Insurance bias: Insurance reimbursement has long rewarded brief medication checks relative to longer psychotherapy sessions, financially incentivizing prescribing medication over listening to patients and treating them in psychotherapy. Pharmaceutical advertising comes from pharmaceutical companies, not from psychotherapy organizations, and it influences our outlook and that of our patients. Many patients have caught this drift: You go to a psychiatrist for pills, not talk. Psychotherapy has increasingly been delegated to psychologists, social workers, and other mental health care workers.

• Dearth of investment in psychotherapy research: The National Institute of Mental Health has drastically shifted its research funding priorities over the past dozen years, largely abandoning clinical research in favor of neuroscience. Lack of funding has brought psychotherapy research in the United States to a halt. In consequence, academia is hiring more neuroscientists and fewer clinical teachers for our residents. This is true even among the shrinking number of training programs that actively promote psychotherapy training, as well as those that pay lip service to the psychotherapy training requirements of the Accreditation Council for Graduate Medical Education.

• Changing of the guard: The older generation of clinician teachers is retiring. Their academic replacements are more likely to be neurobiologically focused, diminishing the clinical teaching pool and depth of residency psychotherapy training.

• Zeitgeist: Psychotherapy can look old fashioned relative to mental health apps and transcranial magnetic stimulation.

• Professional factorialism: Psychotherapists have done themselves few favors. The history of psychotherapy since Freud’s circle has unfortunately been characterized by warring factions, with each branded sect fighting for prominence, rather than coming together to support the modality.

Paradoxically, this should be a golden age for psychotherapy by psychiatrists. Decades of clinical research have established the evidence basis of potent time-limited psychotherapies like cognitive-behavioral therapy (CBT), interpersonal psychotherapy (IPT), panic-focused psychodynamic psychotherapy (PFPP), and an alphabet soup of other acronyms. Psychotherapies on balance work as well as medications for commonly seen disorders like non-psychotic depression and panic. They may have advantages over medications for patients with particular disorders, such as posttraumatic stress disorder, and, in particular, life situations (pregnancy, complicated bereavement, major life role transitions). Psychotherapies are powerful treatments, featured in treatment guidelines.

Moreover, spending time listening to patients helps clinicians to understand them and prescribe both psychotherapy and medication. It’s tempting to call the adaptation of the older medical models to the pandemic a failure for patients and trainees alike. But Rudyard Kipling summarized this sentiment best: “If you can meet success and failure and treat them both as imposters, then you are a balanced man, my son.”

For all of the pain and suffering endured by the world at large and medical trainees nationwide during the worst of the pandemic, there were some positive downstream effects. Medical students and residents found new and creative ways to be more collaborative. Becoming more kind, patient, understanding, and open-minded became a necessity. They learned how to deal with patients who held misconceptions about the vaccines in a persuasive but respectful manner. The world of telehealth opened new doors that will likely remain open. Professionally, trainees got to experience opportunities they otherwise might not have had. Personally (perhaps especially in the field of psychiatry) they got access to healthcare that they previously would have opted out of, missed out on, didn’t have time to obtain, or were ashamed to tap into.

Trainees saw those in the medical field re prioritize their work-life balance and shift their focus to encompass those parts of their lives that were outside of medicine. As burnout rates soared, this perspective and attitude shift increased.

Pandemic May Have Caused Havoc for Trainees But Also Taught Unexpected Lessons

BY ELINA MAYMIND DENENBERG, M.D.

COVID-19 meant a lot of different things to different people. In the world of medicine and medical education, the ripple effects of COVID-19 live on. Lives were lost and shattered. Those in medicine were burnt out. Medical students and residents found new and positive downstream effects. Medical students and residents found new and creative ways to be more collaborative. Becoming more kind, patient, understanding, and open-minded became a necessity. They learned how to deal with patients who held misconceptions about the vaccines in a persuasive but respectful manner. The world of telehealth opened new doors that will likely remain open. Professionally, trainees got to experience opportunities they otherwise might not have had. Personally (perhaps especially in the field of psychiatry) they got access to healthcare that they previously would have opted out of, missed out on, didn’t have time to obtain, or were ashamed to tap into.

Trainees saw those in the medical field re prioritize their work-life balance and shift their focus to encompass those parts of their lives that were outside of medicine. As burnout rates soared, this perspective and attitude shift increased.
Bipolar Disorder II: Frequently Neglected, Misdiagnosed

Unlike its cousin, bipolar I disorder, which has been extensively studied and depicted in popular literature and on screen, bipolar II disorder is poorly understood, underdiagnosed, and insufficiently treated. This has often resulted in an over 10-year delay in diagnosis. By Trisha Suppes, M.D., Ph.D., Holly A. Swartz, M.D., and Sara Schley

Even experienced clinicians know surprisingly little about bipolar II disorder (BD II), despite its inclusion as a distinct entity in DSM since 1994. An abundance of studies supports conceptualization of BD II as a unique phenotype within the bipolar illness spectrum, although many fail to recognize it as distinct disorder apart from bipolar I disorder (BD I).

Alternatively, BD II is considered a “lesser form” of BD I, despite numerous studies showing comparable illness severity and risk of suicide in these two BD subtypes. Perhaps because of its under-recognition, treatment studies of BD II are limited, and too often results from studies of patients with BD I are simply applied to those with BD II with no direct evidence supporting this practice. BD II is an understudied and unmet treatment challenge in psychiatry.

In this review, we will provide a broad overview of BD II including differential diagnosis, course of illness, comorbidities, and suicide risk. We will summarize treatment studies specific to BD II, identifying gaps in the literature. This review will reveal similarities between BD I and II, including suicide risk and predominance of depression over the course of illness, but also differences between the phenotypes in treatment response, for example to antidepressants.

We highlight the perspective of an expert by experience who discusses her lived experiences of BD II in an accompanying interview (see page 21).

Diagnosis History
Alternating states of mania and melancholia are among the earliest described human diseases, first noted by ancient Greek physicians, philosophers, and poets. Hippocrates (460–337 B.C.E.), who formulated the first known classification of mental disorders, systematically described bipolar mood states: melancholia, mania, and paranoia. More than two millennia later, Emil Kraepelin, recognized as one of the founders of modern psychiatry, described manic-depressive illness as a singular disease characterized by alternating cycles of mania or melancholia. However, Kraepelin was more focused on mood changes and cycling than the polarity of episodes per se. Thus, his concept continued on next page
included what we now term recurrent major depressive disorder (MDD). Nevertheless, his and other formulations from this period provide background for our modern concepts of bipolar disorder, differentiating it from unipolar depression (MDD and related disorders).

The hiding in plain sight of patients with BD II was brought to awareness by David L. Dunner, M.D., in the 1960s. When examining a cohort of individuals with mood disorders in a study by the National Institute of Mental Health (NIMH), he identified a subgroup of patients with recurrent episodes of depression who also had a history of at least one period of hypomania and a strong family history of bipolar disorder. This subgroup was found to have a different course of illness compared with those with recurrent depression and a history of mania (BD I). Thanks to this work, BD II was recognized as a distinct disorder, separate from BD I. It finally entered the DSM lexicon in 1994 in DSM-IV and was added to ICD-10 even more recently. Conceptualization of bipolar disorders continues to evolve as the field learns more; for example, changes were made to the DSM-5 diagnostic criteria for BD such that Criteria A for both mania and hypomania now include increased energy as well as elevated or irritable mood (see Table 1). Thus, BD II is now recognized as a disorder of energy as well as mood.

DSM focuses on categorical diagnoses—that is, thresholds for absence or presence of disease. In parallel to this framework, many have argued for considering bipolar disorders along a continuous spectrum of illness. Thus, the term bipolar spectrum is used to describe both the spectrum of severity across BD symptoms as well as combinations of mood symptoms with manic/hypomanic and depressive components. Some refer to BD II as a part of the bipolar spectrum. These concepts reflect a growing awareness that dimensional descriptions of mood disorders may better map our modern concepts of bipolar disorder, differentiating it from unipolar depression (MDD and related disorders).

### Differential Diagnosis

The validity of BD II as a separate disorder has been reified through multiple empirical studies. The clinical diagnosis is reliably separable from BD I, as seen in APA clinical trials preparing for DSM-5 and in careful clinical interviews. In DSM-5 field trials to assess reliability of diagnoses, BD I was among the most recognizable, but BD II fell in the acceptable range and well above MDD as a reliable diagnostic entity. Family studies also support the diagnosis of BD II as an independent entity with distinct familial heritability, according to a 1976 study by Dunner et al. and a 1990 study by J. Raymond DePaulo, M.D., et al., and the authors of this report. Finally, genetic studies have found correlations suggesting the heterogeneity between BD I and BD II is “nonrandom,” supporting the concept of distinct conditions.

BD II diagnosis requires at least one lifetime hypomanic episode and one major depressive episode. Despite clarity of BD II diagnostic criteria, clinicians struggle to accurately identify it in practice. BD II is often either missed or incorrectly diagnosed, resulting in an over 10-year delay in diagnosis. Difficulties in accurate diagnosis arise from several sources. First, DSM-5 criteria for the depressive phase of BD II are identical to those required for a major depressive episode, which make BD II and MDD cross-sectionally indistinguishable. This is particularly notable as MDD diagnoses make up a substantial percent of the incorrect diagnoses for patients with BD II. Second, hypomania, which by definition is a less severe form of mania, may be difficult for patients to distinguish from a “normal” mood state when accompanied by extra energy and good mood. Third, mixed hypomanic mood states are very common in BD II, and in fact more common than euphoric hypomanic states. Mixed mood states are characterized by the presence of symptoms of opposite polarity during a depressive or hypomanic episode. In a mixed hypomania, patients might believe they are simply irritable and angry in the context of depression rather than recognizing the additional hypomanic symptoms warranting a diagnosis of mixed hypomanic state. Finally, patients rarely present for treatment in the midst of a hypomanic episode, a mood state that is either perceived as ego-syntonic or simply not identified as part of their illness during mixed hypomania.

The primary reason patients with BD II seek care is depression. Depression dominates the course of BD II, both in the early and late stages. However, retrospectively identifying episodes of hypomania during a depressive episode can be challenging. Further, many individuals see hypomania (either the euphoric or mixed variant) as part of “normal” mood rather than part of a bipolar spectrum, contributing to misreporting of mood episodes. Especially after unrelenting episodes of depression, it is understandable that many would perceive hypomania as a return to baseline. However, under-recognition of hypomania contributes to incorrect diagnoses. In sum, many individuals with BD II fail to recall, recognize, or report histories of hypomania, leading to an MDD (mis)diagnosis.

In psychiatry, all diagnoses are a one-way road. Individuals who have ever met criteria for a manic episode will continue to carry the diagnosis of BD I—even without further manic episodes. Similarly, patients who have a distant episode of hypomania and at least one prior major depressive episode would be considered to have BD II disorder, even in the absence of additional hypomanic episodes that meet symptom and duration criteria. Thus, accurate diagnosis of BD II relies on careful history taking. To improve diagnostic acumen, it is essential that clinicians systematically screen all patients with MDD for BD and ask careful questions about prior episodes of hypomania.

### Course of Illness and Comorbidity

Kraepelin noted before the medication era that the course of illness for patients with BD generally progresses into more persistent and severe depression with aging. While he was primarily referring to manic-depressive illness, which we would call BD I today, the same principle applies to patients with BD II. In the NIMH collaborative study by Lewis Judd, M.D., et al., which included long-term follow-up of up to 20 years, patients with BD II experienced a

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**Table 1. Mood Episode Criteria in DSM-5**

<table>
<thead>
<tr>
<th>Hypomanic Episode Criteria</th>
<th>Depressive Episode Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Criterion A:</strong></td>
<td><strong>Criterion A:</strong></td>
</tr>
<tr>
<td>Distinct period of abnormally and persistently elevated, expansive, or irritable mood; increased activity or energy*</td>
<td>Depressed mood; loss of interest in activities or pleasure</td>
</tr>
<tr>
<td><strong>Criterion B:</strong></td>
<td><strong>Criterion B:</strong></td>
</tr>
<tr>
<td>Pressured speech</td>
<td>Decreased movement</td>
</tr>
<tr>
<td>Increased self-esteem or grandiosity</td>
<td>Decreased energy or increased fatigue</td>
</tr>
<tr>
<td>Excessive involvement in activities with a high potential for painful consequences</td>
<td>Feelings of guilt or worthlessness</td>
</tr>
<tr>
<td>Distractibility</td>
<td>Suicidality</td>
</tr>
<tr>
<td>Increased goal-directed activities</td>
<td>Lack of concentration; indecisiveness</td>
</tr>
<tr>
<td>Racing thoughts or flight of ideas</td>
<td>Sleep disturbance: insomnia, hypersomnia</td>
</tr>
<tr>
<td>Decreased need for sleep</td>
<td>Change in appetite or weight (&lt;5% in a month)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Depression</th>
<th>Hypomania</th>
<th>Mania</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Criterion B symptoms*</td>
<td>≥5</td>
<td>≥3</td>
</tr>
<tr>
<td>Duration*</td>
<td>2+ weeks</td>
<td>4+ days</td>
</tr>
<tr>
<td>Functioning*</td>
<td>Causes significant distress or impairment in functioning</td>
<td>Not severe enough to disrupt functioning or require hospitalization</td>
</tr>
</tbody>
</table>

* Required for diagnosis. 1 One or both required for diagnosis.

course of illness characterized by more depressive episodes and fewer well intervals over time. There is a longstanding debate in the literature whether patients with BD II suffer the same impairments and risks as those with BD I. BD II was previously—and incorrectly—labeled a “less severe” version of BD I. In fact, studies consistently show comparable disease burden in BD I and II. A recent Swedish study by Alina Karantzid, M.D., et al. reported higher rates of depressive episodes, illness onset at a younger age, and significantly higher rates of psychiatric comorbidity (anxiety disorders, eating disorders, and ADHD) among patients with BD II compared with those with BD I. In this Swedish sample, (n=8,700) no differences were noted in substance abuse between BD I and BD II. Interestingly, individuals with BD II generally obtained more education and achieved a higher level of independence than those with BD I. High rates of psychiatric comorbidity in patients with BD II further compound the challenge of differential diagnosis. There is considerable overlap between BD II and anxiety disorders. Attention-deficit/hyperactivity disorder also frequently co-occurs. Approximately 20% of individuals with BD II also meet criteria for borderline personality disorder (BPD), and up to 40% of those with BPD are incorrectly diagnosed as having BD I or II. Tables 2 and 3 show estimated co-occurring psychiatric illnesses for patients with BD II. The diagnosis of BD II requires a careful clinical interview of both past and current symptomatology.

Suicide is a significant risk for all patients with BD, and historically patients with BD I were viewed as having a higher risk than BD II due to the extremities of mania. However, data from a number of sources support that suicide risk is high across all patients with BD, and relatively little difference is found in risk for patients with BD I versus BD II. Older studies have suggested this risk may be higher for patients with BD II than BD I, and, indeed, the Swedish bipolar registry database study recently indicated that the rate of suicide attempts was significantly higher in patients with BD II though no data on completed suicides were provided. Overall, the reports from the International Society for Bipolar Disorders Task Force on Suicide found that the risk for suicide was estimated at 164 of 100,000 per year in patients with BD versus 10 of 100,000 per year in the general population (see the reference by Ayal Schaffer, M.D., at the end of this report).

**Treatment of BD II**

Treatment guidelines for bipolar disorder often give only a passing nod to distinguishing appropriate treatments for BD I versus BD II. The combined guidelines by the Canadian Network for Mood and Anxiety Treatments (CANNMAT) and International Society for Bipolar Disorders (ISBD) were unusual in making a point of distinguishing the evidence base for BD I versus BD II. They are reported in a 2018 paper by Lakshmi N. Yatham, M.D., et al. (see reference at end of article).

These guidelines have a separate section devoted to BD II, and they clearly state that one cannot directly apply studies on patients with BD I to management of patients with BD II. The conclusion of these guidelines is that there are too few controlled studies in patients with BD II to make detailed evidence-based recommendations or develop evidence-based treatment algorithms. Below is a brief overview of our current knowledge of treatments for patients with BD II with medication and/or psychotherapy.

**Antidepressants**

It is worth highlighting that, while monotherapy antidepressants would be viewed as an inappropriate practice for patients with BD I depression, studies suggest that the risks and benefits may be different for those with BD I and BD II. In at least one study, risk of switching to hypomania was no greater with lithium than with sertraline monotherapy. Other studies have shown antidepressant monotherapy to be an efficacious monotherapy for BD II. Meta-analyses on risk of antidepressant-induced switches are inconclusive, though the risk of treatment-emergent (hypomania or mania) due to medication appears to be less in patients with BD II than in patients with BD I depression receiving monotherapy antidepressants. Absent conclusive data on antidepressant switch rates, without a past record of good response to antidepressant monotherapy, current treatment guidelines suggest starting with lithium or a mood stabilizer before adding or switching to antidepressant monotherapy. Additionally, it is important to note that antidepressants in some patients may worsen the overall course of illness and may not be efficacious in some patients with BD II. Any patient who experiences hypomania or mania (which must be distinguished from transient activation symptoms) while on antidepressant medication should be presumed to be on the bipolar spectrum.

