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AMERICAN PSYCHIATRIC ASSOCIATION

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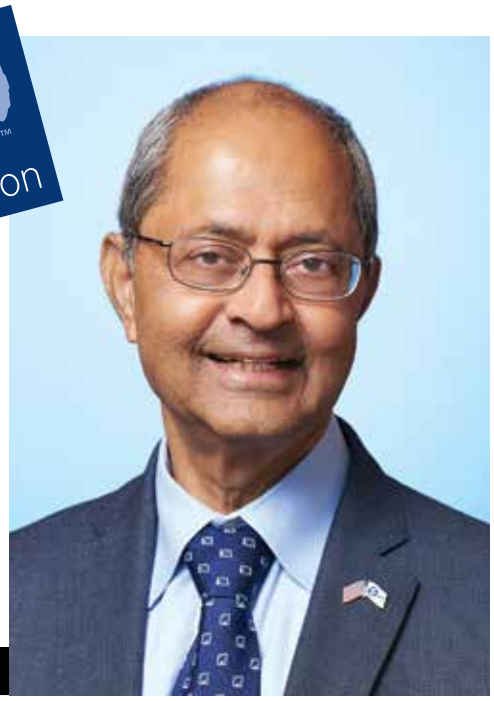
2023 APA Election



Ramaswamy Viswanathan, M.D., Dr.Med.Sc. (left), will become president-elect of APA at the end of APA's Annual Meeting in May, when **Petros Levounis, M.D., M.A.**, becomes president.

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States move swiftly toward increased access to psychedelics.

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Special report provides in-depth information on bipolar II disorder.

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, Kamalika Roy, M.D., M.C.R., of Seattle emerged the winner. Her opponent was Dora-Linda 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. In the race for Area 2 trustee, Kenneth

see **APA Election** *on page 41*

PERIODICALS: TIME SENSITIVE MATERIALS

Register Now for APA's Annnual 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.

AMERICAN PSYCHIATRIC ASSOCIATION ANNUAL MEETING

PSYCHIATRIC NEWS

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AMERICAN PSYCHIATRIC ASSOCIATION

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 600 peer-reviewed sessions and courses and more than 1,000 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 25). 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, there 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

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IN THIS ISSUE

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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 have a DEA registration in any state in which they are prescribing 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 Telepsychiatry and the American Telemedicine Association Telemental Health Special Interest Group.

- "What Happens When the Public Health Emergency Ends? Telepsychiatry 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 Telepsychiatry, and Torous is the chair of APA's Committee on Mental Health Information Technology.

- "Comparison of Telehealth Provisions During & After the Public Health Emergency": This table summarizes the topics discussed in the webinar mentioned above and provides a quick reference on the telehealth provisions enacted during the PHE, their likely status post-emergency, and anticipated kick-in date.

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. **PN**

More information on these resources is posted at https://www.psychiatry.org/psychiatrists/practice/telepsychiatry.

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Francisco's vibrant arts scene, a newly developed Humanities Track will examine how art and culture affect the way we think and feel in our day-to-day lives. The humanities have power not only to entertain, but also to heal. "Catharsis Welcomes Creativity: A Poet's Tale of Exploring Mental Health Through the Arts" and "The Role of the Photographic Arts in Psychiatry" are two offerings that will explore the important roles of art in our lives and well-being.

Last, but certainly not least, our host city is known for looking toward the future, and for us, that future lives in our residents, fellows, and medical students. Much of the scientific program was curated with these attendees in mind. APA has collaborated with PsychSIGN (Psychiatry Student Interest Group Network) to offer content exclusively tailored to medical students, and the Residents, Fellows, and Medical Students Track will provide practical, real-world information in sessions such as "How to Negotiate Contracts: What to Look for in a Job." I encourage our more experienced members to take a moment to stop by and give your support to our RFM attendees.

I hope you will also pay special attention to invited presidential sessions, which include contributions from leaders in other psychiatry organizations; the final report of my Workgroup on a Roadmap for the Future of Psychiatry; late-breaking clinical research; current challenges in medical ethics, mental health policy, advancing diversity, and achieving equity in psychiatry; trends in treatment and policy to address opioid use disorder; psychiatry in the media; and more.

I've shared just a small sample here of the sessions and special symposia that will be featured at the Annual Meeting this year. I look forward to seeing you in San Francisco for the premier psychiatric event of the year, and as always, you can follow me in real time on Twitter @Pres_APA. **PN**

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***

Craig Obey is chief of APA's Division of Government Relations.

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 guaranteed 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.

David Hathcox

So, will partisanship and divided government in Washington, D.C., allow for further progress? Despite the dra-

continued on next page

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 "inequitable 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.

continued from previous page

matic start to the 118th Congress in January and widespread expectations for gridlock, incremental progress again seems possible on mental health issues. Although the scope of such potential action is far from clear, these issues continue to be seen as bipartisan on Capitol Hill and beyond.

That said, the likely approach, interest, and timing of potential action on different issues vary. For example, the newly enacted continuation of telehealth flexibilities has proven to be quite important, now that the PHE designation is about to expire. When the PHE expires, millions also risk losing the Medicaid access they have had during the pandemic. It is far from clear whether Congress will respond to the end of the PHE by making telehealth flexibilities permanent or addressing other access challenges like Medicaid. Telehealth has engendered clear bipartisan interest; access issues like Medicaid less so. These items all have significant costs, and all proposals with fiscal implications will be affected by broader debates over federal spending, including those related to raising the statutory debt limit.

We can expect the debt limit debate to consume much D.C. oxygen before this summer. And the debate over annual appropriations bills that fund public mental health programs will be fever pitched, with many betting that the political parties will be unable to reach agreement, resulting in such spending being put on autopilot for the year. Meanwhile, authorizing committees will be holding hearings and will begin marking up bills.

Two early data points give reason to hope for some progress on mental health, including substance use. First, legislators appear poised to focus on reauthorizing the SUPPORT Act beginning later this year. That important opioid-related legislation was bipartisan when enacted a few years ago, and there is reason to hope Congress will again find the bipartisan will to act.

The second is the bipartisan work on mental health begun last year by the Senate Finance Committee, which played a major role in adding the 100 new residency slots for psychiatry in Medicare. All indications are that the committee plans to continue that work, which could produce further progress on integrated care, including boosting implementation of the Collaborative Care Model in primary care practice, and a series of other items focused on workforce measures, crisis care, and children.

As was the case with the last Congress, the expertise and advocacy of our members are vital contributors to our success with these and the many other important debates to come, not only on the federal level but also on the state level (see article at right). **PN**

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 doublecheck 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 smartphone apps, 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. APA's 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 with newly minted graduate medical education slots, state legislation is still needed to address student loan repayment and other workforce issues (*Psychiatric News,*

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https://psychnews.sychiatryonline.org/doi/10.1176/appi.n.2023.02.2.43).

- **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.

Katherine G. Kennedy, M.D., is chair of the APA Council on Advocacy and Government Relations and an assistant clinical professor at the Yale University School of Medicine, where she leads the Legislative Advocacy Skills Program. She is also co-editor of *A Psychiatrist's Guide to Advocacy* from APA Publishing.

- 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. Don't be surprised when legislators respond! Most state legislators want to connect with their constituents—many will welcome your ideas, and some may even ask for guidance on specific mental health and substance use initiatives.

- 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! **PN**

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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 Boatright, 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 of 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.

New York University Grossman School of Medicine

Hospitals and academic medical centers should conduct routine investigations of disparities in assessments evaluating resident competence, says Dowin Boatright, M.D., M.B.A., M.H.S.

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, Boatright explained.

Yale School of Medicine

Not ensuring that residents are assessed fairly makes their working environment hostile to them, says Nientara Anderson, M.D., M.H.S.

"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," Boatright 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.

"As 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, simply increasing [the number of people of color in medicine] does not obviate the presence of racism."

One finding may highlight how racial and ethnic inclusiveness and equity at all levels of medicine may counter racism toward residents: When the researchers analyzed data from residents who completed their training at historically Black colleges and universities, they found no significant racial and ethnic differences in total Milestone scores and no differences in the ratings for any competency domain during residency.

"Although there's a potential for that result to be biased because of a small sample size, the faculty at these institutions are generally more diverse, and data have shown that positive social contact among different groups can reduce implicit bias," Boatright said.

Boatright 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," Boatright 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.

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.