**Antipsychotics**

Most atypical antipsychotics have not been studied for the treatment of both BD I and BD II depression, with two notable exceptions. Quetiapine registration trials included individuals with BD II, with post-hoc analyses demonstrating efficacy of quetiapine monotherapy for BD II depression. Lumateproenone is the first antipsychotic formally studied for depression response in patients with BD II since quetiapine trials in the early 2000s. Lumateponone, in randomized, controlled trials, performed as well or better for BD II than BD I, according to a 2021 study by Joseph R. Calabrese, M.D., et al. Cariprazine and lurasidone, while both FDA approved to treat bipolar depression, were never formally studied in patients with BD II. There have been case series supporting their use in BD II depression, but no randomized, controlled trials have been carried out. FDA approval to treat patients with BD II depression with lumateporonene came in 2021, 15 years after quetiapine was approved. This glacial rate of accruing new FDA-approved compounds for BD II speaks to the need for more studies in this population.

**Lithium and Anticonvulsants**

While we might expect lithium to be the front-runner treatment for managing BD II, study results...
are varied. Certainly, for hypomania and maintenance treatment of patients with BD II, lithium is a top choice. Lithium has a disappointingly poor track record for treating BD II depression with little indication that response rates are superior to those of antidepressants and atypical antipsychotics. Lamotrigine has good evidence for preventing new depression episodes in the context of BD (both BD II and I). The evidence, however, is less robust for treating acute depression in patients with BD II. In clinical practice, many clinicians prescribe lamotrigine, especially as an adjunctive treatment, for BD II depression, but our ability to make firm recommendations with confidence about lamotrigine is limited.

Other Therapies

Rapid-acting therapies are on the rise across all treatments for depression. There has been a recent surge of clinical work and research examining transcranial magnetic stimulation (TMS), ketamine, and psychedelics and related compounds. More work is needed specifically focused on BD II depression before firm conclusions may be drawn.

There is limited evidence supporting the use of TMS for BD II depression. This evidence base is developing, and more information is forthcoming on the utility of TMS for BD II depression.

Ketamine and Psychedelic Studies

Racemic ketamine has been in use for many years as an anesthetic and more recently was approved by the FDA as intranasal esketamine (the s-enantiomer of racemic ketamine) as a treatment for MDD. Three small studies of racemic ketamine suggest that it is effective for BD II depression. A 2022 observational study by Farhan Fancy et al. assessing patients with BD I versus BD II treated with racemic ketamine included more than 60 patients (n=35 BD II). In this largest open observational study to date involving ketamine and BD, patients with BD II demonstrated a more robust response than those with BD I. More studies are in development exploring this new use of an old drug; to date, there is no information on the role of esketamine for bipolar depression, let alone BD II.

Recently, it’s been difficult to pick up a journal or look at other media without seeing something about psychedelics and related compounds. There is a surge of interest in psychedelics for MDD, although evidence about their effectiveness is still early and with rare exceptions involves small samples. There is one report on treatment of depression with psilocybin in patients with BD II. In this pilot study, 15 patients with BD II were given a one-time dose of psilocybin (25 mg) and provided preparatory, dosing, and integration therapy consistent with psilocybin studies in MDD. In this small open study by Scott Aaronson, M.D., et al., the rate of response at 3 and 12 weeks was more robust than has been observed in MDD studies. An ongoing study is assessing the durability of patients’ response to psilocybin administered one time for patients with BD II depression. While no notable adverse events or increased mood lability were noted in this small sample to date, further study is needed to assess benefits and harms.

Psychotherapy

Most information about psychotherapy for BD II is derived from trials of interventions for BD in general that also included a subset of individuals with BD II. A recent systematic review of psychotherapies for BD II identified over 1,000 individuals with BD II who participated in randomized, controlled trials testing psychosocial interventions to treat depression or prevent recurrence of mood symptoms. However, relatively few of these trials—only eight of 27—examined outcomes in those with BD II separately. From this review, we concluded that there is preliminary evidence supporting the efficacy of several evidence-based psychotherapies for BD II: cognitive-behavioral therapy, psychoeducation, family focused therapy, interpersonal and social rhythm therapy (IPSRT), and functional remediation. None of these psychotherapies has undergone rigorous testing in randomized, controlled trials focused specifically on BD II depression, with the exception of IPSRT, pointing to the need for additional research in this area. To our knowledge, no meta-analysis of psychotherapy for BD II has been published.

IPSRT, the only psychosocial intervention to be tested in a randomized, controlled trial consisting of participants with BD II only (rather than a mixed patient population of BD I and II), focuses on helping individuals develop more regular routines to stabilize underlying disturbances in circadian rhythms. Because abnormalities in circadian biology have been implicated in the genesis of bipolar disorders, including BD II, a chronobiologic behavioral approach may be especially helpful to mitigate BD II symptoms.

Conclusions

BD II is a relatively common disorder affecting approximately 0.4% of the population. Its prevalence, morbidity, and mortality are comparable to that of BD I. Evidence supports conceptualizing BD II as a distinct phenotype, separable from both BD I and MDD. Compared with BD I and MDD, far less is known about BD II and how to treat it. Further, despite being reliably diagnosed in DSM-5 field trials, BD II is frequently misdiagnosed in practice, resulting in a decade-long lag between onset of symptoms and appropriate diagnosis. A neglected condition, BD II causes unnecessary suffering in those who are misdiagnosed or for whom appropriate treatments are unclear. More research is urgently needed to improve identification and treatments for BD II.
Interview With An Expert by Lived Experience

Sara Schley has bipolar disorder II. She is the author of Brainstorm: From Broken to Blessed on the Bipolar Spectrum and has presented a subsequent TEDx talk of the same name. She was interviewed by Holly A. Swartz, M.D., one of the authors of this special report on bipolar disorder II.

Which is worse for you, the depressions or hypomanias? Why?

Depressions are infinitely worse. Antidepressant medications triggered my first diagnosable hypomania. My husband, siblings, and friends reported that I had a hair-trigger temper at that point—not my norm. I must admit that I was not aware of being reactive. I felt good, and I was becoming grateful to be out of depression. I imagine my hypomanic episodes were worse for my family than for me, but I know they were also relieved that I was not depressed. They’d take hypomania anytime over depression.

I should mention that I run a little bit “high” most of the time. I think this would be described as a hyperthymic temperament, rather than hypomania. In general, I don’t feel very different from everyone else in my high-powered, family, at my competitive university, and at the driven corporations where I work. People have always told me things like, “You get twice as much done in a day as anyone I know.” I attributed that to high energy, focus, and ambition. It never really got in the way. These seem like personality traits to me, and they have given me a competitive edge. I wonder if my hyperthymic temperament is connected to my bipolar disorder. What do you think, Dr. Swartz? I bet you have an opinion on that!

Your question about the relationship between hyperthymic temperament and BD II is interesting, and we really don’t have a good answer. Although some people with BD II seem to have a hyperthymic baseline, others do not. But I really appreciate your underscoring that your high energy personality is different from the episodes of hypomania experienced while on antidepressant medications. Can you say more about the depressive episodes?

My depressions, in contrast to hypomanias, are absolutely, horrifically debilitating. When my bipolar switch flips me into depression, my brain simply stops working. This is excruciating for someone like me who is used to being high powered. Here is a brief description of what it feels like to be depressed, taken from my autobiography, Brainstorm: From Broken to Blessed on the Bipolar Spectrum and the subsequent TEDx talk of the same name:

When most people hear or see someone who looks depressed, they think about emotion: “Oh they’re just sad. Let’s fix their sadness.” But that’s not how it is for me. When I am depressed, my brain simply stops working. It’s a physical thing. Here are a few examples of the impact. There are many more.

Simple, everyday conceptual tasks I’ve taken for granted are nearly impossible. One day it literally took me three full hours to unpack two bags of groceries. I get lost between putting away the tomatoes and shelving the cereal boxes. In constant confusion, I’m unable to sequence actions. I forget multiplication. This makes me miserable. I once got an 800 on my math SATs. Shopping malls and supermarkets are impossible; there are too many choices. How long can I stand in an aisle trying to choose between peanut butters? The large or the small? The organic or the nonorganic? The cheap or the higher priced? These decisions paralyze me. And the inability to make decisions floods me with anxiety and shame.

Getting dressed in the morning poses a similar challenge. What goes with what? How do I choose colors? If it’s cold enough outside to need socks and there are none in my drawer, I simply can’t go out. I stop doing laundry. It’s too overwhelming to go through the sequencing it takes to fold, sort, and put away clothes. In the office, the bedroom, and the kitchen, things pile up. It’s not that I don’t want to do dishes; I simply cannot do them. But I hate the kitchen, things pile up. It’s not that I don’t want to do dishes; I simply cannot do them. But I hate the kitchen, things pile up. It’s not that I don’t want to do dishes; I simply cannot do them. But I hate

That’s a very powerful description of depression. How long did it take for you to get diagnosed with bipolar II disorder?

25 years. No kidding.

That’s a very long time! What were the consequences for you of not getting the right diagnosis?

I had a series of debilitating, life-threatening, excruciating depressions including at least seven major bouts lasting on average nine months each. If you’ve never experienced a broken brain, I think it may be hard to imagine how brutal these times are. Relentless hell, minute by minute, hour by hour, day by day. My inner “demons” [were] regularly screaming at me that I was worthless, and my family would be better off if I were dead. Please note that this was never a message I got from my parents or anyone else in my life. To the contrary, I’d won awards and accolades. The source of the demon’s ferocity is a mystery to me. The love from my family and friends is what kept me on planet earth. And later, after my kids were born, I preferred a living hell to leaving them with a legacy of a mother who died by suicide. But believe me, I don’t judge anyone who makes that choice. I get it.

Given my broken brain as described above, I’m quite sure I would have been in the streets or worse were it not for the resources and love of family.

The wrong diagnosis—doctors thought I had major depressive disorder—also led to the wrong drugs. I was given antidepressant medications that seemed to work at first, but then made me much worse. More anxiety, more sleepless nights, more screaming demons. When I’d return to the psychiatrist who had the “mental model” that I was just depressed, he’d give me more antidepressants. Vicious cycle.

I think it’s important to note that my worst and longest depressions occurred when I was on a variety of SSRIs. When the fifth psychiatrist finally gave me my BD II diagnosis along with bipolar-specific medications, I returned to full health and vitality in three months. A miracle.

You chose to tell your story in your recently published autobiography, Brainstorm: From Broken to Blessed on the Bipolar Spectrum. What prompted you to write about your experiences with BD II?

Thank you for asking that. Here’s the story as it unfolded. I was in therapy with my husband and a wonderful couples counselor. I had finally been diagnosed correctly, was on the right medications, and was graced with the miracle of my brain and life back intact.

Now my husband—who had been holding down the fort at home, covering for me in our consulting business, and caring for our 4-year-old twins for 18 months—needed support. And we needed to rebuild our relationship after the trauma of that year and a half. The counselor, who had a Ph.D. in psychology, asked me to tell my bipolar II story. After I did, her jaw dropped. She said, “You have to write this story. My colleagues don’t know about it. They don’t know that there is such a thing as bipolar with no mania.” I went home and had a 14 chapter outline in about three minutes.

I wrote the book over the course of six months and then waited another decade to publish it. I wanted my parents to be in the next world before publishing because it includes a lot of my mom’s story. And I wanted my kids to be old enough to give me permission to share part of their story. When COVID hit and so many were suffering from the pandemic-induced mental health tsunami, I knew it was time. Your endorsement, Dr. Swartz, calling the book “The Kay Jamison of bipolar II” was a huge encouragement. How did you know that’s what I set out to do?

Your first-person account of living with BD II is a great resource for family members and the many individuals living with this illness. It helps to know you are not alone. What are the most important things you want people to know about BD II?

I hope people take away these messages both from my book and this article in Psychiatric News:

• There is a bipolar spectrum—many types of bipolar beyond classic manic depression.
• There is bipolar disorder without mania.
• People with BD II are consistently misdiagnosed with major depression. This is dangerous! We are often given drugs that can make us worse.
• BD II is not a lesser form of BD I. Our depressions are equally bad, if not worse. Our suicide rates are the same.

Thank you so much for sharing your story and wisdom with us.
Ashley Judd to Be Speak at Opening Session

Golden Globe winner and Emmy-nominated actress Ashley Judd has long been a devoted activist and humanitarian, championing women’s rights and public health issues. She has also written about the need to ensure privacy for families following the death of a loved one to suicide.

BY KATIE O’CONNOR

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nown for her roles in “De-Lovely,” “Ruby in Paradise,” actress, writer, and humanitarian Ashley Judd, M.P.A., will be a plenary speaker at the 2023 APA Annual Meeting in San Francisco.

Judd has also gained worldwide acclaim as an avid advocate of human rights, with a focus on gender equality and public health. Since 2004 she has worked with numerous NGOs and traveled the world in support of public health efforts related to maternal health, child survival, HIV prevention, and malaria prevention and treatment.

She currently serves as a Global Goodwill Ambassador for the United Nations (UN) Population Fund, the UN’s sexual and reproductive health agency. She is also the chair of the Women's Media Center Speech Project: Curbing Abuse, Expanding Freedom; a Global Ambassador for both Population Services International and Polaris Project; and a member of the leadership council of the International Center for Research on Women.

Judd earned her master's degree from Harvard's Kennedy School of Government. In 2017, she was the recipient of the Muhammad Ali Kentuckiana Humanitarian Award. Her undergraduate alma mater, the University of Kentucky, established the Ashley T. Judd Distinguished Graduate Fellowship in the Office for Policy Studies on Violence Against Women.

She was also featured on the cover of TIME Magazine's 2017 Person of the Year issue, which honored the thousands of individuals across the world who spoke out about their experiences of sexual harassment and assault, dubbed “The Silence Breakers.”

Judd has written about her family experiences with mental illness. In August 2022, she penned a guest essay in the New York Times about her family's effort to keep police reports related to the suicide of her mother, Naomi Judd, private. Naomi Judd was a well-respected musician who dealt with mental illness for much of her life.

Tennessee law allows police reports from closed investigations, including family interviews, to be made public. “Naomi lost a long battle against an unrelenting foe that in the end was too powerful to be defeated,” Ashley Judd wrote. “I could not help her. I can, however, do something about how she is remembered.”

She wrote that she intends to make the invasion of privacy following an individual’s death by suicide “a personal as well as a legal cause.” She also called for a reformation of law enforcement procedures related to such cases. “Though I acknowledge the need for law enforcement to investigate a sudden violent death by suicide, there is absolutely no compelling public interest in the case of my mother to justify releasing the videos, images, and family interviews that were done in the course of that investigation.”

Last August, Naomi Judd’s family filed for injunctive relief in Williamson County, Tenn., to keep the police records related to her death private. Last December, the Associated Press reported that the family had filed a notice to voluntarily dismiss the lawsuit, due in part to the fact that journalists who requested the police records were not requesting photographs or body cam footage. The notice also said a Tennessee state lawmaker is introducing legislation to make death investigation records private when the death is not the result of a crime.

“I hope that leaders in Washington and in state capitals will provide some basic protections for those involved in the police response to mental health emergencies,” Ashley Judd wrote in her essay, adding that her mother “should be remembered for how she lived, which was with goofy humor, glory on stage, and unfailing kindness off it—not for the private details of how she suffered when she died.”

Actor and mental health advocate Ashley Judd is the plenary speaker at the Opening Session of APA's 2023 Annual Meeting. The Opening Session will be held Saturday, May 20, at 5:30 p.m. in the Moscone Center.
SATURDAY, MAY 20
8 A.M. - 9:30 A.M.
General Sessions
A Collaborative Approach to Managing the Neuropsychiatric Symptoms of Parkinson’s Disease Chair: Ebony Dix, M.D.
Am I Ready for My Patients to See Their Records? A Guide to Clinicians on Patient-Centered Recovery-Oriented Documentation Chair: Maria Mirabela Bodic, M.D.
Answering the Call: Implementing Best Practices for Opioid Use Disorder in General Public Mental Health Clinics to Stem the Tide of the Opioid Epidemic Chair: Molly T. Finnerty, M.D.
“Anyone Could Have Stopped Me”: Early Intervention in the Pathway to Violence to Prevent School Shootings Chair: Shamina Shagaya, M.D., M.D., M.P.H.
BEDside Study and Stomp: Understanding Disordered Sleep Among Adults With Intellectual Disability and Rationalising Antipsychotics Chair: Paul Shanahan
Bridging the Gap Through Primary Care Collaboration: Psychotherapeutic Expertise in Integrated Primary and Behavioral Health Care Chair: David L. Mintz, M.D.
Calling Agents of Change: Equipping Psychiatrists to Identify and Tackle Diversity and Inclusion Chair: Amy Alexander
Champions of Social Justice: Psychiatry in Marginalized Communities (Docuseries Project of SCPS Psychiatry Working in Marginalized Communities) Chair: Ijeoma Ijeaku, M.D., M.P.H.
Creative Collaboration in the Correctional Setting Chair: Peter Nicholas Nowals, M.D. Chair: Dale Davis Sebastian, M.D., M.B.B.S.
Demystifying Personality Disorders in Individuals With Intellectual Disability Chair: Nita V. Bhatt, M.D., M.P.H.
Designing and Implementing a Global Mental Health Curriculum: Challenges and the Way Forward Chair: Kenneth P. Fang, M.D.
Dual Loyalty and Crypto-Apartheid in Psychiatric Acute Services Chair: Cynthia X. He, M.D., Ph.D.
Dynamic Therapy With Self-Destructive Borderline Patients: An Alliance-Based Intervention for Suicide Chair: Eric Plakan
Enhancing Quality of Mental Health Care Through Exploring and Addressing the Spiritual and Religious Dimension: Approaches Across the Lifespan Chair: Dale Davis Sebastian, M.D., M.B.B.S.
Hoarding Disorder: A Comprehensive Overview Chair: Carolyn I. Rodriguez, M.D., Ph.D.
Improving the Diagnostic Accuracy of Bipolar Disorder: An Experimental Workshop Chair: Marsal Sanches
Innovation for Future Generations: Child Adolescent Mental Health Integration in Primary Care Settings Chair: Catherine Horne, M.A.
Interdisciplinary Approach to Adult Autism Assessment at MetroHealth Autism Assessment Clinic: Overview With Two Clinical Cases Chairs: Rajesh Kumar Mehta, M.D., Raman Marwah
It Takes a Village: The First Two Years of a Resilience-Focused Center at Large Urban Health System Chair: Jonathan DePierro
People, Place, and Purpose: Contributions of Faith Traditions to Recovery and Resilience Chair: John Raymond Petet, M.D.
Providing Gender-Affirming Care in Vulnerable Patient Populations Chair: Tamara Murphy, M.D.
Telehealth Solutions for Crisis Management in the Acute Psychiatric Care Setting Chair: Owen McHool
When Behavioral De-escalation Isn’t Enough: Medication Management of Acute Agitation in Manic and Psychotic Patients Chair: David N. Osier, M.D.
Why Despite the Current Changes, the Gender Gap in Psychiatry Persists? What Are We Missing? Chair: Ruby C. Castillo Puentes, M.D., Dr.P.H., M.B.A.
Your Mental Health Starts in Your Gut Microbiota Chair: Gia Merlo, M.D., M.B.A., M.Ed.