Group	Patient Care	Medical Knowledge	Systems-Based Practice	Practice-Based Learning and Improvement	Professionalism	Interpersonal and Communications Skills
Midyear						
Asian	0.76 (0.68-0.84)	0.75 (0.68-0.83)	0.76 (0.68-0.84)	0.79 (0.72-0.88)	0.77 (0.70-0.85)	0.79 (0.71-0.87)
URiM	0.86 (0.75-1.00)	0.79 (0.68-0.91)	0.89 (0.77-1.02)	0.83 (0.72-0.96)	0.85 (0.74-0.98)	0.83 (0.72-0.95)
White	1 [Reference]	1 [Reference]	1 [Reference]	1 [Reference]	1 [Reference]	1 [Reference]
End of Year						
Asian	0.92 (0.80-1.05)	0.91 (0.78-1.06)	0.88 (0.76-1.02)	0.93 (0.81-1.07)	0.92 (0.79-1.08)	0.83 (0.70-0.99)
URiM	1.02 (0.85-1.22)	0.85 (0.7-1.03)	0.90 (0.74-1.10)	0.89 (0.74-1.07)	1.01 (0.81-1.25)	0.89 (0.7-1.12)
White	1 [Reference]	1 [Reference]	1 [Reference]	1 [Reference]	1 [Reference]	1 [Reference]

Numbers are odds ratios; numbers in parentheses indicate the 95% confidence interval. URiM = underrepresented in medicine.

Source: Dowin Boatright, M.D., M.B.A., M.H.S., et al. *JAMA Network Open*, December 29, 2022.

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 care to the kind of community I had grown up in."

Today, Meidl is a third-year resident in the University of Iowa's Public and Rural Psychiatry Track, which provides an additional layer of training in rural psychiatry on top of the standard training in the four-year residency program at the university in Iowa City.

As part of the training, she meets with patients using telepsychiatry at Clarke County Hospital, in southwestern Iowa. During her second year, she served a four-week rotation at a rural clinic where she worked with an Assertive Community Treatment (ACT) team serving patients with serious mental illness, a first-episode psychosis team, and an Integrated Health Home (a program that provides wraparound services to patients with serious mental illness). Throughout the four-year specialty track, trainees hear monthly lectures on topics relevant to rural care.

The Public and Rural Psychiatry 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.

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."

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 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?"

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

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Cleveland MetroHealth Hospital

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%.

Cleveland's Safety Net Hospital Builds 112-Bed Psychiatric Facility

The new hospital and an enlarged training program mark the largest expansion of behavioral health services in northeast Ohio in 30 years.

BY MARK MORAN

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, according to the County Medical Examiner's Office.

Cheryl Wills, M.D., director of child and adolescent psychiatry at MetroHealth, said the new hospital and the expansion of the training program are the 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.

Cleveland MetroHealth Hospital

The new hospital is expanding incrementally—40 adult beds became available when the hospital opened last October. Separate 20-bed units for adolescents, patients with substance use disorders, and geriatric patients are expected to open this year.

"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." **PN**

Information about the Ohio Physician Loan Repayment Program is posted at https://odh.ohio.gov/know-our-programs/primary-care-office/workforce-programs/pco_oplrp_faq. The Cuyahoga County Medical Examiner's Report on opioid deaths is posted at https://cuyahogacounty.us/docs/default-source/me-library/heroin-fentanyl-cocaine-deaths/2022/dec2022-heroinfentanyl.pdf?sfvrsn=b9408506_3. Information about the Cuyahoga County Opioid Mitigation Fund is posted at http://council.cuyahogacounty.us/pdf_council/en-US/2022-2023Budget/Pres-Budget-2022-2023-B.pdf.

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on a first-episode psychosis team, I treat geriatric patients and patients with addiction, and I am the psychiatrist on the ACT team. I'm all of those specialists in one. A major appeal of this work is the difference you can make, because there is such a lack of services."

'So Much More I Need to Learn'

The growth of the training program at Iowa ensures that a crop of young psychiatrists will be "in it for the long haul" to treat patients in underserved areas of the heartland. Meidl said that her work with the ACT team, in particular, was transformative.

"It really impacted what I want to do in my career," she told Psychiatric News. "For an ACT team to work well, you need to have patients [with lived experience] as part of the team, and you have to travel, because the patients we see live so far apart. It takes more organization, but we are able to do it. It was so valuable to learn how I can work with the resources that exist and how I can integrate into the community."

She said that she wants to follow her residency with the public psychiatry fellowship that the university expects to create.

"There's so much more I still need to learn about systems of care for rural communities," Meidl said. "I see myself working in a rural clinic while also building projects and creating connections between hospitals and institutions to bring better care to rural communities." **PN**

iStock/Vladimir Vladimirov

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 the principal investigator of the National LGBTQIA+ Health Education Center, whose goal is to improve health care for LGBTQIA+ people at health centers.

Last December, authorities arrested and charged a man from Texas for making a death threat to one of the center's affiliated physicians, according to the U.S. Attorney's Office for the District of Massachusetts. He claimed in his message that there was a group of people on their way to "handle" the physician, whom he accused of castrating children. "You're all gonna burn," the man said in the message.

That incident was far from isolated. Such attacks have targeted clinics in Akron, Boston, Nashville, Seattle, Washington D.C., and more. Many of the harassment campaigns, which included threatening phone calls, emails, and social media messages, were prompted by conservative pundits and high-profile social media accounts that spread false accusations about the clinics. The attackers asserted that the clinics were mutilating children and giving them "chemical castration drugs," among other claims.

Vanderbilt University Medical Center and Boston Children's Hospital have been the subject of two such harassment attacks. Clinicians at Boston Children's Hospital were accused of giving hysterectomies to children (which the hospital denies, according to a statement posted on Twitter). Vanderbilt was accused of pressuring parents who might be hesitant to consent to gender-affirming care for their children (which the medical center also denies, according to a statement made

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ETHICS CORNER

When Laws Collide With Responsible Patient Care

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

Every 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.

Charles C. Dike, M.D., M.P.H., is chair of the APA Ethics Committee and former chair of the Ethics Committee of the American Academy of Psychiatry and the Law. He is also an associate professor of psychiatry; co-director of the Law and Psychiatry Division at the Yale University School of Medicine; and medical director in the Office of the Commissioner, Connecticut Department of Mental Health and Addiction Services.

The law flew in the face of scientific data indicating that firearms are the 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.

Wisely, in 2017, the Florida law was ruled unconstitutional as it violated the First Amendment rights of physicians. But the damage was already done—a 2019 study showed that one year after the law was repealed, only 5% of surveyed physicians in Florida always talked to at-risk patients about gun safety, according to Melanie G. Hagen, M.D., et al. in the November 2019 *Southern Medical Journal*.

A more recent issue surrounds the Supreme Court's *Dobbs* decision that overturned *Roe v. Wade*. As predicted, states have begun tightening laws around abortion and criminalizing its provision, including the prescription of medication to terminate a pregnancy. For example, in response to the FDA's recent rule expanding

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on its website).

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).

Marilyn Humphries

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.

"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."

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." **PN**

"The 2022 National Survey on LGBTQ Youth Mental Health" is posted at https://www.thetrevorproject.org/survey-2022/.

access to mifepristone, Florida's Agency for Healthcare Administration issued an alert to remind health care providers of the state laws that prohibit termination of pregnancy except in emergency situations. The alert also reminded providers that willful violation of the law could result in criminal penalties. However, waiting until a woman's life is in danger—which would then qualify as an emergency situation—before terminating a pregnancy previously determined by a physician to pose a serious risk of morbidity or mortality to the woman could be unethical.

So, how should psychiatrists respond to situations in which laws enforce unethical practice? Section 3 of APA's *The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry* states that a physician shall respect the law but also recognize a responsibility to seek changes in those requirements that are contrary to the best interests of patients. It further says:

"It would seem self-evident that a psychiatrist who is a lawbreaker might be ethically unsuited to practice his or her profession. When such illegal activities bear directly upon his or her practice, this would obviously be the case. However, in other instances, illegal activities such as those concerning the right to protest social injustices might not bear on either the image of the psychiatrist or the ability of the specific psychiatrist to treat his or her patient ethically and well. While no committee or board could offer prior assurance that any illegal activity would not be considered unethical, it is conceivable that an individual could violate a law without being guilty of professionally unethical behavior. Physicians lose no right of citizenship on entry into the profession of medicine."

Thus, a physician who breaks the law while providing clinically justifiable service to patients cannot be accused of unethical practice. Still, despite the ethical injunction of Section 8 of the Code of Medical Ethics that a physician shall, while caring for a patient, regard responsibility to the patient as paramount, it would be foolhardy to recommend that psychiatrists willfully break laws that might curtail ethical practice and place their freedom or livelihood at risk. Perhaps the best recourse in these challenging situations is to hold dear Section 7's admonition for physicians to recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.