10:30 A.M. - NOON
Award Lecture
George Tarjan Award Lecture: Navigating the Cultural Landscape for Professional Success: An IMG Perspective Chair: Antony Fernandez, M.D.

General Sessions
Acutely Suicidal Young Patient: Delivering Intervention at Time of Crisis to Target Emotional Aftermath and Repetition of Self-Injurious Behavior Chair: Yulia Furloong
Anxious and Irritable Endophenotypes of Major Depressive Disorder Chair: Alan F. Schatzberg, M.D.
AthL-Ethics: A Sprint of Ethical Considerations in Clinical Care, Research, and Publication Chair: Kenneth Roland Kaufman, M.D.
Bridging Research, Accurate Information, and Dialogue to Address Unusual Participation of Underrepresented Populations in Psychiatric Research Chair: Nelly Gonzalez-Lepage, M.D., M.B.A.
Doing Affirmative Dialiectical Behavior Therapy With LGBTQ+ People: A Live Demonstration Chair: Jeffrey M. Cohen, Psy.D.
Dr. IMG in the Multiverse of ECPs: Moving Beyond Training: What Should I Do? Where Do I Go? What Do I Become? Chair: SudhaIkar ShenoY, M.D.
Engagement and Empathy in the Era of the Open Note: Evaluating Our Documentation Chair: Tony W. Thrasier, D.O.
Evidence-Based Practice or Egregious Malpractice? What Psychiatrists Professionals Need to Know About Supervised Consumption Sites Chair: Adelle M. Schaefer, M.D.
Facilitating Alcohol Recovery in the Context of a Learning Health Care System: Challenges and Opportunities for Improving Care Delivery and Research Presenter: Stacy Sterling, D.P.H., M.P.H., M.S.W.
Food, Mood, and the Microbiome: The Gut-Brain Axis—Moving Beyond the Monoamine Neurotransmitter Hypothesis and Toward Understanding the Holobiotic Chair: Christopher E. Hines, M.D.
International Medical Graduate Degrees in American Psychiatry: Past, Present, and Future Chair: Dipil Jeste, M.D.
Is Measurement-Based Care the Future of Psychiatric Practice? Chairs: Carol Alter, Erik Rudolph Vanderlip, M.D., M.P.H.
Long-Term, Lifetime Management of Psychiatric Illness Chair: Ira David Glick, M.D.
Mental Health and Faith Community Partnerships 2023: Needed Now More Than Ever! Chair: Mary Lynn Dell, M.D.
Minor Charges With Major Impacts: Misdemeanors Versus Pre-Arrest Jail Diversion for Individuals With Serious Mental Illnesses Chair: Michael Compton, M.D.
Navigating Career Paths for IMGs: Charting Your Successful Future Chair: Toni Love Johnson
No Good Deed Goes Unpunished: Determining Decisional Capacity for Medically Ill Patients and Getting Sued for It Chair: Philip R. Maksin, M.D., M.A.
Physician Aid in Dying Based on a Mental Disorder: What Have We Learned? Lessons for the U.S. and Rest of the World Chair: Karandeep Gaid
Preparing Psychiatrists for Combat: Providing Collaborative Care in Ukraine and Beyond Chair: Vincent F. Capalbi, H.M.
Declaring Purpose: Journeys Toward Justice, Anti-Racism, and Public Service in Psychiatry Chair: Enrico Guanzon Castillo, M.D.
When Provider Bias Becomes Lethal, High Utilizers in the Health Care System Chair: Kelly-Anne Czyzski Klein, M.D.
Learning Lab
Brain-ival! Using Interactive Games to Teach Psychiatrists About the Neurobiology of Mental Health Challenges Chair: Raghavendra S. Mihajlovic, M.D., M.S.
Presidential Session
Indo-American Psychiatric Association and the Asian Indian: Trials, Victories, and Opportunities Chair: Bhargavdra Sahasvanmah, M.D.
Poster Session
Poster Session 1
1:30 P.M. - 3 P.M.
General Sessions
Achieving Mental Health Parity in New York State: Patient-Centered, Quality-Focused, Clinically-Driven Utilization Review and Eliminating Disparities Chair: Thomas Smith, M.D.
Autoimmune Brain Disorders: Immune Regulation and Psychiatric Symptoms Presenter: GeneLynne C. Mooneyham, M.D.
Behind the Screen: Cyberbullying and Its Connection With Mental Illness and Substance Use Chair: Kanya Nesbitt, M.D.
Building and Sustaining a Statewide Telepsychiatry Network: A Decade Long Experience of the North Carolina Statewide Telepsychiatry Program (NC-Step) Chair: Sy Atteaz Saeed, M.D., M.S.
Conceptual Competence in Psychiatric Training: Building a Culture of Conceptual Inquiry Chair: G. Scott Waterman, M.D.
Digital Applications and Their Utility in Reducing Suicidality in Underrepresented Youth Chair: Aidaspahic S. Mihajlovic, M.D., M.S.
Empathic Listening and Mental Status Assessments: Teaching “Empathic Listening Assessment” to

2023 Annual Meeting Program Now Live
The dates, times, locations, and descriptions of all Annual Meeting sessions appear in the Session Search tool on APA’s website at https://s7.goeshow.com/apa/annual/2023/session_search.cfm. They are also available in the APA Meetings App, which can be downloaded at psychiatry.org/app.
### Best-Selling Author to Discuss How Psychiatrists Can Help Create More Equitable World

Economics and social policy expert Heather McGhee journeyed across the country to understand what Americans believe about each other. Her book from this journey, *The Sum of Us: What Racism Costs Everyone and How We Can Prosper Together*, spent 10 weeks on The New York Times bestseller list. She will be a keynote speaker at the Emerging Voices plenary. **By Jennifer Carr**

Heather McGhee, the author of the 2021 best-seller *The Sum of Us: What Racism Costs Everyone and How We Can Prosper Together*, began her journey to understand inequality in the United States with a question that may have at least once crossed your mind: Why can’t we have nice things?

“In the birthplace of the American dream, we have one of the most unequal economies—with housing, health care, college, retirement increasingly out of reach for most people,” explained McGhee, an expert in economic and social policy, in the first episode of “The Sum of Us” podcast, which explores themes addressed in the book. McGhee will deliver a keynote plenary address at APA’s 2023 Annual Meeting, where she will talk about how psychiatrists can be leaders in helping to create a more equitable world. After her talk, she will join a panel with the presidents of the AMA and the American Bar Association to discuss the role and responsibility of the professions of medicine and law in advocacy and action to advance diversity, equity, inclusion, and belonging in America.

McGhee spent nearly two decades at Demos, a research and advocacy organization, and the American Bar Association to discuss the role and responsibility of the professions of medicine and law in advocacy and action to advance diversity, equity, inclusion, and belonging in America.

“[Everything we believe comes from a story we’ve been told],” Heather McGhee wrote in the introduction of *The Sum of Us*. “I set out on this journey to piece together a new story of who we could be to one another and to glimpse the new America we must create for the sum of us.”

McGhee will deliver a keynote plenary address at APA’s 2023 Annual Meeting, where she will talk about how psychiatrists can be leaders in helping to create a more equitable world. After her talk, she will join a panel with the presidents of the AMA and the American Bar Association to discuss the role and responsibility of the professions of medicine and law in advocacy and action to advance diversity, equity, inclusion, and belonging in America.

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### SATURDAY

**Medical Students, Residents, and Physicians**

**Chair: Parmeshwaran Ramakrishnan**

*From Roots to Stem: A Hands-on Approach to Cultivating Diversity*

**Chair: Ludmila Bay, M.D.**

- High-Intensity Interventions for Youth: Treating the Fast and the Furious
  **Chair: Robert D. Friedman, Ph.D.**

- Inclusive Psychiatric Care for Women: Identity, Community, and Culturally Competent Care During Changing Social Landscape
  **Chair: Kamalike Roy, M.D.**

- Innovative Delivery of Care for Patients Diagnosed With Cancer:
  A Collaborative Team Approach
  **Chair: Maria Rueda-Lara**

- Meaningful Community Participation: An Essential Aspect of Recovery for Persons With Serious Mental Illness
  **Chair: Alexa Wolf, M.D., M.P.H.**

- Models of Care for Pregnant Individuals With Substance Use Disorders
  **Chair: Caridad Ponce Martinez, M.D.**

- Partnering to Address Mental Health Care for Forensically Involved Individuals: Innovative Strategies and Examples of State and County Programs
  **Chair: Luming Li, M.D.**

- PCP Coaching: An Underutilized but Very Effective Method to Increase Mental Health Care Availability in the Community
  **Chair: Sasidhar Gunturu, M.D.**

- Restorative Psychiatry: Disclosure, Broaching Race, Ethnicity, and Culture; and Cultivating Empathic Identity in the Therapeutic Relationship
  **Chair: Ravi Chandra**

- The Measurement-Based Care Imperative: Knowing is Half the Battle
  **Chair: Erik Rudolph Vanderlip, M.D., M.P.H.**

- The Role of the Photographic Arts in Psychiatry
  **Chair: Carlyle Hung-Lan Chan, M.D.**

- Understanding Munchausen’s by Proxy or Factitious Disorder Imposed on Another: Child Abuse by Another Name
  **Chair: Susan Hatters-Friedman, M.D.**

### Learning Lab

- Transcranial Magnetic Stimulation: Future Innovations and Clinical Applications for Psychiatric Practice
  **Chair: Richard Arden Bermudes, M.D.**

- Poster Session 2

- Course ID: C3029 | Reproductive Psychiatry: What Every Psychiatrist Should Know
  **($) Director: Sarah M. Nagle-Yang, M.D.**

### Master Course

- Course ID: MB105A | 2023 Psychiatry Review: Part 1 ($)
  **Directors: Venkat B. Kodli, M.D., Vishal Madan, M.D.**

### 3:45 P.M. - 5:15 P.M.

#### Award Lecture

- Frank J. Menolascino Award Lecture
  **Title: The Search for Better Autism Treatments: Conventional to Complementary/Alternative**
  **Chair: L. Eugene Arnold**

- Addressing the Management of Incidents of Racial Bias and Discrimination in Graduate Medical Education
  **Chair: Constance E. Dunlap, M.D.**

- Advocating for the Integration of Culture Into Forensic Therapeutics
  **Chair: Bushra Khan, M.D.**

- Creating a Life Worth Living: Implementing Dialectical Behavior Therapy on Acute Inpatient Units for Children and Adolescents
  **Chair: Deborah Zlotsnik**

- Detecting the Undetectable: Training Health Care Providers in Identifying Victims of Human Trafficking
  **Chair: Sukanya Vartak**

- Documentary “Envision the Big Picture”: Indigenous Knowledges and a Call to Action for Climate Change
  **Chair: Mary Hashash Roesel, M.D.**

- Emotional Support Animals: What Psychiatrists Need to Know
  **Chair: Ariana Nesbit, M.D.**

- Everyday Analytics: Using Public Data and Free Tools to Yield Meaningful Insights for Your Patients, Your Clinic, and Beyond
  **Chair: Michael Joseph Sernyak, M.D.**

- Expanding Access to Expertise: Innovating to Share Our Knowledge
  **Chair: Robert Paul Roca, M.D., M.P.H.**

- From Racism to Wisdom: Critical Role of Social and Psychological Determinants of Health
  **Chair: Dilip V. Jeste, M.D.**

- Golden Gate Bridge Suicide: The Final Chapter
  **Chair: Mel Ira Blaustein, M.D.**

- Human Asexuality: Understanding Why It Matters to Mental Health Practitioners
  **Chair: Samantha Hayes, M.D.**

- Informing Depression Treatment in the Hispanic/Latinx Community: Sentiment, Practical Application, and Clinical Utility of Pharmacogenomic Testing
  **Chair: Ruby C. Castilla Puentes, M.D., Dr.P.H., M.B.A.**

- Innovative Strategies to Collaboratively Enhance IMG Entry and Success in Psychiatry Residency
  **Chair: Shamshavi Chandrakish, M.D.**

- Metabolic Regulators of Psychological Stress and Brain Trauma
  **Chair: Charles R. Marmar, M.D.**

- Potential for Artificial Intelligence-Powered Chat Therapy in Psychiatry
  **Chair: Young Sukh Jo, M.D.**

- Redefining the Role of the Psychiatrist in the Post-Roe Era
  **Chair: Johanna Beck**

- Representation of South Asian Americans in Media and Its Impact on Identity Formation and Mental Health
  **Chair: Seeba Anam, M.D.**

- Supporting Students and Medical Educators: Trends in the Match, Advising, and Mentoring
  **Chair: Erin Malloy, M.D.**

- Surviving and Thriving Under Cross-Examination
  **Chair: Stephen George Noffsinger, M.D.**

- The Couch, the Clinic, and the Scanner: Changing Models of Psychiatry Over the Past 5 Decades
  **Chair: David Joel Hellerstein, M.D.**

- The Intersection of Trauma, Grief, and Sexuality: Benjamin Britten’s War Requiem
  **Chair: Gene Nakajima, M.D.**

- Tips, Tactics, and Training to Improve Youth Mental Health in Your Community
  **Chair: Anish Ranjan Dube, M.D.**

- Translating Between the Social and Political Determinants of Health
  **Chair: Mandar Jadhav, M.D.**

### Poster Session

- Poster Session 3
Exhibit Hall Is Place to Be!

If you think you are already familiar with APA’s Exhibit Hall, think again. It’s been reimagined as a place to learn about new products, services, and concepts that will be practical and ready for implementation. BY VERNETTA COPELAND

The Exhibit Hall continues to offer attendees new and engaging activities as well as opportunities to learn about new products and services related to psychiatry. After last year’s successful Annual Meeting in New Orleans—where it was obvious that APA members were glad to gather once again—exhibitors are gearing up on a larger scale this year to interact with attendees and share information. Over 250 exhibitors are expected—check out the list of names and a map of the Exhibit Hall in the Annual Meeting Program Guide available at Registration and on the APA Meetings App.

APA continues to put safety first for the health of APA attendees, exhibitors, vendors, and staff. This year’s COVID guidelines require that all attendees at the meeting be fully vaccinated against COVID-19. By attending the meeting, each individual attests and affirms compliance with this request.

The Exhibit Hall is an integral part of the meeting, and the schedule has been carefully planned. To encourage attendance at plenary sessions and to allow exhibitors a break, the Exhibit Hall will be closed each day from 10:30 a.m. to 11:45 a.m. The Exhibit Hall will resume with a Mid-Day Mingle where light food and snacks will be available.

The new Mind & Body Pavilion will be held at the Hilton San Francisco Union Square. Sessions are planned Saturday to Monday, May 20 to 23, from 7:30 p.m. to 9:30 p.m. All non-CME sessions are planned to Monday, May 23, from 9:30 to 10:30 a.m. All non-CME sessions are expected to be available to encourage attendees to focus on their well-being in three areas: Calm, Create, and Challenge. In the “Calm” area, attendees can get a massage with a licensed massage therapist trained to address any tension areas in the upper body. In the “Create” area, attendees can collaborate and paint selected works of art. In the “Challenge” area, attendees can compete with each other in various games such as giant Jenga® and Connect Four®.

Vernetta Copeland is associate director of exhibits and sponsorship sales in APA’s Department of Meetings and Conventions.

Clinical Updates Track to Offer Practical, Usable Insights For Common Clinical Challenges

All the presentations in the track are designed to provide insight and information that will be practical and ready for implementation. BY RONALD WINCHEL, M.D.

Successfully launched at last year’s Annual Meeting in New Orleans, this year’s Clinical Updates Track is designed to address some of the most vexing clinical challenges in the day-to-day practice of psychiatry. The speakers include many leading experts, known for both expertise and teaching skills.

I remember my first APA Annual Meeting (more years ago than I care to remember)—it was also in San Francisco. The enormity of it all was both thrilling and a bit intimidating. Registration complete, I ligged the complimentary blue APA bag back to my hotel. I dropped it onto my bed, and out spilled a cornucopia of catalogues, brochures, and event announcements.

The joy of abundance succumbed to the dismay of bewildering choice. Choosing which session to attend among the hundreds offered can be perplexing. For those members who want to be confident that a particular presentation is going to be primarily oriented toward real-world clinical application, the Clinical Updates Track offers a guiding hand.

Stephen Stahl, M.D., Ph.D., Charles Nemeroff, M.D., Ph.D., Roger McIntyre, M.D., and Wayne Goodman, M.D., are among the 30 internationally distinguished speakers who will present state-of-the-art best-practice reviews of clinical approaches to common clinical challenges.

Among the highlights:

• MAO inhibitors: The oldest of antidepressant categories, MAO inhibitors are still among the most effective medications we have, yet a legacy of anxiety about their use (arguably undeserved) leaves them grossly underutilized. As a result, many of our colleagues have had minimal experience and training in the use of these medications, further perpetuating avoidance of a drug category that provides therapeutic benefits that some patients find with no other medications. Dr. Stahl will review the indications and use of these medications.

• Posttraumatic stress disorder (PTSD): Addressing the needs of patients with PTSD demands that we attend to the evolving clinical science so that we can make informed treatment recommendations. What are the different forms of trauma-informed psychotherapy? What approach is best for your patient? What medications have to offer for individuals with PTSD? How do we address sleep disorders among these patients? Dr. Nemeroff will discuss the state-of-the-art clinical treatment of PTSD.

• Treatment-resistant depression (TRD): TRD is probably one of the most common prompts for asking “What do I do now?” Dr. McIntyre will lead participants through an algorithmic approach about treatment of your patients with TRD.

See Clinical Updates Track on page 43
SUNDAY, MAY 21
8 A.M. - 9:30 A.M.
Award Lecture

Nasrallah Family Award Lecture: New Biology and New Treatments for Schizophrenia and Mood Disorders: My 30-Year Journey With Ketamine Research
Presenter: John H. Krystal, M.D.

General Sessions

A Rebellious Guide to Psychoanalysis
Chair: Mark Rags, M.D.

Anti-Racist Research Design and Practice: Lessons from the Refugee Crisis
Chair: Sarah Qadir, M.D.

Artificial Intelligence (AI) to Analyze Open-Source Digital Conversations on Depression and Suicide: Integration Into Psychiatric Practice
Chair: Maria Antonia Oquendo, M.D., Ph.D.

Becoming a “Good Enough” Psychotherapy Supervisor
Chair: Katherine Gershman Kennedy, M.D.

Building a Better Psychiatric ED: A Focus on Special Populations
Chair: Brandon C. Newsome, M.D.

Charting Future Intersectionalities: Mental Health, Spirituality, and Marginalized Children and Adolescents
Chair: Mary Lynn Dell, M.D.

Chronic Cyclical Disasters: A Community Context-Sensitive Approach to Promoting Adaptive Disaster Response
Chair: Sander Koyfman, M.D., Grant H. Brenner, M.D.

COVID-19 Changed the Way We Talk About Burnout and Mental Health: Building Individual and Systems-Level Interventions to Promote Well-Being
Chair: Laurel Mayer, M.D.

Everything You Wanted to Know About Digital Health Technology but Were Afraid to Ask
Chair: Sherry Ann Nykel, M.D.

Here Fishy, Fishy... Catfishing and Other Cyber Crimes Across the Ages
Chair: Rana Elmaghraby

I Think You’re Muted: Diagnosing and Treating Catatonia Via Video Platforms in the Ambulatory Setting
Chair: Jane Richardson, M.D.

Innovative Versus Inappropriate: Examining a Psychiatrist’s Role to Support Mental Health in a Politically Divided Society
Chair: Mira Zein, M.D., M.P.H.

Lights, Camera, Action! Creating a Short Film to Put Asian American Mental Health in the Spotlight
Chair: Elizabeth Ma, M.D., Ph.D.

Look Who Came to Treatment Team: Threat Management and Working With Federal Agencies to Manage High-Risk Patients
Chair: John S. Rozel, M.D.

Mental Health Apps: How to Recommend and Review
Chair: John Torous

Minimizing Outpatient Malpractice Risk
Chair: Stephen George Nofsinger, M.D.

No Wrong Door: Ushering in Collaborative Solutions for College Mental Health
Chair: Meera Menon, M.D.

Overcoming Disparities in Alcohol Treatment Among BIPOC Women
Chair: Deidra Roach, M.D.

Promoting Women’s Mental Health in a Difficult Environment: Current Challenges in the United States
Chair: A. Evan Elyer, M.D., M.P.H.

Revisiting the Imposter Phenomenon
Chair: Tanuja Gandhi, M.D.

Risky Business? An Analysis of Recent Medical Malpractice Claim Trends and Risk Mitigation Strategies
Chair: Allison Fucellie, M.P.A.

Rollout of Measurement-Based Care in Different Health Care Settings: Successes and Pitfalls
Chair: Jessica Lynn Thackaberry

Safety and De-Escalation
Presenter: Jose M Viruet, L.C.P.C.

Successful Aging: How African Americans and Hispanics Do It, the Connection With Nature, and Motivating Our Patients Through Outdoor “Prescriptions”
Chair: Maria D. Llorente, M.D.

What Is the Role of Psychiatry in K-12 Schools?
Addressing High-Risk Scenarios While Supporting the Continuum of Mental Health Care in Schools
Chair: Justine J. Larson, M.D., M.P.H.

When the Supervisor Needs a Supervisor: Navigating Challenges in the Supervision Dyad
Chair: Amber Frank

Presidential Session

Rethinking Core Values: How Medical “Professionalism” Perpetuates Discrimination Against Black, Indigenous, and People of Color (BIPOC)
Chair: J. Corey Williams

Poster Session

Course ID: C3028 | Evaluation and Treatment of Neurocognitive Disorders ($)
Director: Allan A. Anderson, M.D.

Master Course

Course ID: MB1058 | 2023 Psychiatry Review: Part 2 ($)
Directors: Venkata B. Kolli, M.D., Vishal Madaan, M.D.

8 A.M. - 5 P.M.

Course

Course ID: CS059 | Buprenorphine and Office-Based Treatment of Opioid Use Disorder ($)
Directors: John A. Renner, M.D., Petros Levounis, M.D., M.A.

Master Courses

Course ID: M8063 | Consultation-Liaison Psychiatry Master Course ($)
Director: James Lloyd Lavenson
Course ID: M8066 | Sleep Disorders and Their Management: An Overview of Common Sleep Conditions Associated With Mental Health Disorders ($)
Director: Emmanuel Durning

10:30 A.M. - NOON
Award Lecture

Oskar Pfister Award Lecture: From the Margins to the Center: It is Not Just About “Them”
Presenter: William C Gaventa Jr, M.D.

General Sessions

40 Years of the Association of Women Psychiatrists: A Historical and Contemporary Look at Social Justice in Psychiatry
Chair: Christina T. Khan, M.D., Ph.D.

Addressing the Mental Health Needs of Sub-Saharan Africans at Home and in the United States: The Role of Diaspora Psychiatrists and Mobile Technology
Chair: Charles Dike, M.D., M.P.H.

Behind the Incel Movement—the Misogyny and the Violence Chair: Keyla Fisher, M.D., J.D.

Biologizing the Psychobabble: The Emerging Neuroscience of Psychotherapy
Chair: Christopher Miller

Bridging the Gap: Epidemiology, Clinical Care, and Policy at the Intersection of Serious Mental Illness and HIV
Chair: Alison R. Huong, M.D., Ph.D.

Caring for the Whole Person: A Practical Update on Common Medical-Psychiatric Comorbidities and Preventative Care for Clinical Practice
Chair: Kate Richards, M.D.

Catharsis Welcomes Creativity: A Poet’s Tale of Exploring Mental Health Through the Arts
Chair: Frank Clark

Closing the Treatment Gap: How Can Psychiatry Help?
Chair: Laura E Kusaka, Ph.D.

Cult Leaders: The Fine Line Between Mental Illness and Opportunism
Chair: Ashley H. VanDercar, M.D., J.D.

Darkness Illuminated: How Evolutionary Psychiatry Can Shed New Light on Depression and Improve Clinical Care
Chair: Christopher Gargus

Evolving Controversies in Treating Gender Dysphoric Youth
Chair: Jack Drescher, M.D.

How to Provide Gender-Affirming Mental Health Care in a Clinical Setting
Presenter: Dan Karasic, M.D.

I Am Assessing a Minor That Said He/She Will Shoot Its School. What Should/Can I Do?
Chair: Cristian Zeni, M.D., Ph.D.

Person of Color Living With Mood Disorders: Community Engagement and a Call to Action
Chair: Monica J. Taylor-Desir, M.D.

Psychopharmacology Master Class: The Art of Psychopharmacology
Chairs: David L. Mintz, M.D., Carl Salzman, M.D.

Supporting the Mental Health of Health Care Workers During COVID-19 and Beyond
Chair: George L. Alvarado, M.D.

Teaching Decision-Making Capacity: An Asynchronous Workshop
Model Chair: Cara Angelotta, M.D.

The Overturning of Role: Wade: Implications for Women’s Mental Health
Chair: Madeleine Anne Becker, M.D., M.A.

The Role of Animals in the Treatment of Mental Disorders
Chair: Nancy R. Gee, Ph.D.

Town Hall: COP2: A Global Response to the Mental Health Needs of Our Climate Crisis
Chair: Elizabeth Haase

Learning Lab

Supporting Person-Centered Care: A Simulation of Hearing Voices
Chair: Sherin Khan

Presidential Session

The Evolving Canadian Mental Health System: Challenges and Opportunities for Psychiatrists
Presenters: Gary A Chaimowitz, Allison Freeland

Poster Session

Poster Session 5

Course ID: M8056 | Consultation-Liaison Psychiatry Master Course ($)
Director: James Lloyd Lavenson
Course ID: M8066 | Sleep Disorders and Their Management: An Overview of Common Sleep Conditions Associated With Mental Health Disorders ($)
Director: Emmanuel Durning

1:30 P.M. - 3 P.M.

Award Lecture

Kun-Po Soo Award Lecture: Journey From the West to the East: Diagnostic and Therapeutic Approaches to Treatment-Resistant Mood Disorders
Presenter: Tung-Ping Su, M.D.

General Sessions

Addressing Anti-Racism and Structural Competency in Schools: A Collaborative Approach
Chair: Aishuarya Kamakshi Rajagopalan, D.O., M.H.S.

Applying for Psychiatry Residency? Some Tips and Tricks From PDs
Presenters: Benedicto R. Borja, M.D., Rashi Aggarwal, Jason E Curry, D.O.

Asians in America: Not a Model Minority and Not a Minority Chair: Dora-Linda Wang, M.D.

Benzodiazepines—Prescribing and De-Prescribing
Chair: Ron M. Winchel, M.D., Catherine Crane

Brain Health and Well-Being in Older Adults: The Impact of Lifestyle Interventions
Chair: Helen Hisea Kyo- men, M.D.

Complex Neuropsychiatric Presentations in Consultation-Liaison Psychiatry: Acute Psychosis, Delirious Mania, and Catatonia
Chair: Laura T. Safar, M.D.

Confident Clozapine Prescribing: Motivating Clinicians to Address Racial and Ethnic Disparities in Clozapine Utilization
Chair: Claire C. Holderness, M.D.

Creating Spanish/English Networks to Support Mental Health of Hispanic/Latino Communities
Chair: continued on next page
Critical legal and policy changes in recent years have profoundly impacted women and girls in the United States. During this Annual Meeting session, experts will discuss steps psychiatrists can take to mitigate these harmful policies’ adverse effects.

BY KATIE O’CONNOR

Recurrent legal and policy changes, especially those that deny women and girls autonomy over their own bodies, have adversely impacted the mental health of women and girls across the country. These policies have also taken a toll on psychiatrists and their colleagues, who are continuing to provide care to these patients. These challenges will be discussed in detail at APA’s 2023 Annual Meeting in the session titled “Promoting Women’s Mental Health in a Difficult Environment: Current Challenges in the United States.”

“The central theme in many of these policy developments is denial of individual sovereignty over the body and personal control in the most intimate aspects of life,” said Evan Eyler, M.D., Ph.D., the session’s chair and a professor of psychiatry at the Robert Larner M.D., College of Medicine at the University of Vermont. “That manifests in a wide variety of misogynistic and anti-LGBTQ policies and practices that very negatively impact our patients and make psychiatric practice more difficult and emotionally challenging.”

The presenters include Carole Warshaw, M.D., director of the National Center on Domestic Violence, Trauma, and Mental Health; Leslie Gise, M.D., a clinical professor in the Department of Psychiatry at John A. Burns School of Medicine, University of Hawaii; and Amanda Koire, M.D., Ph.D., a clinical fellow in psychiatry at Brigham and Women’s Hospital.

The presenters will detail what patients across the country are experiencing, including being forced or coerced into carrying a pregnancy to term and being forced to experience masculinizing puberty for transgender girls. Gise and Warshaw will also address climate and disaster policies that place women and girls particularly in jeopardy, as well as policies within the legal system that allow stigma associated with substance use and mental illness to be leveraged against women by abusive partners. Finally, the presenters will outline the many policies that disproportionately impact women from Indigenous, Latinx, and Black communities.

The presenters will also provide an opportunity for participants to discuss how these issues are coming up in their own lives and work and the strategies they are employing to maintain their own well-being.

“This session will provide a setting in which psychiatrists can collaborate on strategies to address these crucial developments, problem solve, and offer mutual acknowledgement and support,” Eyler said.

### Reconnect With Friends at San Francisco Museum of Modern Art

While you are in San Francisco for APA’s 2023 Annual Meeting, be sure to attend one of the meeting’s most popular events: the APA Foundation’s Annual Benefit, which will be held this year at the spectacular San Francisco Museum of Modern Art on Monday, May 22. Join with friends, colleagues, and APA leaders to celebrate the Foundation’s work to create “A Mentally Healthy Nation for All.” Festivities start at 7 p.m. Purchase your tickets now at apafdn.org/benefit.
Section: Preliminary Program Guide • ANNUAL MEETING 2023 • SAN FRANCISCO

IMG Track Offers Advice, Counsel, and Guidance for International Graduates

International medical graduates (IMGs) make up about 29% of all psychiatrists practicing in the United States. Because psychiatry has become a very competitive specialty, IMGs face new challenges. 

Tips on applying for residency, acculturation, immigration, and career paths—these are some of the APA Annual Meeting sessions curated especially for international medical graduates (IMGs) in the IMG track at APA’s 2023 Annual Meeting. 

IMGs make up about 29% of all psychiatrists practicing in the United States. More medical students than ever are applying to psychiatry residency programs, making psychiatry more competitive than it has ever been. While this offers us the hope of building a robust workforce of psychiatrists practicing in the United States. More medical students than ever are applying to psychiatry residency programs, making psychiatry more competitive than it has ever been. 

They will make recommendations to help IMGs contribute to culturally responsive mental health care, education, research, administration, leadership, and advocacy. 

Acculturation as a Component of Immigration: Challenges of the Psychiatric Workforce: While moving for a residency position is exciting, the culture shock can be jarring for many IMG residents. The panelists in this session will address acculturation; the barriers to assimilating to a new culture, and the challenges of immigration, finding mentorship, and academic placement. 

Acculturation: Lessons Learned from Treating Mental Illness Among Arab Americans Chair: Rana Elmaghraby, M.D. 
Comprehensive Care of the Transgender Patient: A Multidisciplinary Approach Chair: Murat Altinay, M.D. 
Considerations in the Use of Seclusion or Restraint: Introducing a New APA Resource Document Chair: Jacqueline A. Hobbs, M.D., Ph.D. 
Double Trouble: Management of AUD and Co-Occurring Disorders Chair: Laura E Kavako Ph.D. 
Dying to Tell You: How Personal Grief Shapes the Practice of Psychotherapy From the Perspective of Gay-Identified Psychiatrists Chair: Robert Michael Kertzner, M.D. 
Healing Moral Injury, Developing Moral Resilience Chair: Monica J. Taylor-Davis, M.D. 
Innovating Chalk Talks 3.0: Incorporating Virtual Learning Platforms to Improve in-Person Learning Chair: Paul Riordan 
Neuroscience in the Courtroom Chair: Octavio Choi, M.D. 
New Guideline Recommendations for Strengthening Psychiatric Practice Chair: Catherine Crane, Jacqueline Posada, M.D. 
Now Is the Time to Rethink Adolescent and Young Adult Community Mental Health Care Chairs: Vanessa Vorhes Klodnick, Ph.D., L.C.S.W., Debra Ann Cohen, Ph.D., M.S.W. 
Pediatric Bipolar Disorder: Advances in Diagnosis and Treatment Presented: Janet Wozniak 
Project Engage: Engaging Communities to Gain Mental Well-Being and Equity Everywhere Chair: Milton Leonard Wainberg, M.D. 
Responding to the Impact of Suicide on Clinicians Chair: Eric Plakun, M.D.

1:30 P.M. - 5:30 P.M.
General Sessions

A Clinician’s Guide to the Management of Behavioral and Psychological Symptoms of Dementia in the Era of Boxed Warnings Chair: Rajesh R. Tampi, M.D., M.S. 
A Journey to Death: The Story of Migrant Children Chair: Gabrielle Shapiro 
A Roadmap to Psychiatric Residency: Assisting Stakeholders in the Medical Student Advising and Residency Recruitment Process Chair: Shambhavi Chandraiah, M.D. 
Behind Closed Doors: Providing Psychiatric Treatment and Promoting Safety Remotely for Survivors of IPV Chair: Elizabeth Etelson 
Biomarkers in Psychiatry—Are We Ready for Prime Time? Chair: Nina Krugljac, M.D. 