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. **PN**

***The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry* is posted at https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/Ethics/principles-medical-ethics.pdf. The 2019 article, "Patients and Guns: Florida Physicians Are Not Asking," is posted at https://sma.org/southern-medical-journal/article/patients-and-guns-florida-physicians-are-not-asking/.**

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.

> "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 fundamentals, 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." **PN**

Dionne Hart, M.D., is a member of APA's Council on Advocacy and Government Relations, an APA delegate to the AMA House of Delegates, a member of the Minnesota Medical Association Board of Trustees, president of the Minnesota Association of African American Physicians, chair of the National Medical Association's Region IV, and the AMA liaison to the National Commission on Correctional Health Care Board of Representatives. She can be reached on Twitter at @lildocd. Eileen McGee, M.D., is a retired adult, child, and adolescent psychiatrist in the Cleveland area with experience as a private practitioner and community psychiatrist in a Federally Qualified Health Center. She is Area 4's treasurer and head of the Program Committee.

Psychedelics

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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.

There needs to be a public conversation about how to incorporate psychedelics into American society, says Joshua S. Siegel, M.D., Ph.D.

Psychiatrists should explain that psychedelics are promising but almost exclusively investigational at this time, says Jonathan E. Alpert, M.D., Ph.D.

The majority of the proposed laws involving psychedelics do not align with current federal drug policy, says James E. Daily, J.D., M.S.

"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

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Digital Startups: Where to Begin

APA's 2022 Mental Health Innovation Exchange provided an in-depth look at technologies that may someday lead to improved patient management. This is the last of a series of reports about the exchange.

BY POLET LOYNAZ AND ELEANOR ADAMS

TECH TIME

New 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 concurrently 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, more resources allow 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 commented: "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."

Arevian has been one of the few physicians to break into this digital startup space and offers insight to others hoping to do the same. He said that "the key is not requiring very much [money]" and suggested turning to smaller pots of university funding and expanding on technology that already exists.

Two technologies that may be a valuable starting place for aspiring clinicians are Chorus and VR. Chorus is an easy-to-use, automated digital platform where clinicians create personalized text messages or interactive voice apps specific to their patients' needs. The app uses machine learning to analyze patient speech patterns and predict and track their clinical state over time. Innovative mental health technologies like this give small startups the ability and power to create digital platforms that directly benefit their patients.

> "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.

Psychologist Todd Maddox, Ph.D., shared his experience with AppliedVR: "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."

He continued, "In fact, if you're in the clinical world and have any interest in creative technologies, you are the perfect person to create the technology. Everyone has different lenses and different expertise."

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. **PN**

Polet Loynaz and Eleanor Adams are second-year medical students at UC Davis. They are both mentees of Steven Chan, M.D., M.B.A., a clinical informaticist, addiction medicine psychiatrist, and a member of APA's Telepsychiatry Committee.

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discovery into psychedelic agents with the same scientific integrity and regulatory standards applied to other promising therapies in medicine. Clinical treatments should be determined by scientific evidence in accordance with applicable regulatory standards and not by ballot initiatives or popular opinion."

The authors of the *JAMA Psychiatry* study wrote that although the proposed laws differ considerably, all of them, directly or indirectly, contradicted or sidestepped the Controlled Substances Act (CSA) of 1970.

"Some of the proposed bills that we studied are narrow enough that they do not directly contradict the federal Controlled Substances Act. For example, some of the bills only go as far as calling for a policy study and would not directly legalize or decriminalize these drugs," study researcher James E. Daily, J.D., M.S., told *Psychiatric News*. He is a researcher, lecturer, and data scientist at the Center for Empirical Research in the Law at Washington University in St. Louis. "But those bills tend to at least contemplate future decriminalization or legalization. It is safe to say that a substantial majority of these proposed state laws either directly contradict the CSA or are at least not in alignment with current federal drug policy."

Alpert noted that legislative reform regarding cannabis followed a similar pattern.

"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."

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.

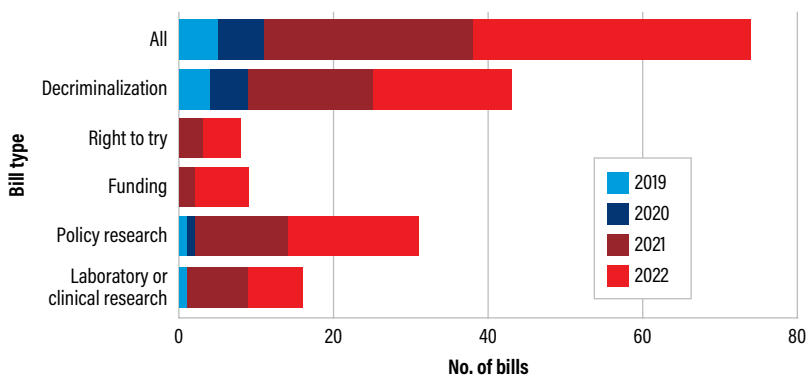
As *Psychiatric News* went to press, at least five states had introduced new bills regarding psychedelics since January 1.

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. **PN**

"Psychedelic Drug Legislative Reform and Legalization in the U.S." is posted at https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2799268. "Position Statement on the Use of Psychedelic and Empathogenic Agents for Mental Health Conditions" is posted at http://apapsy.ch/Psychedelic_Drugs.

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.



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

Taking on the Medical Director Role: Risk Management Considerations

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.**

iStock/Sinenkiy

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 treating 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:

- Ensure you have insurance coverage for the dual role as a medical director and treating psychiatrist.
- 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**

Gloria Umali, R.N., M.S., C.P.H.R.M., is assistant vice president of the Risk Management Group of AWAC Services Company, a member company of Allied World. Risk Management services are provided as an exclusive benefit to insureds of the APA-endorsed American Professional Agency Inc. liability insurance program.

ON MENTAL HEALTH, PEOPLE, AND PLACES

The Long Journey From Arigbawonwo

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

Ezra E. H. Griffith, M.D., is professor emeritus of psychiatry and African American Studies at Yale University.

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

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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

KC Hodge

Bexx Caswell-Olson, M.S.L.I.S., holds up a light meter to a shelf of antique books in the Melvin Sabshin, M.D. Library & Archives to measure the amount of visible and infrared light to which the books are exposed.

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 preseveration 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 told *Psychiatric News* during her visit. "But I'm also taking a closer look at the collection as a whole to get a better sense of what condition the books are in and what the biggest needs are."

Preservation Assistance Grants are awarded to small and midsize institutions to help improve their ability to preserve and care for their humanities collections, with the help of conservators like Caswell-Olson.

APAF's collection boasts a wide variety of works, including 15th and 16th century volumes, which chronicle witchcraft, superstition, and demonology. It includes, for example, a copy of *The Malleus Maleficarum*, which is often translated as "The Hammer of Witches" and was originally published in Germany in 1486.

Altogether, the collection includes rare books, personal papers and manuscripts, audiovisual media, and oral histories that document both the history of the field of psychiatry as well as APA's origins, development, activities, and achievements. The collection provides glimpses into the earliest mental illness treatments, as well as examples of advocacy, Gorland said.

Caswell-Olson is working on a report detailing her suggestions as to how APAF can ensure the library's longevity. She called the library "a beautiful, well-designed space" and noted that some books could use some special attention. Not only do some of the oldest volumes need additional preservation work, but so too do the volumes that date back to the late Victorian era. "The quality of materials they used then 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." **PN**

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

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of being born with the proverbial silver spoon securely placed in his mouth. He realized in medical school that it would be worthwhile for him to become adept at student politics and to think about matters such as leadership, service, and representation of others who lacked voice in their surroundings.

Joel graduated from medical school in 1987 and went into the required rotating internship in a rural hospital of northern Nigeria. He saw the year as a worthwhile experience learning how to provide medical care with minimal resources. Although frustrating at times, he could sense his increasing clinical sophistication and confidence. This process also helped him recognize that he had no social or family connections that could help him set up a medical practice in Nigeria. Thus, the most viable option was to migrate overseas and obtain postgraduate training in Europe or North America. He accepted the pathway of a two-year contract with the Trinidad government. At the end of that, his wife was recruited by a New York City hospital. It was she who obtained the visas that facilitated resettlement in the United States in 1992. It then took him another two years to win a place in the psychiatry residency program at Harlem Hospital. After that, he specialized in forensic psychiatry at the State University of New York in Syracuse.

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.