Clinical Pearls: Lessons Learned from Treating Mental Illness Among Arab Americans Chair: Rana Elmaghraby, M.D. 
Comprehensive Care of the Transgender Patient: A Multidisciplinary Approach Chair: Murat Altinay, M.D. 
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Healing Moral Injury, Developing Moral Resilience Chair: Monica J. Taylor-Davis, M.D. 
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Sanya Virani, M.D., M.P.H., will cover the topic of dealing with microaggressions; Elie Aoun, M.D., will present on challenges unique to IMGs from the post-pandemic world; Nhi-Ha T. Trinh, M.D., M.P.H., will present on the impostor syndrome; and Ian Hunter Rutkofsky, M.D., will speak on challenges unique to IMGs from Caribbean medical schools. 

Tips and Tricks for IMGs Applying for Residency: What does it take to match successfully? This section aims to delve into topics like mentorship, interviewing, letters of recommendation, resume/CV, research/scholarly projects, extracurricular activities, board scores, personal statement, commitment to psychiatry, and signaling/tokens as pertaining to the residency application process. Our experienced panel of residency training directors—Benedicto Borja, M.D., Rashi Aggarwal, M.D., Jason Curry, D.O., will provide statistics pertaining to IMGs and offer practical ideas relevant to different stages in an IMG’s career. 

- Challenges for IMGs in Psychiatry in 2023: Top Issues and Solutions: Using case examples and small group discussion, panelists will identify the top challenges for IMGs in today’s era and offer practical solutions. Dora-Linda Wang, M.D., will address the challenges in the post-pandemic world; Nhi-Ha T. Trinh, M.D., M.P.H., will cover the topic of dealing with microaggressions; Elie Aoun, M.D., will present on the impostor syndrome; and Ian Hunter Rutkofsky, M.D., will speak on challenges unique to IMGs from Caribbean medical schools. 

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Session on Firearm Violence to Stress Nonpartisanship

Understanding the epidemiology of gun violence will equip psychiatrists for public health advocacy. BY TERRI D’ARRIGO

In 2018, the National Rifle Association posted a tweet that began with “Someone should tell self-important anti-gun doctors to stay in their lane.” Many in the medical community considered that to be a gauntlet thrown, and since then health professionals have demonstrated the myriad ways they have seen firearm violence harm and kill their patients. At APA’s 2023 Annual Meeting, a session titled “I Am and Kill Their Patients” will explore the challenges and barriers to implementing these laws and policies and legislation that support safe firearm violence that will better enable attendees to frame the issue in terms of public health.

Attendees will come away from the session with an understanding of regional firearm laws, including Extreme Risk Protection Orders (“red flag” laws) that allow family members or law enforcement to petition a judge to remove a firearm from the environment of a person considered to be at risk of harming themselves or others. The session will explore the challenges and barriers to implementing these laws and delve into how these laws have reduced morbidity and mortality from firearm violence, thus equipping attendees to be more effective as advocates for public health strategies to address the issue.

Finally, attendees will learn how to get involved at the hospital, city, and state levels to advocate for policies and legislation that support safe firearm practices. PN

Presidential Work Group on the Future of Psychiatry Chair: Robert L. Trestman, M.D., Ph.D.

Technology-Assisted Treatment Interventions for Substance Use Disorders Chair: Larissa J. Mooney, M.D.

Poster Session 8

Course ID: MB079 | Late-Life Mood and Anxiety Disorders ($5) Directors: Art C. Walszak, M.D., Susan W. Lehmann, M.D.

Course ID: MB083 | Master Course: Child and Adolescent Psychiatry ($5) Director: John T. Walkup, M.D.

1:30 P.M. - 3 P.M.

Award Lectures

Adolf Meyer Award Lecture: Can Psychiatry Really Make Medicine Better? Lessons From Three Clinical Trials Presenter: Michael Sharpe, M.D.

Chester Pierce Award Lecture: Chester Middlebrook Pierce and Human Dignity Chair: Ezra E.H. Griffith, M.D.

Focus Live

Focus Live: Suicide Preventive Interventions and Knowledge Chair: Christine Yu Moutier, M.D.

General Sessions

A Public Health Crisis: Treating Intimate Partner Violence (IPV) With a Focus on LGBTQ+ Populations Chair: Amir K. Ahuja, M.D.

Access and Equity: The Level of Care Utilization System (LOCUS) and the Self-Assessment for Modification of Anti-Racism Tool (SMART) Chair: Rachel Melissa Talley, M.D.

Asian American Mental Health, Advocacy, and Empowerment in the Age of COVID-19 Chair: Seeba Anam, M.D.

Challenges for International Medical Graduates (IMGs) in Psychiatry in 2023: Top Issues and Solutions Chair: Nhi-Hu T. Trinh, M.D., M.P.H.

Fertility Preservation and Family Planning in Residency and Beyond: What Residents, Faculty, and Administrators Should Know Chair: Stefana Morgan, M.D.

Innovate, Collaborate, and Motivate: A Model for Improving Female Retention, Mentorship, and Professional Engagement Chair: Monica D. Ormeno, D.O.

Innovation, Access to Care, and Promoting Psychiatry and Mental Health in Ghana Presenter: Vincent I. O. Agaypong, M.D., Ph.D.

Neurobiology and Treatment of Posttraumatic Stress Disorder Chair: Charles Barnett Nemeroff, M.D., Ph.B.

Priorities in Mental Health Research Presenter: Joshua A. Gordon, M.D., Ph.D.

Psychiatry Training and Parenting—the Dual Learning Curve Chair: Manal Khan

The Future of Virtual Care for People With Serious Mental Illness Chair: Nicole Rachel Kozloff, M.D.

The Promise of Precision Medicine for Treating Alcohol Use Disorder and PTSD Chair: Charles R. Marmar, M.D.

The Role of Psychodynamic Psychotherapy in Psychiatric Practice Chair: Richa Bhatta, M.D.

The Thought Content Continuum (TCC): Fringe Beliefs, Overvalued Ideas, and Delusions Gone Viral Chair: Kanshik Solanki

What the Clinician Needs to Know About the Personality Disorders: Aggressive, Avoidant, and Borderline Chair: James Harry Reich, M.D.

Presidential Sessions

Getting Serious About Equality, Diversity, and Inclusion Chair: Adrian James, M.B.B.S.
Interactive, Educational, and Fun? Yes, Learning Labs are Back!

Attendees can learn about such topics as entering a career in academic medicine and mastering social media, as well as improving their use of telepsychiatry in a post-pandemic world. BY NICK ZAGORSKI

Loosely speaking, the social media revolution has been accelerating for a few years, reaching its climax in 2013 when Facebook surpassed one billion users. In the past few years, social media has continued its rapid growth, with more than 630 million people using Facebook every single month. By 2023, Facebook is expected to reach 3 billion users. In the United States, more than two-thirds of adult internet users use social media. Social media has become part of everyday life for many people, and it is changing the way we communicate and interact with each other.

Social Media-Related Sessions

- "American Idols—the Role of Influencers in Shaping the Public’s Understanding and Utilization of Mental Health Care.” Chair: Anna Russell, D.O.
- "Alcoholics Anonymous: The Role of Social Media in Treatment.” Chair: Pratik Bahekar, M.B.B.S.
- "The Future of Mental Health Is Social Media.” Chair: Simone Ariel Bernstein, M.D.
- "Technologies to Advance Access to Mental Health: Social Media, Texting, and 988.” Chair: John Luo, M.D.
- "Social Media and Psychiatry: Effects of Social Media on Users, Research, Advocacy, Networking, and Intervention Opportunities.” Chair: Mariana Pinto Da Costa, M.D.
- "Social Media for Seniors: Pros, Cons, and Scams.” Chair: Maria D. Llorente, M.D.
- "Virtually Represented: The Impact of Social Media Usage on Trainee Wellness.” Chair: Carisa Maureen Kymissis, M.D.
- "Mission-Based Media Collaborative Work Concerning ‘Controversial’ Topics in Psychiatry.” Chair: Jessica Gold, M.D.

A Psychiatrist, a Teacher, and a Pediatrician Walk Into a Bar: A Multidisciplinary Approach to Active Shooter Drills in Schools Chair: Margaret A. McKeathen MD

Alcohol Use Disorder as the “Elephant in the Room”: The Changing Conversation Around Alcohol in the United States Presenter: George F. Koob, Ph.D.

Ascertaining Evidence and Strategies for Medical Treatment of Adolescents With Substance Use Disorders (SUD) Chair: Nita V. Bhatt, M.D., M.P.H.

Back to the Future: Psychiatry and Abortion in a Post-Roe v. Wade World Chair: Kathleen A. Crapanzano, M.D.

Bridging the Digital Divide: The Interplay of Innovations in Digital Mental Health and Health Care Disparities Chair: Nicole Christian-Brathwaite, M.D.

Collaborating With South Asian Communities to Combat Microaggressions Chair: Ranna Parekh, M.D., M.P.H.

COVID-19 Microchips, Chemtrails, and Q: What Can the Fringe Teach Us? Chair: George David Annas, M.D., M.P.H.

Cultural and Spiritual Considerations in Mindfulness-Based Interventions Chair: Farooq Nareen, M.B.B.S.

Depression and Social Determinants of Health Chair: Tattiana A. Falcone, M.D.

Empowering Trainees to Engage in Scholarly Work and Leadership Roles Chair: Donna Marie Sudak, M.D.

Flipping the Power Dynamic and Learning From People With Lived Experience: The Peer Advisor Program Model? Chair: Stephanie Le Melle, M.D., M.S.

How to Set Up and Sustain a Telepsychiatry Practice Chair: Shabana Khan

“I Am in My Lane”: A Public Health Approach to the Role of Health Care Providers in Firearm Violence Chair: Aradhana Bela Sood, M.D.

“I Need a She-Ro”: Mentoring Through Narratives, Stories of Women in Leadership for the Advancement of Psychiatry Chair: Christina T. Khan, M.D., Ph.D.

Management of Shame and Guilt in Work With Social Determinants of Mental Health Chair: Constance E. Dunlap, M.D.

Mass Killers and Mass Shooters: Perspectives on Initiatives to Investigate and Reduce Mass Killings in a Systematic Quantitative Manner Chair: David V. Sheehan MD, M.D., M.B.A.

Mission-Based Media Collaborative Work Concerning ‘Controversial’ Topics in Psychiatry Chair: Jessica Gold, M.D.

The Continuum Through Psychiatry Under AAMC, GME, CME: An IMG Perspective Chair: Daniel Castellanos

Trauma and Psychosis: Pathways, Therapeutic Plans and Prevention Strategies Chair: Paul J. Rosenfield, M.D.

Treatment-Resistant Depression: Definitions, Associated Factors, Available Treatment Approaches, and Vistas for the Future Presenter: Roger McIntyre

When a Difference Becomes a Distress: Addressing Race-Based Variations in Psychiatric Emergency Treatment Chair: Jonathan Alpert, M.D.

Zoomers in Mind: Engaging the Youth Mental Health Crisis Chair: Aaron J. Krasner MD, M.D.

session will highlight the many high-tech advances in TMS since the first magnetic device was cleared in 2008, as well as low-tech strategies any clinician can use to optimize TMS therapy.

• Launching and Navigating a Successful Career in Academic Medicine: Any young physician interested in academia has a chance to learn from one of the best: Laura A. Roberts, M.D., M.A., the Katharine Dexter McCormick and Stanley McCormick Memorial Professor and chair of psychiatry and behavioral sciences at Stanford University School of Medicine.

• Crises Simulation Lab: In this returning event, participants will learn some of the basics of how to respond effectively in a crisis—natural or manmade—and get a chance to play one of many responder roles in a simulation of a crisis event.

• Learning Neuroscience Through Interactive Activities: Who said learning can’t be fun? Attendees at this workshop will get to experience the “Brain-ival” as they form teams and tackle puzzles, trivia, and more. Along the way, they will also learn important elements of neuroscience, the foundation of psychiatric knowledge.

see Learning Labs on page 32
Annual Meeting Panel to Examine
The Evolution of Physician Aid in Dying

Panel members will discuss the challenge of defining standards for “irremediability” in psychiatric disorders and will discuss the impact of expanding laws regarding physician-assisted dying on marginalized populations suffering from life distress. BY MARK MORAN

Physician Aid in Dying (PAD), also known as Medical Aid in Dying (MAiD) has been legalized or decriminalized in over a dozen jurisdictions around the world, and assisted dying policies continue to evolve, including in the United States. Many jurisdictions are exploring whether to introduce PAD laws or expand existing law to include PAD based on a mental disorder.

This year’s Annual Meeting in San Francisco will feature a panel discussion titled “Physician-Assisted Death and Psychiatric Disorders.” PAD for mental disorders has been permitted for two decades in the Netherlands and Belgium, and 2023 marks the legalization of the practice in Canada (to be introduced as of March 2023).

John Petet, M.D., will explore how capacity for PAD may differ from capacity to refuse treatment. He is an associate professor of psychiatry at Harvard Medical School and director of the psychosocial oncology and palliative care fellowship at the Dana-Farber Cancer Institute.

“I plan to focus on the role of the psychiatrist in evaluating patients for capacity to request MAiD, which is a role we play in several U.S. jurisdictions now,” he told Psychiatric News. “I’ll be suggesting that rather than a straightforward assessment of depression and the intellectual understanding of what is involved, the psychiatrist as a physician helping patients to consider this unique and permanent request has a responsibility to assess for potentially treatable contributing conditions, including demoralization.”

Case examples will illustrate that at stake is not only the patient’s cognitive capacity and DSM diagnosis, but also the patient’s emotional capacity and the professional and clinical responsibility of the doctor to the patient.

K. Sonu Gaind, M.D., a professor of psychiatry at the University of Toronto and past president of the Canadian Psychiatric Association, will review the Canadian experience, as Canada moves toward providing MAiD for patients with psychiatric disorders. Gaind is on the Council of Canadian Academies Expert Panel reviewing PAD for mental disorders.

Marie Nicollin, M.D., Ph.D., psychiatrist and researcher at the Belgian Research Foundation Flanders and Georgetown University, will discuss the history of PAD for patients with psychiatric disorders in the Netherlands and Belgium.

Panel members will discuss the challenge of defining adequate standards for “irremediability” in psychiatric disorders and patient requests for PAD and discuss the potential impact of expanding PAD laws on marginalized populations suffering from life distress.
Learning Labs

continued from page 30

- LAL Workshop: Long-acting injectable antipsychotics are a highly effective yet highly underused option for treating patients with schizophrenia and other psychotic disorders. Donna Rolin, Ph.D., A.P.R.N., director of the psychiatric mental health nurse practitioner program at the University of Texas at Austin School of Nursing, will offer important details on how to prepare and administer these injections.

- How to Set Up a Tele-Practice: While many psychiatrists are using telehealth services today, undoubtedly many still have questions on technical and regulatory guidelines. This interactive session will review the important considerations related to establishing and/or maintaining a fully virtual or hybrid practice. Topics include equipment selection, license requirements, maintaining privacy, and more.

- Hearing Voices: In this moving workshop, attendees will get an image of what it’s like to experience auditory hallucinations. It is hoped that participants will gain empathy and reassert their thoughts on positive symptoms as they attempt to carry out routine clinical activities while experiencing distracting audio stimuli designed by people with lived experience.
Session to Explore the Progress of Precision Psychiatry

How close is the psychiatric field to matching the right patients with the right treatment? Listen and find out. BY NICK ZAGORSKI

With innovation being one of the core themes of this year’s APA Annual Meeting, it is fitting that there will be a session focusing on a topic expected to play a major role in future psychiatric care: precision psychiatry.

Taking concepts from the broader field of precision medicine, precision psychiatry aims for more individualization in patient care from the moment of diagnosis through treatment.

“In psychiatry, we don’t classify disorders using biological systems the way a field like oncology does,” said session chair Daniel R. Karlin, M.D., the chief medical officer at MindMed, a company developing psychedelic and non-psychedelic psychiatric medicines and digital companion devices. Even in other fields like cardiology, physicians can rely on measurable physiological metrics (for example, stroke volume or blood pressure), whereas psychiatrists make a diagnosis based on phenomenology.

“It’s how patients tell us they feel, and how we think they feel based on clinical observations,” he said. The rest are disorders like depression that are highly likely to be biologically heterogeneous.

“What precision psychiatry asks is, Can we look at the information which we already have—such as a patient’s medical record and the patient’s behavioral phenomenology—with a finer grain so that we can make more precise diagnoses, ultimately working toward meaningfully incorporating biological information such as genomics?” Karlin said.

This session will discuss the evolution of precision psychiatry, which was conceptualized as a field just recently but has a long tradition, Karlin explained. “If you think back to the early years of psychiatry and psychoanalysis, we had a rich system where doctors focused on what patients said and how they acted to develop robust diagnostic formulations and offer what could be called precision treatment in today’s vernacular—highly individualized psychotherapeutic interventions,” he said.

Today, busy psychiatrists have to be more efficient with their time, but this is where machine learning programs and other digital tools can be helpful.

Karlin and his co-presenters will highlight how technology is being used to collect more detailed patient data and discuss how soon some of these tools will be ready for routine use.