Over the next 15 years, he moved through both inpatient and outpatient hospital positions and finally reached a senior post leading the Department of Psychiatry at New York City's Richmond University Medical Center. His major roles as a clinician educator and physician executive reflect the benefits of his experiences with mundane impediments and barriers to smooth success. I often contemplate his deft manner of handling an administrative meeting or his distinguished performance as an expert witness in court and marvel at the long journey from the Nigerian hamlet to the pinnacle of his present profession. I wonder at the elements that nourish such resilience and accomplishment. **PN**

VIEWPOINTS

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

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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 factionalism:** 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 nonpsychotic 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 psycho-

see **Psychotherapy** *on page 39*

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 saw firsthand how the medical system was overtaxed.

Physicians across many specialties, who previously would have been mentors to medical students and residents, were burnt out. Medical students and residents were left with permanent scars as they sometimes understood the pandemic and the virus, along with the precautions they had to follow, in a way that was often very different from that of friends and family. They were oversaturated with death and negativity by the media. At its worst, those training to save lives and alleviate suffering felt the frustration of joining a broken medical system. The already overburdened system was unable to provide fair, equitable medical help and support to people impacted by COVID-19. Trainees experienced a major shift in curriculum and training as programs attempted to meet everyone's needs. Physicians and staff pivoted constantly to allow training to progress, all while already being spread thin.

It's tempting to call the adaptation to COVID 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

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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 health care 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 reprioritize 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.

In a world filled with pain and suffering, trainees provided patients and loved ones with support and hope despite the problems and fear they were experiencing. At the very beginning of the pandemic, as the world was shutting down, I worked with a trainee about to enter his next level of training. In addition to this already anxiety-provoking transition, he was also planning a huge get together for a major life event. As we peeled back more and more layers of the onion during each visit, I helped the trainee manage sadness, frustration, disappointment, and anger. As months went on, I also helped him gain hope, perspective, and resilience. He was entering a stage in his career that would be fraught with new challenges as the medical system diverted care and moved to universal testing and masking. He was also facing the reality that some life events would need to be put on hold—at least in the way he had envisioned them. At his lowest point, grieving the death of someone lost to COVID-19, he shared that this experience had changed him forever. The story and the suffering that each of us experienced during this time were unique. The sentiment is one I've heard numerous times over the last few years.

Some argue that the failures we experienced during the pandemic far outweighed the successes. Even failure is an opportunity to refine, redefine, and elevate. The pandemic was fraught with many negatives but also contained many positives that trainees will carry with them for the rest of their careers. **PN**

Rick Prather/Art by Benjavisa Ruangvaree/Shutterstock/Bipolar II Disorder: Recognition, Understanding, and Treatment

PSYCHIATRIC NEWS
Special Report

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

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Trisha Suppes, M.D., Ph.D., is a professor of psychiatry, staff psychiatrist at the VA Palo Alto, and director of the Exploratory Therapeutics Laboratory at Stanford University. Holly A. Swartz, M.D., is a professor of psychiatry at the University of Pittsburgh School of Medicine and director of the Center for Advanced Psychotherapy at Western Psychiatric Hospital. They are co-editors of *Bipolar II Disorder: Recognition, Understanding, and Treatment* from APA Publishing. APA members may purchase the book at a discount at https://www.appi.org/Products/Mood-Disorders/Bipolar-II-Disorder. Sara Schley is the author of *Brainstorm: From Broken to Blessed on the Bipolar Spectrum* (Seed Systems, 2022). She is the founder of a consulting business and has worked with hundreds of renowned companies worldwide.

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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 categorial 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 onto continuous biological markers of disease, compared with *DSM's* categorical approach, but the debate about diagnostic boundaries and disease etiology continues. Importantly, conceptualizations of BD as a spectrum condition versus discrete diagnostic categories (that is, BD I or BD II) are not mutually exclusive but rather speak to ongoing efforts to understand and best describe the phenomenology of BD.

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

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

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

	Depression	Hypomania	Mania
Number of Criterion B symptoms[a]	≥5	≥3	≥3
Duration[a]	2+ weeks	4+ days	7+ days or hospitalization
Functioning[a]	Causes significant distress or impairment in functioning	Not severe enough to disrupt functioning or require hospitalization	Disrupts social and occupational functioning or hospitalization or psychotic features

[a] Required for diagnosis. [b] One or both required for diagnosis.

Source: Holly A. Swartz, M.D., Trisha Suppes, M.D., Ph.D. (eds.), *Bipolar II Disorder: Recognition, Understanding, and Treatment,* APA Publishing, 2019.

Table 2. Overlapping Symptoms of Bipolar II Disorder Mood Episodes and Common Comorbid Disorders

Comorbid Disorder	Overlapping Symptoms With Depressive Episodes	Overlapping Symptoms With Hypomanic Episodes
Anxiety disorders	Irritability, psychomotor agitation, poor sleep, low energy (easy fatigability), negative cognitions, rumination, social avoidance, cognitive dysfunction	Irritability, psychomotor agitation, racing thoughts, cognitive dysfunction
Impulse control disorders	Psychomotor agitation, cognitive dysfunction	Hyperactivity, irritability, psychomotor agitation, distractibility, inattention, impulsivity
Substance use disorders	Substance use described as "self-medicating"	Impulsive excessive substance use
Personality disorders	Negative cognitions, interpersonal problems, social withdrawal, rejection sensitivity, suicidality, subjective emptiness	Impulsivity, angry outbursts, irritability, mood lability, affective dysregulation
Eating disorders	Change in eating patterns (increased or decreased)	Change in eating patterns (increased or decreased)

Source: Holly A. Swartz, M.D., Trisha Suppes, M.D., Ph.D. (eds.), *Bipolar II Disorder: Recognition, Understanding, and Treatment,* APA Publishing, 2019.

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 Karanti, 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 (CANMAT) 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 (hypo)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. Lumateperone is the first antipsychotic formally studied for depression response in patients with BD II since quetiapine trials in the early 2000s. Lumateperone, 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 lumateperone 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 frontrunner treatment for managing BD II, study results

continued on next page

Table 3. Medical Comorbidities Associated With Both Bipolar I and Bipolar II Disorders

Category	Specific Conditions
Classic inflammatory disorders	Inflammatory bowel disease, systemic lupus erythematosus, autoimmune thyroiditis, Guillain-Barré syndrome, autoimmune hepatitis, rheumatoid arthritis, multiple sclerosis, psoriasis, allergies and asthma, chronic obstructive pulmonary disease
Gastrointestinal disorders	Irritable bowel syndrome, peptic ulcer disease, liver disease, inflammatory bowel disease
Chronic infections	Toxoplasma gondii, HIV/AIDS, cytomegalovirus, human herpes virus 6, possibly herpes simplex virus 1
Cardiovascular disease	Myocardial infarction, cerebral vascular disease, atherosclerosis, hypertension
Metabolic disorders	Type II diabetes mellitus, dyslipidemia, obesity/overweight, metabolic syndrome, gout
Pain disorders	Fibromyalgia, migraines

Source: Holly A. Swartz, M.D., Trisha Suppes, M.D., Ph.D. (eds.), *Bipolar II Disorder: Recognition, Understanding, and Treatment,* APA Publishing, 2019.

Table 4. Mood Stabilizer Monotherapy in Bipolar II Disorder

	Hypomania	Depression	Maintenance	Rapid cycling
Lithium	+++	+/++	+++	+
Divalproex	+++	+	++	+
Lamotrigine	–	++	+++	+
Carbamazepine	++	+	++	+

Note: +++ = strong evidence (evidence from previous studies whose designs can support causal conclusions and studies that in total include enough of the range of participants); ++ = moderate evidence (evidence from previous studies whose designs can support causal conclusions but have limited generalizability [i.e., moderate external validity], or studies with high external validity but moderate internal validity); + = some evidence; – = evidence of lack of efficacy.

Source: Holly A. Swartz, M.D., Trisha Suppes, M.D., Ph.D. (eds.), *Bipolar II Disorder: Recognition, Understanding, and Treatment,* APA Publishing, 2019.

continued from previous page

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 have 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. **PN**

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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.

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

A 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 beyond 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!

Q *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?*

A 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 this mess. The chaos makes me crazy, and I am embarrassed to invite anyone over into this scene—even though I'm desperate for company and terrified to be alone with my brain.

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

A 25 years. No kidding.

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

A 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.

Q *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?*

A 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 that's what I set out to do?

Q *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?*

A 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.

Q *Thank you so much for sharing your story and wisdom with us.*

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APA's 2023 Annual Meeting: Enjoy the Full Adventure!

This special section contains information on APA's 2023 Annual Meeting in San Francisco, APA's first full, jam-packed in-person meeting since 2019. The section includes the scientific program as of press time and articles providing additional information on some of the major sessions. For the latest program information, visit APA's Session Search at https://s7.goeshow.com/apa/annual/2023/session_search.cfm.