“Part of the conversation will involve reigning in the hype,” Karlin said. “We would all love a future where a simple blood test could answer all of our questions, but if not developed with careful attention to clinical meaningfulness, today’s exciting advances in neuroscience or technology ultimately may not improve patient care.”

But progress is being made, Karlin noted. The ability to monitor patients in real time with the help of mobile devices and acquire quantitative data on activity, sleep, and other characteristics could be transformative. “Psychiatry entails much observation, and our ability to observe improves daily.”
Optimizing Physician Learner and Provider Resilience, Engagement, Wellness, and Mental Health: Chair: Sidney Zisook, M.D.

Powerful Beliefs: The Interplay Between a Patient’s Spiritual Practices and Psychiatric Outcomes: Chair: Kayla Fisher, M.D., J.D.

Psychotherapy Models for Patients on Ketamine Treatment in Patients With Suicidal Risk: Chair: Tatiana A. Falcone, M.D.

The Fragmented Life: Examining Relationships Between PTSD, Nightmares, and Sleep Moving Toward Integrated Personalized Care: Chair: James West, M.D.

The Future of Psychotherapy: Creating Healing Moments Instead of Waiting for Them: Chair: Jeffrey S. Smith, M.D.

The Impact of Psychiatric Diagnoses and Treatments on Active-Duty Military Members: Chair: Heather Hauck, M.D.

Trauma, Transitions, and Trajectories: Centering Youth of Color Mental Health: Chair: Gina Newsome Duncan, M.D.

Unleash the “Paws”itivity! Using Animal-Assisted Therapy in Colleges and Universities: Chair: Meera Menon, M.D.

Mental Health Stigma and Its Implications Among the Ukrainian Immigrant Population: Chair: Paulina Nadia Pys

Moral Injury in Health Care Providers: What Clinicians and Hospital Leadership Can Do: Chair: Steven Paul Cuffe, M.D.

Multidisciplinary Partnering in an Effort to Address Mental Health and Substance Use Concerns in Central Appalachia: Chair: R. Lawrence Merkel Jr., M.D.

Presidential Session
Collaborating With Compassion in Contemporary Medical Spaces: A Psychodynamic Seminar Chair: Joanna E. Chambers

1:30 P.M. - 3 P.M.
General Sessions
A Silent Disease: Looking at Chronic Pain in Children Chair: Grace Ibitamuno

Anti-AAPI+ Racism: Coalition Building and Healing Our Communities and Workforce: Chair: Adam Chan

Audits and/or Profits? Understanding the 2023 Changes in Coding and Documentation Requirements, an Interactive Workshop: Chair: Jeremy M. Marcus, M.D.

Beyond Race, Sex, and Gender: Intersectionality, Intersex, and Non-Binary Identities: Chair: Albert Ning Zhou, M.D.

Challenges and Solutions in Management of COVID-19—Positive Patients With Acute Inpatient Psychiatric Treatment Needs: Lessons Learned in 2.5 Years: Chair: Samidha Tripathi, M.D.

Dementia or Primary Psychiatric Disorder? Early Diagnosis and Treatment of Neurocognitive Disorders in the Psychiatric Setting: Chair: Vineeth P. John, M.D., M.B.A.

Demystifying Disaster Psychiatry: What Can District Branches Do?: Chair: Leslie Gise, M.D.

Emerging Biomarkers of Response to Ketamine—Opportunities and Challenges: Chair: Gustavo Costa Medeiros

Focused Brief Group Therapy: An Integrative Interpersonal Process Group Approach Using Measurement-Based Care: Chair: Martyn Whittingham

Gender-Affirming Psychiatric Care: Discussion and Preview of Forthcoming APA Textbook Chair: Teddy Goetz

Informing and Empowering Providers to Have Difficult Conversations: Goals of Care in Mental Health: Chair: Christine DeCaire, M.D.

Life in ACEs: An Interactive Experience to Teach About Social Determinants of Health: Chair: Paul J. Rosenfeld, M.D.

Lifestyle Interventions for Mental Health: Drugs Are Not Everything: Chair: Anna Szczegielniak, M.D., Ph.D., M.Sc.

Management of Patients Who Repeatedly Ingest Foreign Objects: Chair: Kenneth Michael Certa, M.D.

My Head Hurts! Migraines, Misery, and Mental Health—a Case for Diagnosing and Treating Comorbid Headache Disorders: Chair: Mia Minen


“No One Leaves Home Unless Home Is the Mouth of a Shark”: Collaborating to Advance the Emotional Health of LGBTQ Individuals in Crisis Zones: Chair: Omar Fatall, M.D., M.P.H.

Phenomenology of Identity: Mobilizing Narrative Medicine Toward the Care of Eating Disorders: Chair: Laila Knio, M.D., M.S.

Public Testimonies as a Form of Community-Based Research to Educate Professionals on the State of Our Current Mental Health Care System: Chair: Jane Tien Thay Nguyen

Seeking Euphoria: Trauma, Addiction, and the Family Structure: Chair: Marcus Hughes

Shared Care: The Integration of Alcohol-Associated Organ Damage and Psychiatric Care: Chair: Laura Nagy Sylvia The Wood NYmph: A Documentary Film on Dissociative Identity Disorder and Barriers to Research, Treatment, and Acceptance of Childhood Sexual Abuse: Chair: Timothy David Breuer, M.D.

Telepsychiatry in Residency Training: Lessons Learned, Value as Standard Curriculum, What Residents Want, and Where We Go From Here: Chair: Alec Kiszczewski, M.D.

The Impact of Sleep, Fatigue, and Circadian Misalignment in Special Populations: Medical Education, Military, and Public Safety: Chair: Connie L. Thomas, M.D.

To Look or Not to Look: Vicarious Trauma From Reviewing Graphic Images Chair: Rana Aggarwal, M.D.

Trying to Prevent the “Fall off the Cliff”: Implementing Collaborative Care for the Good of All in College Health Care: Chair: Lisa M. Frappier, D.O.

Virtually Represented: The Impact of Social Media Usage on Trainee Wellness: Chair: Carisa Maureen Kynnisis, M.D.

What Does It Take to Implement Collaborative Care in Resource-Constrained Settings: Generalizable Lessons From Diverse Settings in Rural Nepal Chair: Bibhav Acharya, M.D.

A Patient-Centered Research Road Map to Inform the Clinical Practice of Bipolar Disorder: Chair: Mark Frye Approaches to Treatment-Resistant OCD: Chair: Wayne K. Goodman, M.D.

Back to the Future: A Dynamic Structural Framework of Migration and Mental Health: Chair: Pamela Montano, M.D.

Battle-Tested Meditation: Military Psychiatric Approach to Meditation and Spirituality and Translating the Knowledge Gained to the Civilian Practice: Chair: Bhagwan A. Bahroo, M.D.

Behavioral Health Practice Managed Services Organizations (MSO): Addressing Access to Quality Care for Consumers, Payers, and Providers Chair: Yavor Moghimi, M.D.

Borderline Adolescents: Therapeutic Innovation, Collaboration With Families, Motivation of Caregivers: Chair: Maurice Carcais, M.D., Ph.D.

Bringing Recovery to College Mental Health: Chair: Mark Ragins, M.D.

Clinical Effects and Indications of Clinical Effects and Indications of...
Study Finds Childhood Adversity Linked to Brain Differences in White, Black Children

Different experiences of childhood adversity may contribute to differences between the brains of Black and White children. The study intensifies the urgency to address adverse social determinants of mental health, experts say. BY KATIE O’CONNOR

he history of psychiatry and neuroscience is stained with attempts to scientifically prove the fallacy that there are inherent differences between the brains of Black and White people.

“Physicians and scientists tried to demonstrate that African Americans were inferior to justify discrimination and systemic racism,” said Walter E. Wilson Jr., M.D., M.H.A., chair of APA’s Council on Minority Mental Health and Health Disparities. “Challenging that narrative with data is incredibly important. We need to rewrite that unfair history.”

A study published in February in The American Journal of Psychiatry offers important new insights into the false appearance of race-related differences in brain structure between Black and White children. The study found that childhood adversity, which Black children are more likely to experience, may result in lower brain matter volume in regions that are important for regulating the emotional response to threat.

“What the data show is the overwhelming impact of structural racism on the developing brain, which is going to have big implications for these kids’ emotional health as they start to get older, especially if we don’t address the different aspects of structural inequities and racism,” said one of the study’s authors, Nathaniel Harnett, Ph.D. He is the director of the Neurobiology of Affective Traumatic Experiences Laboratory at McLean Hospital and an assistant professor in psychiatry at Harvard Medical School.

The research team used data from the Adolescent Brain and Cognitive Development (ABCD) Study released in March 2019, which included 9,382 participants aged 9 and 10. They gathered family demographic data through surveys that the participants’ parents com-

KEY POINTS

Black children are far more likely to experience adversity compared with White children. Nathalie Dumornay, B.S.; Lauren A.M. Lebois, Ph.D., Kelly J. Ressler, M.D., Ph.D., and Nathaniel Harnett, Ph.D., investigated how adverse experiences impact the brain. Among the findings:

- The parents or caregivers of Black children were more likely than those of White children to be unemployed, have lower educational attainment, and have lower incomes.
- Childhood adversity was associated with lower gray matter volume in the amygdala and several regions of the prefrontal cortex.
- Adversity contributes to slight differences in gray matter volume between Black and White children in key regions of the brain associated with regulating the emotional response to threat.

Bottom Line: Experts say this study emphasizes the need to address systemic inequities and to support Black children and their families.

Deprivation Index, which uses 17 socioeconomic indicators, including poverty, housing, and employment, to characterize a given neighborhood. Family conflict was assessed using the Youth Family Environment Scale, and trauma history was assessed using the Schedule for Affective Disorders and Schizophrenia for School-Age Children for DSM-5. The authors used structural MRI data to investigate the relationship between racial disparities in adversity exposure and differences in brain structure.

Study Found Large Differences in Experiences With Adversity

The authors found that White children's parents were more likely to be employed, have higher educational attainment, and greater family income compared with Black children’s parents (88.1% of White parents made $35,000 a year or more versus 46.7% of Black parents). White children also experienced less family conflict, less material hardship, less neighborhood disadvantage, and fewer traumatic events compared with Black children.

There were also important differences between Black and White children in their gray matter volume. White children showed greater gray matter volume compared with Black children in 10 brain regions. But Harnett emphasized that, overall, these differences were small.

“Children absorb more than we think they do,” says Walter E. Wilson Jr., M.D., M.H.A. “We often like to think that 9- or 10-year-olds aren’t especially aware of their surroundings or that when adults have problems, the children don’t have to worry. But this study proves that kids are absorbing their environments and the things their parents deal with, like paying rent or getting food on the table, have a major developmental impact on children.”

“We need to appreciate that when we’re talking about how experiences impact the brain, we’re not talking equally about different groups,” says Nathaniel Harnett, Ph.D. “If we really want to find equitable, generalizable markers of psychiatric disease, it’s important to dive into the details of what’s really happening with our participants.”

BY KATIE O’CONNOR
FDA Approves Second Antibody Therapy for Alzheimer’s

Lecanemab was approved in January under the FDA’s accelerated approval pathway. The medication is meant for individuals with mild cognitive impairment or mild dementia. BY NICK ZAGORSKI

T he Food and Drug Administration (FDA) in January approved lecanemab for the treatment of Alzheimer’s disease, marking the second approval of an antibody designed to break down Alzheimer’s-associated amyloid plaques in the past 18 months.

Unlike the controversy that surrounded the approval of aducanumab (brand name Aduhelm) in June 2021, the response to the approval of lecanemab (brand name Leqembi) by the scientific community has been relatively quiet. Researchers who spoke with Psychiatric News and others mostly attribute this response to data that suggest lecanemab slows cognitive decline.

"Lecanemab is not a major breakthrough in Alzheimer’s care, but it is the first amyloid-based therapy to demonstrate benefits with respect to cognition," said Art Walaszek, M.D., a professor and vice chair for education and faculty development of psychiatry at the University of Wisconsin School of Medicine. Walaszek was not involved in the clinical development of lecanemab.

Those benefits were demonstrated in a clinical trial (called Clarity AD) involving nearly 1,800 adults with early stage Alzheimer’s (diagnosed with mild cognitive impairment or mild dementia). On average, the participants who received lecanemab infusions (10 mg/kg) every two weeks demonstrated statistically less cognitive decline over 18 months than those who received placebo infusions. The findings were published January 5 in the New England Journal of Medicine (NEJM).

The primary measure used in the trial was the score on the Clinical Dementia Rating—Sum of Boxes (CDR-SB). This 18-point scale assesses six domains impacted by dementia (memory, orientation, judgment and problem solving, community affairs, home and hobbies, and personal care). The more cognitive impairment that a patient has, the greater his or her CDR-SB score will be.

After 18 months, scores in the lecanemab group rose by 1.2 points compared with about 1.7 points in the placebo group; both groups had average scores of 3.2 at baseline. Secondary cognitive measures showed a similar slowing of decline for adults taking lecanemab. In other words, if the lecanemab-treated patients continued to decline at the same rate after 18 months, they would eventually reach the level of cognitive decline seen in the placebo-treated group, but not until month 25, explained Christopher van Dyck, M.D., a professor of psychiatry and neurology at Yale University and lead author of the NEJM article. Van Dyck has served as a paid advisor to Eisai and has received research support from Biogen and Eisai to conduct clinical trials on both aducanumab and lecanemab.

The most common adverse events (affecting more than 10% of the participants) in the lecanemab group were infusion-related reactions, the authors reported in NEJM. These events included ARIAs, or amyloid-related imaging abnormalities. ARIAs reflect temporary internal swelling or bleeding that occur when amyloid plaques are removed. Most of the ARIAs among participants were considered to be minor and asymptomatic, though some participants reported such symptoms as headaches, blurred vision, and falls.

Walaszek noted that “the rate of ARIAs was lower with lecanemab than aducanemab, so it appears safer, but I would caution these are not data from a head-to-head trial.” He also noted that three trial participants on anticoagulants died from stroke-related events, but it’s not yet clear what role lecanemab played.

Eisai to Seek FDA Approval

Interestingly, lecanemab was approved by the FDA without factoring in the Clarity AD data. As with aducanumab in 2021, this antibody received accelerated approval based on promising phase 2 biomarker data. Accelerated approval allows companies to speed a drug for a life-threatening illness to market based on a surrogate endpoint that reasonably predicts future clinical benefit to patients. For lecanemab and aducanumab, the surrogate endpoint is reduced amyloid plaques in the brain.

The use of amyloid as a biomarker has been controversial among many researchers, who note there is little evidence linking the degree of amyloid buildup to Alzheimer’s symptoms. Shortly after the FDA granted the accelerated approval of lecanemab to Eisai Co. (who co-developed lecanemab with Biogen), the company announced plans to submit the data from the phase 3 trial and file for full FDA approval.

Full approval could be a significant step since an accelerated approval is a conditional status; companies must continue to do postmarketing studies to demonstrate a clinical benefit, and if they fail, then the FDA can withdraw the approval. In addition, the Centers for Medicare and Medicaid Services (CMS) in April 2022 announced that Medicare would not cover any amyloid-based Alzheimer’s therapy with accelerated approval outside of a clinical trial setting. Antibodies with traditional approval will be covered if the patients allow their data to be collected as part of a CMS-approved study. CMS noted it may reconsider its coverage policy of such medications once new data are available.

“What Medicare ultimately has to say will be critical, because there is a health-equity component involved,” said Walaszek. “We know minority groups like Black and Hispanic individuals have higher rates of dementia due to socioeconomic and health disparities; these same disparities reduce their access to professional caregivers or other services.

But with an estimated annual price of $6,500, lecanemab may be out of reach for many who might benefit, noted van Dyck. “We don’t want lecanemab to become a therapy exclusively for the well-to-do.”

The Paradox of Slowing

Even if out-of-pocket costs for lecanemab were to come down, the medication may not see extensive use, Walaszek cautioned. “First, there are infrastructure issues to consider. A clinic would need to have infusion centers, which are widely available, but may not be able to scale up to accommodate extra patients coming in twice a month.” Clinics that provide lecanemab also need access to PET scans to identify amyloid buildup and MRI scans to periodically test for ARIAs.

“Lecanemab also produces a modest change in cognitive decline, which is comparable to what we see for older Alzheimer’s medications like donepezil or rivastigmine,” he said. The short-coming of these existing medications is that they only temporarily slow cognitive impairment. “In the lecanemab trial, the separation between the drug and placebo kept increasing over 18 months, which some people believe indicates that lecanemab will have durable effects. I’m not sure if that’s the case, but time will tell how long this benefit lasts.”

There are also important ethical questions to consider, said Kostas Lyketsos, M.D., the Elizabeth Plank Althouse Professor for Alzheimer’s Research at Johns Hopkins Medicine. Lyketsos was not involved in the development of lecanemab but has received past research support and consulting fees from Eisai.

“It’s the paradox of slowing,” he told Psychiatric News. “In the short term, you can keep patients at a mild dementia stage for six or seven months longer, continued on facing page
Health organizations, schools, and youth advocacy groups continue to sound the alarm about mental illness among youth. New studies have offered insight about the rise in suicide among youth before the COVID-19 pandemic began.

BY KATIE O’CONNOR

In October 2022, over 130 health organizations, including APA, asked President Joe Biden to declare a national emergency in children’s mental health. “We urge you to treat the youth mental health crisis as the national emergency it continues to be,” the organizations wrote in a letter.