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

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.

Known for her roles in "De-Lovely," "Ruby in Paradise," and "Double Jeopardy," 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 Kentucky 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 onstage, and unfailing kindness off it—not for the private details of how she suffered when she died." **PN**

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Because most of the spaces in APA's courses fill early, you are encouraged to enroll in advance to ensure you get a space in the course or courses of your choice. Course enrollment must be done as part of your Annual Meeting registration—only registered meeting attendees may purchase course tickets.

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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: Shanila Shagufta, 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 Psychiatrists Working in Marginalized Communities) *Chair: Ijeoma Ijeaku, M.D., M.P.H.*

Creative Collaboration in the Correctional Setting *Chair: Peter Nicholas Novalis, M.D., Ph.D.*

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. Fung, 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 Plakun*

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 Experiential Workshop *Chair: Marsal Sanches*

Innovation for Future Generations: Child & Adolescent Mental Health Integration in Primary Care Settings *Chair: Catherine Hormats, 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 Marwaha*

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 Peteet, 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 Muir*

When Behavioral De-Escalation Isn't Enough: Medication Management of Acute Agitation in Manic and Psychotic Patients *Chair: David N. Osser, M.D.*

Why Despite the Current Changes, the Gender Gap in Psychiatry Persists? What Are We Missing? *Chair: Ruby C. Castilla 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.*

Presidential Session

Not Just Hannibal Lecter: Psychiatric Representations in Crime Fiction and Stigmatization *Chair: Susan Hatters-Friedman, M.D.*

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 Furlong*

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 Unequal Participation of Underrepresented Populations in Psychiatric Research *Chair: Nelly Gonzalez-Lepage, M.D., M.B.A.*

Doing Affirmative Dialectical 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: Sudhakar Shenoy, M.D.*

Engagement and Empathy in the Era of the Open Note: Evaluating Our Documentation *Chair: Tony W. Thrasher, D.O.*

Evidence-Based Practice or Egregious Malpractice? What Psychiatric 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 Holobiome *Chair: Christopher E. Hines, M.D.*

International Medical Graduates in American Psychiatry: Past, Present, and Future *Chair: Dilip 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. Muskin, 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 Gaind*

Preparing Psychiatrists for Combat: Providing Collaborative Care in Ukraine and Beyond *Chair: Vincent F. Capaldi II, M.D.*

Reclaiming 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: Kelley-Anne Cyzeski Klein, M.D.*

Learning Lab

Brain-ival! Using Interactive Games to Teach Neuroscience *Chairs: Ashley Walker, David A. Ross, M.D., Ph.D.*

Presidential Session

Indo-American Psychiatric Association and the Asian Indian: Trials, Victories, and Opportunities *Chair: Bhagirathy Sahasranaman, 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: GenaLynne C. Mooneyham, M.D.*

Behind the Screen: Cyberbullying and Its Connection With Mental Illness and Substance Use *Chair: Kanya Nesbeth, M.D.*

Building and Sustaining a Statewide Telepsychiatry Network: A Decade Long Experience of the North Carolina Statewide Telepsychiatry Program (NC-Step) *Chair: Sy Atezaz 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

continued on next page

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.

AMERICAN PSYCHIATRIC ASSOCIATION
ANNUAL MEETING

continued from previous page

Medical Students, Residents, and Physicians *Chair: Parameshwaran Ramakrishnan*

From Roots to Stem: A Hands-on Approach to Cultivating Diversity *Chair: Ludmila De Faria*

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

Inclusive Psychiatric Care for Women: Identity, Community, and Culturally Competent Care During Changing Social Landscape *Chair: Kamalika 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: Alexia Wolf, 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-Lun 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

Poster Session 2

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

Course

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

Master Course

Course ID: M8105A | 2023 Psychiatry Review: Part 1 ($) *Directors: Venkata B. Kolli, M.D., Vishal Madaan, M.D.*

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

Award Lecture

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

General Sessions

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 Zlotnik*

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 Hasbah Roessel, 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 in Psychiatry *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: Shambhavi Chandraiah, 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 Suhk 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 PN

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**

"[E]verything 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."

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 orga-

see **Heather McGhee** *on page 43*

Oscar & Associates

Attendees at APA's 2022 Annual Meeting in New Orleans get a snack at one of the Mid-Day Mingles in the Exhibit Hall.

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 books, products, and medications; enjoy coffee and snacks; hear from psychiatry's thought leaders; get a massage; and play games with colleagues. ***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 in person 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 Stage will serve as the main hub for attendees to meet up with colleagues; charge personal devices; listen to lively presentations; or just take a few moments to rest between sessions in a casual, relaxed setting. Non-CME presentations will be offered in a few formats. The Product Showcases, which will be held in two theaters in the Exhibit Hall, include 16, 60-minute sessions. For early risers, Product Showcases have been added each morning at 9:30 a.m. to include breakfast items along with coffee and tea (dependent on company preference). The 30-minute Huddles and 30-minute Coffee & Conversations sessions will also take place at *The Stage*. The popular Coffee & Conversations sessions are designed to promote engagement among attendees with APA thought leaders and dynamic presenters on exciting and timely topics.

Therapeutic Updates are an extension of the Exhibit Hall. They 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 on a first-come, first-served basis, so be sure to mark your calendars to attend!

The new Mind & Body Pavilion will 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® games.

Don't forget to drop by APA Central and learn more about the benefits of membership. Check out the PsychPRO booth, APA's mental health registry, and sign up to participate if you haven't already. Purchase your *DSM-5-TR* at the APA Publishing Bookstore at a discount. The Career Expo offers recruitment possibilities for those searching for employment opportunities, and the Publishers Expo provides the latest publications you need for your professional library.

We are looking forward to a great meeting, so plan now to take part in all the Exhibit Hall offerings and the Annual Meeting as a whole. **PN**

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

Exhibit Hall Information

Exhibit Halls A-C, Exhibition Level, Moscone Center

Saturday, May 20
11:45 a.m.-4 p.m.

Sunday , May 21
9:10 a.m.-10:30 a.m.
11:45 a.m.-4 p.m.

Monday, May 22
9:10 a.m.-10:30 a.m.
11:45 a.m.-4 p.m.

Tuesday, May 23
9:30-10:30 a.m.
11:45 a.m.-1:30 p.m.

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 pf 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 lugged 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.

Ronald Winchell, M.D., is chair of the Subcommittee on the Clinical Updates Track of APA's Scientific Program Committee.

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 do 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 Psychosis *Chair: Mark Ragins, 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 *Chairs: 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 Nykiel, M.D.*

Here Fishy, Phishy ... 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 Noffsinger, 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 Eyler, 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 Funicelli, 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

Poster Session 4

8 A.M. - NOON

Course

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

Master Course

Course ID: M8105B | 2023 Psychiatry Review: Part 2 ($) *Directors: Venkata B. Kolli, M.D., Vishal Madaan, M.D.*

8 A.M. - 5 P.M.

Course

Course ID: C8059 | 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 Levenson*

Course ID: M8066 | Sleep Disorders and Their Management: An Overview of Common Sleep Conditions Associated With Mental Health Disorders ($) *Director: Emmanuel During*

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.Div.*

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: Kayla 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. Hwong, 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 Kwako 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 Gurguis*

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.*

Persons 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 *Roe v. 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, Alison Freeland*

Poster Session

Poster Session 5

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: Aishwarya 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: A Panel Discussion *Chairs: Ron M. Winchel, M.D., Catherine Crone*

Brain Health and Well-Being in Older Adults: The Impact of Lifestyle Interventions Chair: Helen Hisae Kyomen, 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/Latinx Communities *Chair:*

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Ruby C. Castilla Puentes, M.D., Dr.P.H., M.B.A.

From the Front Lines of Trauma to the Front Lines of Medicine: Addressing Moral Injury in Health Care Workers Through a Military Perspective *Chair: Bhagwan A. Bahroo, M.D.*

Impact of the Environment on Adolescent Development—Findings From Bipoc Scholars in the ABCD Study START Program *Chair: Gayathri J. Dowling, Ph.D.*

Innovations in Community-Based Mental Health Interventions Within and Beyond the Military *Chair: Jerry Trotter, M.D.*

Integrating Patients' Work Identity Into Practice: The Military as an Exemplar in How It Cares for Military Service Members, Veterans, and Families *Chair: Walter J. Sowden, Ph.D.*

Making "Good Trouble" in Psychiatry: Creating More Equitable Systems of Mental Health Care (in the Spirit of U.S. Rep. John Lewis) *Chair: Cynthia Turner-Graham, M.D.*

Perspectives on Developing a Global Mental Health Training Curriculum: Education, Research, and Policy *Chair: Seeba Anam, M.D.*

Physician, Heal Thyself by Healing Systems *Chair: Sunil D. Khushalani, M.D.*

Psychiatric Diagnosis: Do Race and Ethnicity Still Matter? *Chair: William Bradford Lawson, M.D., Ph.D.*

Recognizing and Addressing Burnout Among Health Care Workers in Rural Nepal: A Proof-of-Concept Study Using Visual Learning Aids *Chair: Eva Studer, M.D.*

Recovery, Remission, Cessation: New Operational Definitions to Assist in the Evaluation of Treatments and Outcomes *Chair: Brett Hagman, Ph.D.*

The Association of LGBTQ+ Psychiatrists (AGLP) and the American Psychiatric Association *Chair: Pratik P. Bahekar, M.B.B.S.*

The Heart of the Matter, "Narrative Means to Therapeutic Ends": Exploring Narrative Therapy and the Healing Power of Stories in Medicine *Chair: Nada L. Stotland, M.D., M.P.H.*

Training Together: Building and Bolstering Trainee Communities in a Post-Pandemic World *Chair: Jessica Gold, M.D.*

Ukrainian Mental Health Care Provider Stress Relief With Breath-Centered Mind-Body Practices *Chair: Patricia Lynn Gerbarg, M.D.*

United We Stand: An Integrated Approach to Psychotherapy Training *Chair: Hinda F. Dubin*

Virtual Reality in Suicide Prevention: A New Frontier in Teaching and Training *Chair: Igor I. Galynker, M.D., Ph.D.*

Learning Lab

Launching and Navigating a Successful Career in Academic Medicine *Chair: Laura W. Roberts, M.D., M.A.*

continued on next page

Panelists to Discuss Strategies to Protect Women's MH

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**

Recent 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. **PN**

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.

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Poster Session

Poster Session 6

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

Courses

Course ID: C3006 | A Measurement-Based Care Approach to Identification and Management of Treatment-Resistant Depression ($) *Director: Madhukar H. Trivedi, M.D.*

Course ID: C8091 | Neurology Update for Psychiatrists ($) *Director: Sanjay Pratap Singh, M.D.*

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

Award Lectures

Manfred S. Guttmacher Award Lecture: Antisocial Personality Disorder: From Myths to Multimodal Imaging *Chair: Donald W. Black, M.D.*

Simon Bolivar Award Lecture: The First Call for Human Rights in the Americas (1511): Father Antonio De Montesinos and His Relevance to the Mission of the Psychiatrist *Chair: Eugenio M. Rothe, M.D.*

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 Fitelson*

Biomarkers in Psychiatry—Are We Ready for Prime Time? *Chair: Nina Kraguljac, D.O.*

Clinical Pearls: Lesson 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 Kwako 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-Desir, 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 *Chairs: Catherine Crone, Jacqueline Posada, M.D.*

Now Is the Time to Rethink Adolescent and Young Adult Community Mental Health Care *Chairs: Vanessa Vorhies Klodnick, Ph.D., L.C.S.W., Deborah Ann Cohen, Ph.D., M.S.W.*

Pediatric Bipolar Disorder: Advances in Diagnosis and Treatment *Presenter: 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.

Technologies to Advance Access to Mental Health: Social Media, Texting, and 988 *Chair: John Luo, M.D.*

The Evolution of Exposure-Based Psychosocial Treatments: What's Known and What's Next! *Chair: Robert D. Friedberg, Ph.D.*

The Future of Patient Safety and Quality Improvement Education and Practice: A National Collaboration Among Psychiatry Residency Training Programs *Chair: Jacqueline A. Hobbs, M.D., Ph.D.*

The Mental Health Impacts of Climate Change: A Diversity and Health Equity Approach *Chair: Andreea Seritan, M.D.*

Too Much Is Never Enough: Compulsive Sexual Behavior in Psychiatric Practice *Chair: Kathryn Baselice, M.D.*

Treating Evangelical Christians: Challenges and Opportunities *Chair: John Raymond Peteet, M.D.*

Presidential Session

Interventional Psychiatry: Advances, Acceptability, and Access *Chair: Saydra Wilson*

Poster Session

Poster Session 7 **PN**

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. ***BY VIKAS GUPTA, M.D., M.P.H., AND LAMA BAZZI, M.D.***

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 ready and able to serve communities in need, it presents new challenges and opportunities for IMGs. With these factors in mind, the sessions in the IMG Track are focused on the career needs of IMGs including resident-fellow members and early career psychiatrists.

The IMG track includes these sessions:

- **IMGs in American Psychiatry: Past, Present, and Future:** Our speakers—Dilip Jeste, M.D., Jair Soares, M.D., Ph.D., Daniel Castellanos, M.D., and Geetha Jayaram, M.B.B.S., M.B.A.—have a breadth of experience that has translated into creative solutions serving not only IMGs, but our entire profession. Our panelists will share their personal experiences and discuss possible solutions to help us transform barriers into opportunities in the domains of administration, advocacy, research, and leadership. They will make recommendations to help IMGs contribute to culturally responsive mental health care, education, research, administration, leadership, and advocacy.

Vikas Gupta, M.D., Ph.D., and Lama Bazzi, M.D., serve on the IMG Subcommittee of APA's Scientific Program Committee.

- **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. Sanya Virani, M.D., M.P.H., will outline the common questions that immigrants ask as they integrate into a new culture and encounter new experiences such as living and practicing medicine in a new country. Isheeta Zalpuri, M.B.B.S., will discuss the importance of cultivating equity in the professional development of IMGs through mentorship, sponsorship, and coaching. Mohammed Molla, M.D., will discuss challenges related to finding an academic position for non-U.S. international medical graduates after completion of residency, and Vishal Madaan, M.D., 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 imposter 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 session 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.,

see **IMG Track** *on page 42*

MONDAY, MAY 22

8 A.M. - 9:30 A.M.

General Sessions

An Athlete's Achilles Heel: The Risk Stratification of Athletes and Barriers to Mental Health Care *Chair: Bhagwan A. Bahroo, M.D.*

Are You Here to Help? The Intersection of Mental Health, Policing, and Race in a Crisis Response *Chair: Dionne Hart, M.D.*

Changing the Trajectory: Innovations in First-Episode Psychosis to Reduce Risk of Violence, Suicide, and Legal Involvement *Chair: Deirdre Grace Caffrey*

Climate Psychiatry 102: Climate Change and Implications for Community Psychiatry *Chair: Wesley Eugene Sowers, M.D.*

Current and Future Treatment of Depression: Glass Half Full or Half Empty? *Presenter: Charles Barnet Nemeroff, M.D., Ph.D.*

Deconstructing the Missing White Woman Syndrome: Intimate Partner Crime and Racial Bias in Media Portrayals of Missing Persons Cases *Chair: Susan Hatters Friedman, M.D.*

Ethical and Practical Implications of Psychedelics in Psychiatry *Chairs: Gregory Samuel Barber, M.D., Charles Dike, M.D., M.P.H.*

Ethics and Engagement in Mental Health *Chair: Tony W Thrasher, D.O.*

External Control Arms in Psychiatry: Current Use and Future Directions *Chair: Andrew Krystal*

Getting to the Core: The NIAAA Health Care Professional's Core Resource on Alcohol and Other Alcohol Education Resources *Chair: Laura E Kwako Ph.D.*

"I Need a Psychiatrist but Can't Find One": An Introduction to the Integrated Care Elective to Increase Access to Care *Chair: Sasidhar Gunturu, M.D.*

Identity, Relationship, Cultural Trauma, and Mental Health Journeys: Lived Experience of an Asian American Psychiatrist *Chair: Ravi Chandra*

Leveraging Technology to Enhance Mental Health Interventions *Presenters: John Michael Kane, M.D., Skip Rizzo, Ph.D.*

Meeting the Health Needs of LGBTQIA+ and Marginalized Psychiatry Trainees *Presenter: Teddy Goetz*

Novel Positive Psychiatry Interventions: Helping Patients, Professionals, and Populations *Chair: Erick Messias, M.D.*

Pillars of Mental Health: Attachment and Social Connectedness Over the Lifespan *Chair: John H. Halpern, M.D.*

Publishing During Training: Maintaining Motivation in Academic Writing *Chair: Danielle W. Lowe, M.D., Ph.D.*

"Roma": Enhancing Compassion as a Means to Resilient Well-Being Through Transcendental Style in Film and Participant Mindful Viewing *Chair: Francis G. Lu, M.D.*

Seeking Value: Practical Methods for Getting More and Paying Less *Chair: Deepika Sastry, M.D., M.B.A.*

Supporting the Helpers: A Discussion of the Role of Psychiatry and Psychology in Well-Being Efforts for Health Care Workers During COVID-19 *Chair: Erin K. Engle, Psy.D.*

The Unconscious Roots of Racial Bias: Implications for Psychotherapeutic Care and Training *Chair: Beverly J. Stoute, M.D.*

Presidential Sessions

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

Poster Session 8

8 A.M. - 5 P.M.

Master Courses

Course ID: M8079 | Late-Life Mood and Anxiety Disorders ($) *Directors: Art C. Walaszek, M.D., Susan W. Lehmann, M.D.*

Course ID: M8083 | Master Course: Child and Adolescent Psychiatry ($) *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-Ha 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. Agyapong, M.D., Ph.D.*

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

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 Bhatia, M.D.*

The Thought Content Continuum (TCC): Fringe Beliefs, Overvalued Ideas, and Delusions Gone Viral *Chair: Kanishk 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.*

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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 in My Lane: A Public Health Approach to the Role of Health Care Providers in Firearm Violence" will offer strategies on how health professionals can convey the message that preventing firearm violence is a matter of public health, not politics or partisanship.