Medical groups, schools, and advocacy organizations have been raising the alarm about the ongoing crisis in youth mental health, which was only exacerbated by the COVID-19 pandemic. New research shows that emergency department (ED) visits for suicidal ideation have been on the rise since before the pandemic, and suicide among youth may be linked to lack of access to care.

“We are increasingly seeing studies that make a strong case for big policy interventions,” said Anish Dube, M.D., M.P.H., chair of APA’s Council on Child and Adolescent Psychiatry.

“Suicidal ideation have been on the rise among youth may be linked to lack of access to care.”

The shortage of child and adolescent psychiatrists has been well known for a while, but very often policymakers are reluctant to address the problem because they think, “If the shortage doesn’t translate to worsening of child or adolescent mental health, what is the point in addressing it?” says Anish Dube, M.D., M.P.H.

The current generation of youth has gone through a lot in the past three to four years,” Dube said. “There is a lot of increased pressure on young people to try to figure out how to succeed in a rapidly changing world, and I think for many of them the future is uncertain.”

Suicidal Ideation ED Visits Increasing Before Pandemic

A study published last November in Pediatrics analyzed Illinois hospital administrative data for ED visits coded for suicidal ideation for youth aged 5 to 19 years. Audrey Brewer, M.D., M.P.H., and colleagues compared visit rates across three 22-month periods: January 2016 to October 2017, November 2017 to September 2019, and October 2019 to June 2021. They specifically analyzed how the COVID-19 pandemic impacted ED visits by comparing data from fall 2019 with data from fall 2020. Brewer is an instructor of pediatrics at Northwestern University Feinberg School of Medicine and an attending physician in the Division of Advanced General Pediatrics and primary care at the Ann & Robert H. Lurie Children's Hospital in Chicago.

In total, Brewer and her colleagues found that counties with 3.62 per 100,000 youth, compared with 3.62 per 100,000 youth in counties with partial or no designation. The study also found that the youth suicide rate decreased as the number of practicing child psychiatrists increased.

Bottom Line: Both studies point to the need to increase the number of child and adolescent psychiatrists, as well as introduce short-term options to increase access to mental health care for youth.

What Is Causing the Ongoing Youth MH Crisis?

As advocates and mental health professionals continue to raise the alarm about the youth mental health crisis, studies continue to highlight just how much youth are struggling with mental health.

- A study published in Pediatrics found that emergency department (ED) visits for suicidal ideation increased by 59% from 2016-2017 to 2019-2021.
- There were significant spikes in ED visits for suicidal ideation in both the fall of 2019 and the fall of 2020, after the COVID-19 pandemic began.
- A study published in JAMA Pediatrics found that counties with mental health professional shortage area designations had youth suicide rates of 5.09 per 100,000 youth, compared with 3.62 per 100,000 youth in counties with partial or no designation.

- The study also found that the youth suicide rate decreased as the number of practicing child psychiatrists increased.

**KEY POINTS**

- **What Is Causing the Ongoing Youth MH Crisis?**
- **Bottom Line:** Both studies point to the need to increase the number of child and adolescent psychiatrists, as well as introduce short-term options to increase access to mental health care for youth.

Youth aged 14 to 17 had the highest frequency of monthly visits. While ED visits related to suicidal ideation did not greatly differ between the fall of 2019 and fall of 2020, there was a significant increase in hospitalizations through the ED during the fall of 2020. The authors posited that this could indicate that patients had more severe symptoms during the pandemic.

“The data is humbling to me,” Brewer told Psychiatric News. “It’s important that we think about what people have gone through, what they continue to go through, and how families are dealing with what’s happening with their kids.”

Brewer and her colleagues noted in the study that the results are likely mirrored throughout the rest of the country. Illinois is a large, diverse state, with both rural and urban populations.

The potential causes of the increase are likely multifactorial, Brewer said, and she pointed out the systemic factors that impact the mental health concerns of racial and ethnic minority youth.

“ Youth who live in communities that may face gun violence on a daily basis...”

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**What Is Causing the Ongoing Youth MH Crisis?**

Health organizations, schools, and youth advocacy groups continue to sound the alarm about mental illness among youth. New studies have offered insight about the rise in suicide among youth before the COVID-19 pandemic began.

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- There were significant spikes in ED visits for suicidal ideation in both the fall of 2019 and the fall of 2020, after the COVID-19 pandemic began.
- A study published in JAMA Pediatrics found that counties with mental health professional shortage area designations had youth suicide rates of 5.09 per 100,000 youth, compared with 3.62 per 100,000 youth in counties with partial or no designation.

- The study also found that the youth suicide rate decreased as the number of practicing child psychiatrists increased.

**Bottom Line: **Both studies point to the need to increase the number of child and adolescent psychiatrists, as well as introduce short-term options to increase access to mental health care for youth.

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What Are the Psychotherapy Needs Of Incarcerated Individuals?

Just like other patients, individuals in jails and prisons may benefit from psychotherapy. There is a wide range of modalities that can be used and tailored to the particular needs of each person. By Peter N. Novalis, M.D., Ph.D.

I t goes without saying that incarcerated individuals need and deserve to have the full range of services that would be available to them in the community. The therapeutic methods used should depend on the treatment plan developed to match the needs of the individual receiving the psychotherapy with the resources available, including the skills of the therapist. For example, the therapist may rely less on psychoanalytic methods, which require commitments of time and education that cannot be met by the typical person in an institution.

However, one should avoid imagining that there is a “typical” incarcerated person. Some people have a long history of crime and may be likely to commit crimes upon release. These individuals need to reshape their criminal thinking styles via a confrontation of people, including their peers, that is often best done in group formats. In fact, many of the mental health needs of incarcerated individuals are best met in a combination of group therapies for certain topics (such as criminal thinking or intimate partner abuse) coupled with individual therapy for issues that cannot or should not be aired in groups.

The time frame for therapy may be strongly dependent on the individual’s sentence, since much psychotherapy is given in pre-sentence settings to persons with unknown stays due to the uncertain outcomes of the legal process. Therefore, it helps to be prepared to use brief psychotherapy strategies when the time frame is not firmly established.

Entry or re-entry into a jail or prison is often a crisis and engenders what has been called disenfranchised grief, that is, the loss of the many things (income, housing, family relationships, self-esteem) that is not typically acknowledged in our society. Elements of crisis and grief therapy are therefore important. In addition, the leading complaints of newly admitted persons are anxiety and insomnia, but many medical directors are reluctant to allow medication treatment; this leaves open the use of therapies such as progressive relaxation, guided imagery, and CBT-I (cognitive-behavioral therapy for insomnia), which can be learned effectively in as little as a single 90-minute session.

Since most incarcerated individuals are eventually released, preparing them for transitioning back to the community should be routine, just as discharge planning starts at the time of admission to an acute care psychiatric unit. Assessing for suicidality and addressing suicidal and self-harming behaviors (even those that may occur after release) are standard fare and take a lot of interdepartmental coordination.

A number of studies address the effectiveness of therapies for people in correctional settings; see the study by Isabel A. Yoon, M. Sc., et al., noted at the end of this article. The evidence basis that supports many forms of psychotherapy is called the common factors theory and is sometimes linked to a famous expression from Alice’s Adventures in Wonderland that “Everybody has won, and all must have prizes.” For more about this, see the study by Bruce E. Wampold, Ph.D., et al., also noted at the end of this article. But even if most psychotherapies are winners, not all get the first prize. I believe that the type of psychotherapy best suited for people in crisis who have uncertain time schedules, limited education and coping skills, and minimal trust in their therapists is supportive psychotherapy—a form of psychotherapy that is unfortunately often devalued in the community in comparison with its more psychodynamic neighbors. Supportive psychotherapy has traditionally placed emphasis on educational and informational processes, even if the use of education seems to evoke the notion of cognitive therapies. With its emphasis on the development of a trusting relationship with a therapist, the core techniques of supportive psychotherapy are also what I would liken to the stem of a flower, which nurtures its petals. These core techniques can be combined with more specialized techniques that are tailored to the skills of the therapist and the needs of the individual.

For example, it is possible to engage in confrontations of an individual’s criminal behavior by combining them with underlying supportive psychotherapy techniques. The therapist’s ability to provide support to individuals with personality disorders also tends to counter a tendency to engage in therapeutic nihilism, that is, the belief that nothing is available to help such individuals. Whichever specialized methods are used, there is a common core of alliance building and other techniques (for example, dealing with the oppositional behaviors often called “resistance”) that are fundamental to working with incarcerated persons.

Pause for a moment to reflect upon the last two words of the preceding paragraph. Attention to the reasons individuals become incarcerated has led many groups including APA to examine the effects of social injustice in creating mental health issues and in placing individuals in jails and prisons. Social inequality, social injustice, the predominant cash bail system, and an emphasis on incarcerating persons who commit misdemeanors, in addition to systemic racism, result in a vast overrepresentation of Black and Hispanic persons in jails and prisons and create a concomitant awareness on their part that they have been treated unjustly. The last word of the previous paragraph, “persons,” also draws attention to the need for person-oriented terminology when discussing persons in jails and prisons.

Many advocacy groups have been purging their vocabulary of objectifying nouns such as “felon,” “convict,” and “prisoner” in lieu of terms such as “incarcerated person,” similar to the use of “person” in place of terms such as “a schizophrenic” or “a borderline.” Consistent with some advocacy groups, I have continued to use the term “prisoner” in recent writing, but I will reconsider that in the future.

When doing psychotherapy with incarcerated persons, I recommend that you do the following:

- Become familiar with techniques for crisis, trauma, and grief management and address initial adjustment problems such as insomnia.
- Learn and use the techniques of supportive psychotherapy as your basic repertoire. Assess for suicidality and view the treatment of self-harming behaviors as a new challenge every time they occur.
- Try to see each person you treat as an individual and avoid unsupported generalizations. Find out why a person has committed a crime and consider what type of approach will address future behaviors including interpersonal violence.

PETER N. NOVALIS, M.D., PH.D., has more than 30 years’ experience treating people with serious mental illness, mostly in the public sector. He has primarily been a clinician with a long-term interest in supportive psychotherapy. He is the lead author of Psychotherapy in Corrections: A Supportive Approach from APA Publishing. APA members may purchase the book at a discount.

See Psychotherapy Needs on page 42
Psychedelic Renaissance: Clinical Health Justice, Patient Safety, and Equity Need to Be Put First

Jacques Ambrose, M.D., MPH is the senior medical director at Columbia University Medical Center and an assistant professor of psychiatry at Columbia Vagelos School of Medicine. Jeffrey Zabinski, M.D., M.S.W., is an assistant professor of psychiatry at Columbia Vagelos School of Medicine.

With the impending FDA review of the phase 3 data for MDMA-assisted psychotherapy for PTSD, experts reflect on ethical considerations, appropriate use, and access.

**BY JACQUES AMBROSE, M.D., MPH, AND JEFFREY ZABINSKI, M.D., M.S.W.**

The groundswell of interest in psychedelics in psychiatry, medicine broadly, and in popular culture continues without a peak in sight.

Though the term “psychadelic” was coined in the 20th century, these compounds have an extensive history of use by Indigenous peoples, often related to traditional or ceremonial use.

There are many overlapping terms and substances with different mechanisms often referred to as producing a psychedelic effect, though “classic psychedelic” refers primarily to serotonin 2A receptor agonists such as psilocybin, DMT, and LSD. Research is progressing rapidly, with phase 3 trials and FDA approval on the horizon in the next few years. An incredibly diverse array of psychiatric disorders are the targets of investigation, with MDMA-assisted psychotherapy for PTSD and psilocybin for treatment-resistant depression at the leading edge for likely indications for approval. There is a clear necessity, a fortiori, to critically explore the diverse ethical and practical issues surrounding psychedelic research and the impact of their progression and potential clinical implementation.

With the impending FDA review of the phase 3 data for MDMA-assisted psychotherapy for PTSD, we must urgently and proactively reflect on ethical considerations, appropriate use, and access. William R. Smith, M.D., Ph.D., and Paul Appelbaum, M.D., in a review posted September 15, 2022, in *Neuropsychopharmacology* identified key challenges about novel ethical and policy issues related to psychedelics, including informed consent, under-ground use, commercialization, and questions around regulation and legalization. Major hurdles are ahead, such as the legal recategorization and rescheduling of psychedelic compounds, appropriate patient screening, minimizing risks in real-world practice, and ensuring that the barriers to access do not prevent the most at-risk patients from getting care.

We must temper the zeal for the potential of these compounds with the reality of clinical evidence. Currently, there already existed questionable practices in pseudo-therapeutic spaces to lure the well-intentioned but desperate and vulnerable patients; with tremendous and seductive promises of psychedelics, it is highly likely that underground utilization of psychedelic compounds will grow. Many startups and biomedical clinics, often purporting ketamine treatment as a model, are financially profiting from this enthusiasm—bringing a marketing blitz that is reminiscent of the false expectations that portended the opiate crisis.

As physicians and stewards of sound science, we must not let our desperation for novel therapeutics cloud our better judgment when the clinical evidence base is still incomplete.

Relating to the possibility or evenuality that evidence-based psychedelic treatments become FDA approved, we must recognize the inherent training gap, which will limit rapid practical implementations for needed patients. Furthermore, there will also be a need for an extended interdisciplinary team model for treatment in order to properly scale the treatments. Without the involvement of the interdisciplinary team, an individual psychiatrist would be challenged to be able to provide care at a sufficient volume to meet the anticipated treatment needs. In addition, appropriate credentialing and the minimum required skills for consistency and effective psychedelic-assisted psychotherapy have not been well established. There have been a few efforts at developing guidelines, credentials, and training requirements. However, while a treatment is yet to be formally approved, numerous interim programs that purport to teach psychedelic-assisted psychotherapy have appeared. Psychiatrists and other therapists are paying huge sums to obtain training, such as taking certificate courses and going on group retreats; there have been online reports of implicit expectations for training participants to use psychedelic substances to better improve insights into the patient experience.

In the clinical health justice and equity lens, novel treatments have historically neglected the access, inclusion, and research outcomes of minoritized populations, such as ethnicoracial minorities and Indigenous cultures. For example, how can psychiatrists better be prepared to avoid cultural appropriations of Indigenous practices, manage burdensome insurance authorization, and expand access to rural and underserved communities? In addition, how do we balance the sensitive neurodevelopment of the pediatric populations in the ethical research of psychedelics and their use in treatment?

Undoubtedly, there will be no simple solution. Similar to clozapine and esketamine, a Risk Evaluation and Mitigation Strategy (REMS) program may be needed to provide oversight and improve standardization of risk monitoring. In access and equity, psychiatrists should continue to organize, advocate, and discuss with their legislators at the state and federal levels. Oregon is possibly an example of a test case of regulated use of psychedelics in service centers with licensed facilitators.

We must be mindful of the risks of unsubstantiated practices without an evidence base that can sometimes cross into the harmful or unethical. As we navigate this era of great promise for psychedelic therapeutics, our duty to our patients requires a thoughtful, equity-driven, and evidence-based approach.


**Psychotherapy**

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therapy and pharmacotherapy more assuredly. Combined treatment by a single professional—the psychiatrist—is surely more coordinated and likely more effective than split treatment. So psychotherapy, and a psychotherapeutic understanding of patients, is a good thing. Yet it’s imperative.

As a long-time psychotherapy researcher and practitioner, I abhor seeing this grand and useful tradition fading from our profession. With pressure against psychotherapy coming from larger forces, we need to fight for the field on a broader level.

One forum within APA is the Caucus on Psychotherapy, headed by Jeffery Smith, M.D. This loose network boasts some 1,300 APA members. I’ve joined, and I encourage all interested psychiatrists to do the same. We can meet and work together to encourage the promotion of psychotherapies within our organization. (Psychotherapy News, https://psychotherapynews psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2022.03.3.13).

As the current president of the International Society of Interpersonal Psychotherapy (ISIPT; https://interpersonalpsychotherapy.org/), I can happily report that this volunteer member organization is working hard to promote not just IPT but psychotherapy generally around the globe. Like the Academy of Cognitive and Behavioral Therapies (ACBT, to which I also belong) and the American Psychoanalytic Association (APsaA), the ISIPT offers periodic training courses and certifies therapists, trainers, and supervisors to ensure the precision and rigor of treatment and avoid the risks of eclecticism. (It’s good to know more than one psychotherapy, but it’s best to use each purely for a given patient.)

Like other such organizations, ISIPT has an advocacy role, responding to the handling of psychotherapy (not just IPT) in drafts of treatment guidelines and in health care policy proposals. Moreover, we are trying to coordinate with organizations like ACBT, APsaA, the Society for Psychotherapy Research, and APA to advocate jointly to promote psychotherapy as a modality. A united front is more convincing than competing rivals.

I’m grateful that *Psychiatric News* prints columns like this one, offering an opportunity to remind psychiatrists of an important part of their heritage and treatment options. I encourage psychiatrists who practice psychotherapy not only to keep helping their patients in this way but further to get involved: in the APA Caucus on Psychotherapy, in teaching therapy to trainees and young practitioners, and in advocating for psychotherapy.


To join the Caucus on Psychotherapy, go to https://my.psychiatry.org/s/special-interest and sign into your member profile.
Shortened PANSS Developed for Children and Adolescents

The 10-item pediatric Positive and Negative Syndrome Scale (PANSS) is almost as accurate as the 30-item PANSS and can be administered in a fraction of the time. 