"Firearm violence is a polarizing topic, where any discussion of it is often equated with gun control," session chair Aradhana Bela Sood, M.D., M.S.H.A., told *Psychiatric News*. She is a senior professor for child and mental health policy at Children's Hospital of Richmond at Virginia Commonwealth University. "As medical providers who deal with the aftermath of firearm-related morbidity and mortality, we would be well served to shift rhetoric that appears to infringe on individual rights to a focus on gun safety and preventive practices."

Psychiatrists who wish to address firearms violence should focus on public health, says Aradhana Bela Sood, M.D., M.S.H.A.

The session will cover the epidemiology of firearm violence and provide a historical perspective of the polarization surrounding the causality of 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**

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Psychiatry Around the Globe: Needs and Opportunities *Chair: Afzal Javed, M.B.B.S.*

Resilience and Well-Being in Older Adults With Neuropsychaitric Disorders *Chair: Helen Lavretsky, M.D.*

Poster Session

Poster Session 9

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

Courses

Course ID: C3010 | Integrative Treatment of Anxiety Disorders ($) *Director: Edward Silberman*

Course ID: C3011 | Psychodynamic Psychopharmacology: Enhancing Outcomes in Pharmacologic Treatment Resistance With Practical Psychodynamics ($) *Director: David L. Mintz, M.D.*

Course ID: C3008 | Understanding Narcissistic Pathology and Its Treatment With Transference Focused Psychotherapy ($) *Director: Frank Yeomans, M.D., Ph.D.*

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

Award Lecture

John Fryer Award Lecture: Out of the Frying Pan and Into the Fryer: 54 Years of LGBTQ+ Advocacy Within Psychiatry *Presenter: Nanette K. Gartrell, M.D.*

General Sessions

A Psychiatrist, a Teacher and a Pediatrician Walk Into a Bar: A Multidisciplinary Approach to Active Shooter Drills in Schools *Chair: Margaret A. Mc Keathern 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 Naeem, M.B.B.S.*

Depression and Social Determinants of Health *Chair: Tatiana 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.*

Queer in the Cornfields: How Psychiatrists Can Help Rural Youth Navigate the Coming Out Process *Chair: Ronald R. Holt, D.O.*

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 Disparity: Addressing Race-Based Variation in Psychiatric Emergency Treatment *Chair: Jonathan Alpert, M.D., Ph.D.*

Presidential Session

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

Poster Session

Poster Session 10 PN

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**

Love it or loathe it, social media is becoming a massive platform for spreading news and information about mental health. Several sessions at this year's Annual Meeting will discuss the role of social media in psychiatric practice, including a special presentation that will be a part of APA's Learning Labs.

Yes, APA's popular educational workshops are making a grand return at the San Francisco meeting. The eight interactive sessions slated for this year include the panel session titled "Using Social Media to Educate, Advocate, and Empower," which will be chaired by Jake Goodman, M.D.

Goodman, a psychiatry resident at the University of Miami's Jackson Memorial Hospital, became a social media sensation during the COVID-19 pandemic with a series of photos and videos advocating for mental health awareness and detailing his own challenges with depression to his more than 2 million followers.

"Social media can appear overwhelming and intimidating. And that's OK. We never had a lecture in medical school about how to create a video or write a tweet to educate the public about a new medical advancement," Goodman said. But with a little help from the panelists, participants can learn how to write engaging content and build an online brand. All they need to do is bring a phone and an open mind.

Other Learning Labs slated for this year include the following:

- **Transcranial Magnetic Stimulation [TMS]: Future Innovations and Clinical Applications for Psychiatric Practice:** This panel 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*

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.
- "Alternatives to Facts: Mental Health Impact of Social Media, Phone Applications, and Technology." 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.

TUESDAY, MAY 23

8 A.M. - 9:30 A.M.

Focus Live

Focus Live: Personality Disorders *Chair: Lois W. Choi-Kain, M.D., M.Ed.*

General Sessions

Acculturation as a Component of Immigration: Challenges of the Psychiatric Workforce *Chair: Sanya A. Virani, M.D., M.P.H.*

Advances in Affect-Focused Psychotherapies for Posttraumatic Stress Disorder *Chair: John C. Markowitz, M.D.*

Animals on Campus: Ethical, Legal, and Logistical Considerations (a Hemha Guide) *Chair: Leigh White, M.D.*

Applying Quality Improvement Methods to Implement Principles of Collaborative Care *Chair: Amy M. Bauer, M.D.*

At-Home Sublingual Ketamine for Depression: Large-Scale Outcomes and Safety *Chair: Thomas D. Hull, Ph.D.*

Creating and Sustaining Diversity, Equity, and Inclusion Strategies in Medicine *Chair: Ranna Parekh, M.D., M.P.H.*

Emerging Potential Biomarkers to Inform Bipolar Clinical Practice *Chair: Balwinder Singh, M.D., M.S.*

Existentialism and Climate Change: The Next Frontier in Mental Health *Chair: Andre R. Marseille, Ph.D.*

Fighting for Our Future: The Effects of Anti-Asian Racism and the COVID-19 Pandemic on Asian College Students and Asian Medical Trainees *Chair: Amy Alexander*

Food Addiction: A New Substance Use Disorder? *Chair: Ashley N. Gearhardt, Ph.D.*

From the Battlefield to Home Base: Traumatic Brain Injury Advances in Active-Duty Military to Veteran Health Care *Chair: Sofia Elisa Matta, M.D.*

Harmful Alcohol Use in Women: New Horizons in Assessment and Treatment *Chair: Deidra Roach, M.D.*

Learning Health Care Systems and Real World Research *Chair: Philip Wang, M.D.*

Mental Health 360: A Comprehensive Approach to Address Mental Health Disparity Facing Asian American Community *Chair: Xiaoping Shao*

Motivate Psychopharmacology Teaching by Innovative and Collaborative Transfer of Knowledge From Bench to Bedside *Chair: Mujeeb Uddin Shad, M.D., M.S.*

On the Front Lines: A Resident/Fellow Perspective on Workplace Violence in Psychiatry *Chair: Amanda Wallace*

Psychiatry in the Courts: APA Confronts Legal Issues of Concern to the Field *Chair: Reena Kapoor, M.D.*

SAMHSA's Statistics and Strategies You Should Know to Keep Black Americans Safe *Chair: Billina R Shaw, M.D., M.P.H.*

Social Media for Seniors: Pros, Cons, and Scams *Chair: Maria D. Llorente, M.D.*

The Challenge of Addressing Depression and Unhealthy Alcohol Use in Low- and Middle-Income Countries: Lessons From Our Experience in Colombia *Chair: William Chandler Torrey, M.D.*

Presidential Sessions

The Role of Community Psychiatry in Mental Health Systems of the Future *Presenter: Altha J. Stewart, M.D.*

What Is on the Horizon for WPA and Future of Collaboration Between WPA and APA? *Presenter: Danuta Wasserman*

Poster Session

Poster Session 11

8 A.M. - 5 P.M.

Master Course

Course ID: M8065 | Master Course in Clinical Psychopharmacology ($) *Director: Alan F. Schatzberg, M.D.*

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

Award Lecture

Award for Research in Psychiatry Lecture: The Brain Stimulation Revolution in Psychiatry: Past, Present, and Amazing Future *Presenter: Mark Stork George, M.D.*

General Sessions

A Practical Approach to Social Determinants of Mental Health in Children and Youth *Chair: German E. Velez, M.D.*

Abortion Is Just the Beginning *Chair: Carol C. Nadelson, M.D.*

Adaptation of Cognitive Behavior Therapy Across Cultures *Chair: Farooq Naeem, M.B.B.S.*

Adding a New Diagnosis to *DSM*: How Prolonged Grief Disorder Became an Official Diagnosis *Chair: Paul Appelbaum, M.D.*

Alternatives to Facts: Mental Health Impact of Social Media, Phone Applications, and Technology *Chair: Pratik P. Bahekar, M.B.B.S.*

America's Overdose Crisis Amid the COVID-19 Pandemic: What Are We Learning? *Chair: Nora D. Volkow, M.D.*

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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 Peteet, 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."