Robert L. Findling, M.D., M.B.A., notes that the inclusion of hallucinations—considered one of the hallmark symptoms of schizophrenia—in the pediatric PANSS did not appear to improve the accuracy of the evaluation.

A 10-item version of the Positive and Negative Syndrome Scale (PANSS) can reliably assess psychosis symptoms in children and teens, according to a report in the Journal of the American Academy of Child and Adolescent Psychiatry.

With the traditional PANSS, which was developed for adults, an interviewer evaluates the patient for 30 symptoms, rating each symptom on a scale of 1 (absent) to 7 (extreme). These symptoms fall under five domains:

- Positive symptoms (for example, hallucinations and delusions)
- Negative symptoms (for example, social withdrawal)
- Excited symptoms (for example, hostility)
- Cognitive symptoms (for example, poor attention)
- Affective symptoms (for example, depression and anxiety)

An adult evaluation using the PANSS can take about an hour to administer, which places a burden on both the patient and interviewer, noted Robert L. Findling, M.D., M.B.A., professor and chair of psychiatry at Virginia Commonwealth University School of Medicine. When using the scale to evaluate children and adolescents, the interviewer has discussions with both the youth and their parents, which can add more time.

Other researchers have tested shorter versions of PANSS that attempt to maintain the precision of the 30-item scale while reducing the time it takes to administer the evaluation. These include a 19-item scale and two brief 6-item versions. However, as with the 30-item PANSS, these shortened versions of the scale were developed using adult patient data, Findling explained.

“It’s important that we develop and test a pediatric-specific scale, because while the diagnostic criteria for psychotic disorders are the same for youth and adults, the symptom presentations do differ,” he said.

To create a pediatric PANSS, Findling and colleagues used baseline data from an eight-week clinical trial that compared the safety and efficacy of the antipsychotics olanzapine and risperidone with the older antipsychotic molindone in youth. For that study, which was published in The American Journal of Psychiatry, 116 participants aged 8 to 19 years with early onset schizophrenia or schizoaffective disorder were assessed with the 30-item PANSS along with other behavioral assessments every week for eight weeks.

Findling and colleagues evaluated different combinations of symptoms using this patient data set to find a combination that maximized both fidelity to the full-length PANSS (for both mild or severe symptom profiles) and time savings. The researchers sought to include symptoms from the five domains of the 30-item PANSS when creating the pediatric PANSS but did not pick any specific items ahead of time. “We wanted to let the data speak for itself,” he said.

The pediatric PANSS included 10 symptoms evenly spread across the five domains. They were as follows:

- Delusions and unusual thoughts
- Emotional withdrawal and apathy
- Hostility and poor impulse control
- Inattention and disorganized thinking
- Anxiety and feelings of guilt

The 10-item PANSS took significantly less time to administer and matched the 30-item PANSS in the A/P data set 88% of the time. It was also accurate for both mild and severe symptom scores and could reliably identify symptom changes over time.

“Overall, I think this shortened version performs pretty well, as it preserves the PANSS’s broad coverage of symptoms in a format that is briefer and easier to interpret,” Findling said. “We need to validate this scale in more diverse populations.”

This study was supported by funding from Signant Health. The trial that provided the data was supported by the National Institute of Mental Health.

“Averaged Optimized Version of the Positive and Negative Symptoms Scale (PANSS) for Pediatric Trials” is posted at https://www.jaacap.org/article/S0890-8567(22)01974-8/fulltext.

Youth

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or poverty may need different interventions than other youth,” she said. “We need to think more about how historical and structural racism and discrimination may play a role in these outcomes.”

Lack of Mental Health Professionals Linked With Youth Suicides

A study published in JAMA Pediatrics by Jennifer Hoffmann, M.D., M.S., and colleagues last November illustrates just how strong the association is between lack of access to mental health professionals and the increased risk of suicide among youth. Hoffmann is an assistant professor of pediatrics at Northwestern University Feinberg School of Medicine and an attending physician in the Division of Emergency Medicine at the Ann & Robert H. Lurie Children’s Hospital in Chicago.

Hoffmann and colleagues analyzed data from the Centers for Disease Control and Prevention on suicide deaths among youth aged 5 to 19 years from 2015 to 2016. They then looked at counties that are considered mental health professional shortage areas, which the U.S. Health Resources and Services Administration designates based on the number of mental health professionals relative to the overall population, the area’s level of need for mental health services, and the availability of services in contiguous areas. Of the 3,150 counties in the country, 16 were excluded because they had fewer than 100 children aged 5 to 19, and one was excluded due to missing data.

The annual youth suicide rate in counties with mental health professional shortage area designations was 5.09 per 100,000 youth, compared with 3.62 per 100,000 in counties with partial or no designation. The youth suicide rate decreased as the number of practicing child psychiatrists increased, and the rates were lower in counties with a children’s mental health hospital. The authors also found that youth suicide by firearm occurred more often in counties with shortages of mental health professionals. In total, 68% of counties included in the study were designated as mental health professional shortage areas.

While mental health professional shortages are widespread across the country, the authors also found that they are more severe in rural areas, in communities with lower household incomes, and in areas with lower educational attainment, Hoffmann explained. “Unfortunately, these are the very same communities where children are more likely to experience poor mental health outcomes,” she said.

Addressing the Shortage Through Policy

Hoffmann’s study underscores the need for federal investments to bolster the pediatric mental health workforce, she said.

There are several bills pending in Congress that would make such investments. The Investing in Kids’ Mental Health Now Act (S 4747) would incentivize states to increase Medicaid reimbursement for mental health and substance use disorder treatment services for youth, providing direct support to the pediatric mental health workforce and improving access to children’s mental health care.

Having more mental health professionals in a community not only has obvious benefits in that more children can receive the services they need, Dube said, but it also helps to normalize mental health services for youth in the community as a whole. “Child and adolescent psychiatrists aren’t just seeing individual patients,” he said. “We are embedded in the communities through schools or community groups or even religious organizations. It has the larger effect of bringing mental health into regular conversations.”

Hoffmann’s study was supported by an Academic Pediatric Association Young Investigator Award. Brewer’s study received no outside funding.

Rare Neuropsychiatric Variants Present in 1% of Individuals

**Individuals with such rare genetic variants were found to be at increased risk of multiple psychiatric illnesses, though in many instances the adverse effects on cognition or behavior were subtle. BY NICK ZAGORSKI**

Though many neurodevelopmental and psychiatric disorders arise from a combination of genetic, environmental, and social factors, there are instances—for example, Down’s syndrome—where adverse genetic changes are the primary cause.

Such genetic changes—known as pathogenic variants—were believed to be quite rare in the general population. However, recent research from a team at Geisinger’s Autism and Developmental Medicine Institute in Lewisburg, Penn., suggests that about 1 in 89 people in their health system may have these changes, which are associated with an increased risk of autism spectrum disorder, schizophrenia, depression, and more.

“A lot of the work done with these rare genetic variants to date has involved cataloging based on a patient’s medical issue,” said senior investigator Christa L. Martin, Ph.D., the chief scientific officer at Geisinger, a large health care provider in central and northeast Pennsylvania. Such work begins when a patient comes to a clinic with unusual developmental symptoms and genetic tests are done to identify a potential cause of these symptoms, Martin explained. Over time, as researchers collect, curate, and share their findings, centers can develop genetic databases.

Geisinger also has an extensive genome repository, called MyCode, which includes over 180,000 patients from their health system. Martin and her team decided to analyze a subset of their repository to get a sense of how prevalent these pathogenic variants are in this broader adult population.

Martin and her team screened about 90,000 samples for two types of potentially harmful genetic variants: copy-number variants—in which a large segment of DNA is either lost or gained—and single-nucleotide variants—alterations to just a single unit of DNA but one drastic enough to cause a gene to be nonfunctional. They identified copy-number variants in 708 participants (0.78%) and single-nucleotide variants in 312 participants (0.34%), resulting in a combined prevalence of 1.1%. Some of these findings were published in the January issue of The American Journal of Psychiatry.

“The next time you are in any decent-sized crowd, you can imagine that at least one person around you has one of these potentially severe variants,” Martin said.

She added that her team’s data are a very conservative estimate; they only included variants with enough evidence to be considered as “high confidence” for causing disease (31 copy-number variants and 94 single-nucleotide variants). There are hundreds of other known variants associated with neurodevelopmental problems and others yet to be identified.

“This is a baseline that will only grow,” she said.

**Rare Variants Associated With Diverse Cognitive Effects**

The researchers initially focused on diagnoses of 12 neurodevelopmental and psychiatric conditions, including attention-deficit/hyperactivity disorder (ADHD), autism spectrum disorder, bipolar disorder, intellectual disability, motor disorder, and schizophrenia. Overall, 34.3% of individuals with single-nucleotide variants and 30.1% with copy-number variants had at least 1 of these 12 diagnoses, compared with 14.6% of individuals without these variants. When the researchers also considered diagnoses of depression and anxiety, they found that the prevalence of a psychiatric disorder increased to 68.6% of adults with single-nucleotide variants and 66.4% of adults with copy-number variants.

The disorder most associated with these variants was intellectual disability, which was about eight times more likely to occur in someone with a single-nucleotide variant or a copy-number variant than those without.

The researchers also took a closer look at the health records from a subset of individuals with single-nucleotide variants. They found many instances where a patient was given no official neurodevelopmental or psychiatric diagnosis, but clinician notes suggested the patient was experiencing cognitive difficulties or other psychiatric symptoms.

Martin said that these findings highlight how broadly these rare pathogenic variants can manifest. “There’s a perception that these variants cause significant developmental problems, but they can also produce more subtle shifts in cognitive ability, or even not manifest until adulthood,” Martin said.

“This one genetic change, though significant, does not define an individual.”

Martin hopes her group’s findings contribute to the discussion of when and for whom genetic testing should be conducted.

“Today there is agreement that genetic testing can be helpful once someone is diagnosed with a neurodevelopmental disorder like autism, but it could be prudent to start screening newborns in families with a history of such disorders,” Martin said. “Early intervention for conditions like autism or schizophrenia is critical, and there are measures parents can take to provide better care once they know there might be an increased risk in their child,” she said.

Martin said studies suggest that patients are receptive to receiving genetic testing. “We are in an era of knowledge seekers where people want as much information as possible about their health.”

These genetic studies were supported by grants from the National Institute of Mental Health. **PN**

**As 1% is a conservative estimate for the prevalence of rare pathogenic variants, Christa L. Martin, Ph.D., thinks that more genetic screening of infants who might be at risk of a neurodevelopmental disorder is warranted.**

APA Election

**continued from page 1**

B. Ashley, M.D., of New York City defeated Glenn A. Martin, M.D., of Forest Hills, N.Y. The winner of the Area 5 trustee race was Heather Hauck, M.D. She defeated Sudhakar Madakasira, M.D., of Flowood, Miss.

The winner of the race for resident-fellow member (RFM) trustee-elect was Sarah El Halabi, M.D., M.S., a psychiatry resident at Westchester Medical Center in New York. She defeated Sarah A. Friedich, D.O., M.B.A., M.S., chief resident at Jefferson Health’s Albert Einstein Medical Center in Philadelphia, and Sarin Pahlkidian, D.O., a psychiatry resident at the Kirk Kerkorian School of Medicine at the University of Nevada. El Halabi will serve for a year in the RFM trustee-elect position and then rotate into the RFM trustee position.

Election results were approved by the Tellers Committee in February, but the results are not official until the Board of Trustees reviews them at its meeting this month. All of the winning candidates will assume their positions on the Board at the close of APA’s Annual Meeting in May. **PN**

**Complete results, including vote counts for each race, are posted at psychiatry.org/election.** **PSYCHNEWS.ORG   41**
Adversity

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“What we’re seeing is the history of these individuals; the racialized nature of that, and the way we construct our society to overburden certain groups with these disparate experiences, which really contribute to these differences.”

Harnett and his colleagues found that childhood adversity was associated with lower gray matter volume in the amygdala and several regions of the prefrontal cortex. Black children showed lower gray matter volumes in the amygdala, the hippocampus, and several subregions of the prefrontal cortex compared with White children. These regions of the brain are key to regulating the emotional response to threat, Harnett explained.

Differences in exposure to adversity accounted for many, though not all, of the differences in gray matter that the research team identified. He noted that there are numerous adversities that Black children are more likely to experience that were not measured by the ABCD study, which could account for the additional differences in gray matter volume. Additionally, the study did not look into positive factors that could impact brain structure, Harnett said.

Study Provides Deeper Context to Understand Youth

In an accompanying commentary, Deanna Barch, Ph.D., and Joan Luby, M.D., pointed to some of the additional adverse social determinants of health that were not examined in the study, such as a youth’s personal experience of racism. They wrote that some people such as a youth’s personal experience of racism. They wrote that some people such as a youth’s personal experience of racism. They wrote that some people such as a youth’s personal experience of racism. They wrote that some people such as a youth’s personal experience of racism. They wrote that some people such as a youth’s personal experience of racism. They wrote that some people such as a youth’s personal experience of racism. They wrote that some people such as a youth’s personal experience of racism. They wrote that some people such as a youth’s personal experience of racism. They wrote that some people such as a youth’s personal experience of racism. 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Heather McGhee

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Organization focused on public policy solutions to inequality, working her way from an entry-level position to the president of the organization. While with Demos, she drafted legislation, testified before Congress, and contributed regularly to news shows. But the question of why Americans, all Americans, can’t have nice things gnawed at her. And in June 2018, she stepped down as president of Demos to travel across the United States, where she revisits some of the stories of solidarity and hope that were introduced in her best seller—stories of everyday people overcoming their differences to win the fights that unite them: the right to clean water, living wages, reproductive rights—and more. Listeners can explore ways to get involved and take action through an episode-by-episode companion guide.

The Sum of Us podcast launched in July 2022. With McGhee as the host, listeners join alongside her road trip across the United States, where she has appeared in such outlets as The New York Times, The Wall Street Journal, Politico, and National Public Radio.

The Emerging Voices: DEIB (Diversity, Equity, Inclusion, and Belonging), Innovation, and Leadership plenary will take place on Monday, May 22, from 10:30 a.m. to noon. After the plenary, McGhee will be available for a book signing at the APA Bookstore in the Exhibit Hall from 12:15 p.m. to 12:45 p.m.

Clinical Updates Track

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• Benzodiazepines: We know that there are many patients on benzodiazepines who should probably be tapered off. And we also know that there are times when these medications are highly appropriate, even if only for a brief duration. The role of benzodiazepines in our pharmacologic toolkit has been emerging as a polarizing issue in our field. Prescribe? De-prescribe? Who? When? How? A panel of four experts will consider the pros and cons of benzodiazepines and discuss the appropriateness of their use in different clinical scenarios and techniques for de-prescription when appropriate.

• Obsessive-compulsive disorder (OCD): Treating OCD can be a major challenge. We’re understandably thrilled when a patient reports an excellent response to either initial medication or psychotherapeutic interventions because outcomes of initial interventions are often insufficient or disappointing. Dr. Goodman will review treatment options for those who must go to another step.

All the presentations in the Clinical Updates Track are designed to provide insight and information that will be practical and ready for implementation as soon as you get back to your office or clinic.

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- Robust continuing medical education opportunities.
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Position Highlights:
Our growing behavioral health team is seeking a fulltime psychiatrist to provide 7 consecutive days of inpatient care, call, and 13 days of outpatient clinic per month. The psychiatrist will develop and document a plan of care for each patient, administer appropriate treatment and/or referrals, conduct consults in ED and med/surg units. Other responsibilities include making diagnostic and therapeutic decisions, prescribing, performing competently all medical procedures considered essential for the scope of practice.

We offer a competitive salary and benefits package. Join our team and discover why people who work with us have voted us as one of New Mexico’s Best Places to Work and designated CHRISTUS St. Vincent a Family Friendly business for the last 5 consecutive years.

Organization & Culture Summary:
CHRISTUS St. Vincent is a not-for-profit integrated health system located in the beautiful mountain-west city of Santa Fe, New Mexico. Our 200 bed facility is a Level III trauma center providing the region’s 300,000+ residents with compassionate, high quality care. Our 2,500+ associates and providers work through hospital and regional outpatient clinics to offer 39 major medical services and lines of specialty care.

As a member of the Mayo Clinic Care Network, we are part of a select group of independent health systems which have been granted special access to Mayo Clinic’s expertise and resources. This membership allows our physicians to combine their understanding of unique medical needs with Mayo Clinic expertise so that our patients get exactly the care they need right here, close to home.

CHRISTUS St. Vincent is a compassionate family of healthcare providers who care deeply about making a positive, healthy impact in our community.

Santa Fe Living:
Enjoy 300+ sunny days per year, short commute times, as well as a thriving cultural, art, and music scene. Livability.com ranked Santa Fe #4 for “The Best Home Base Cities for Adventure Enthusiasts.” With 300 miles of bike trails, an extensive wilderness trail, the legendary Santa Fe Margarita Trail and five ski areas, streams and lakes, we enjoy two or less hours of the historic downtown plaza, Santa Fe offers ample outdoor opportunities to enjoy year round. We are New Mexico’s Capital City and have earned national and international recognition. To learn much more about Santa Fe living, visit: https://www.santafechamber.org/the-basin-of-santa-fe.html

Requirements:
- MD/D.O is required
- State medical license
- Board certified or eligible (Dual boarded in psychiatry and addiction medicine preferred but not required)

Interested candidates please send CV with contact information to Magan.Varela-Lujan, Manager Provider Recruitment, at Magan.Varela-Lujan@atfim.org.