"The psychiatrist helping patients to consider this unique and permanent request has a responsibility to assess for potentially treatable contributing conditions, including demoralization," says John Peteet, M.D.

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 Nicolini, 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. **PN**

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Breaking the Silence: Innovative Community-Based Approaches to Addressing the Mental Health Crisis in AAPI Populations *Chair: Justin A. Chen, M.D., M.P.H.*

Bridging Military and Civilian Psychiatry: Differences in the Diagnosis and Treatment of Adjustment Disorders *Chair: David Asher Nissan, M.D.*

Challenges and Opportunities in Implementing 988: A Tale of Three Cities *Chair: Ashley M. Overley, M.D.*

Ethics Dilemmas in Psychiatric Practice *Chair: Charles C. Dike, M.D., M.P.H.*

Hiding in Plain Sight: Youth Mental Illness: Lessons in Centering Youth and Lived Experience From a Ken Burns Documentary *Chair: Sarah Yvonne Vinson, M.D.*

Innovative Perspectives From Indigenous Visionaries in Psychiatry Supporting Community Resilience in Addressing SDoMH Grounded in Culture *Chair: Mary Hasbah Roessel, M.D.*

Looking for the Missing Piece(s): Addressing the Behavioral Health Workforce Crisis *Chair: Miriam C. Tepper, M.D.*

Psychiatric Neuroscience: A Reckoning *Chair: Joseph J. Cooper, M.D.*

Security and Privacy Concerns in the Future of Mental Health *Chair: John Luo, M.D.*

Social Determinants of Mental Health *Chair: Rajesh R. Tampi, M.D., M.S.*

Sounding the Alarm for Children's Mental Health *Presenters: Warren Y. K. Ng, M.D., Tami D. Benton, M.D.*

The Mental Health Impact of COVID-19 in at-Risk, Underrepresented Minorities *Chair: Tatiana A. Falcone, M.D.*

Transgender Care: Using the New WPATH Standards of Care Version 8 *Chair: Dan Karasic, M.D.*

Who Do We Care for/Who Do We Care About: Defining Mental Illness and Redefining Treatment for Individuals With Criminal-Legal Contact *Chair: Merrill Richard Rotter, M.D.*

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Presidential Session

A Model for Carrying Out Low-Cost Multicentric Studies: A Unique Research Model From India *Presenters: Vinay Kumar, Sandeep Grover, Om Prakash Singh, M.B.B.S.*

Poster Session

Poster Session 12

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

Courses

Course ID: C3027 | Agitation: Identification, Evaluation, and Treatment: From the Experts ($) *Director: Kimberly D. Nordstrom, M.D., J.D.*

Course ID: C3005 | Change Is the Goal of Psychodynamic Therapy: Practical Strategies and New Evidence ($) *Director: Richard Fredric Summers, M.D.*

Course ID: C3004 | Family Focused Therapy: An Outpatient Approach to Bipolar Disorder ($) *Director: David J. Miklowitz, Ph.D.*

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

General Sessions

#American Idols: the Role of Influencers in Shaping the Public's Understanding and Utilization of Mental Health Care *Chair: Anna Russell, D.O.*

A Subacute Inpatient Unit for People Experiencing Homelessness and Serious Mental Illness in NYC *Chair: Carine Nzodom, M.D.*

Advancing Racial Equity in Early Intervention Services (EIS) for Psychosis Through Partnership With Diverse Stakeholders *Chair: Sapana Patel, Ph.D.*

Assessing Psychic Pain and Proximal States of Mind Associated With Suicidal Thinking and Behavior *Chair: Jane G. Tillman, Ph.D.*

Autism Spectrum Disorder: Practical Management and Cutting-Edge Treatments *Chair: Eric Hollander, M.D.*

Crazy in Love: The Portrayal of Sexual Orientation and Mental Health in Popular Feature Films *Chair: Howard Rubin*

CURED: The Past, Present, and Future of LGBTQ Rights and the APA *Chair: Amir K. Ahuja, M.D.*

Dr. Max Fink Centennial Symposium *Chair: Andrew Francis, M.D., Ph.D.*

Eat to Treat: Improving Mental Health of a Nation Through Nutritional Innovations *Chair: Bhagwan A. Bahroo, M.D.*

Expanding the Impact of Collaborative Care *Chair: Anna Ratzliff, M.D., Ph.D.*

Facing Campus Sexual Assault and Relationship Violence With Courage *Chair: Helen W Wilson, Ph.D.*

Implementing Effective Communication Skills Training for Psychiatrists in a Virtual World: A Primer and Methodology *Chair: Lauren Marie Pengrin, D.O.*

Megalomania in the American Psyche: Dangerous Influence in Conscious and Unconscious Life *Chair: Ravi Chandra*

No Laughing Matter: Fandom, Fanaticism, and the Joker *Chair: Vasilis K. Pozios, M.D.*

Talk as Treatment: Psychotherapy for Substance Use Disorders *Chair: Carla Marienfeld*

The Algorithm Will See You Now: The Current State of Precision Psychiatry's Deployment Into Research and Practice *Chair: Daniel Rollings Karlin, M.D., M.A.*

The Future of Mental Health Is Social Media *Chair: Simone Ariel Bernstein, M.D.*

The Goldilocks Zone of Addiction Treatment Programs: Designing the 'Just Right' Intervention for Marginalized Communities *Chair: Ozlem Gunal, M.D., Ph.D.*

The New Public Health Psychiatry: Addressing the Social Determinants of Mental Health *Chair: Kenneth Stewart Thompson, M.D.*

What Terror Research Teaches Us About Risk, Treatment, and Policy *Chair: Najat Khalifa, M.D.*

Yes, We Can: Increasing Clozapine Uptake at a Safety Net Health System *Chair: Rebecca Tourtellotte*

Presidential Session

American Society of Hispanic Psychiatry: Community Activities and Addressing the Underrepresentation of Hispanic/Latinx Clinicians and Investigators *Chair: Juan Andres Gallego, M.D., M.S.*

Poster Session

Poster Session 13 PN

Learning Labs

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- **LAI 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, licensure requirements, maintaining privacy, and more.

- **Hearing Voices:** In this moving workshop, attendees will get an idea of what it's like to experience auditory hallucinations. It is hoped that participants will gain empathy and reassess 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. PN

WEDNESDAY, MAY 24

8 A.M. - 9:30 A.M.

General Sessions

A Journal's Systematic Effort to Tackle Structural Racism *Chair: Lisa Dixon, M.D.*

A Paradigm Shift: The Evolving Concepts of Innovation and Integration in Telebehavioral Health *Chair: Hossam M. Mahmoud, M.D., M.P.H.*

ADHD: New and Novel Therapeutics and Technology *Chair: Michael Van Ameringen, M.D.*

Advancing Psychiatry Using Insights From Philosophy of Science *Chair: Awais Aftab, M.D.*

Advocacy Across the Lifespan: Training, Promotions, and Late Career *Chair: Brandon C. Newsome, M.D.*

Asian Medical Trainees and the Model Minority Myth *Chair: Vanika Chawla*

Autogynephilia: Historical Context, Clarifications, and Controversy *Presenters: Amir K. Ahuja, M.D., Jack Turban, M.D., M.H.S.*

Avoiding Legal Trouble With Medications for Opioid Use Disorder *Chair: Adelle M. Schaefer, M.D.*

Equity, Ethics, and the World as It Is: An Oxford Debate on Whether Private Practice Psychiatrists Should Accept Insurance *Chair: David W. Brody, M.D.*

Evaluation of the REMs Programs for Psychiatric Medications *Chair: Catherine E. Cooke, Pharm.D., M.S.*

Identifying and Addressing Treatment and Training Gaps in Perinatal Mental Health *Chair: Diana Clarke, Ph.D.*

Imagine Sisyphus Happy: Application of Community Programs to Improve Outcomes of Serious Mental Illness in Active Duty Military Settings *Chair: Laura Marrone, M.D.*

Navigating Leadership in Residency: Trial by Fire *Chair: Daniel Castellanos*

Neuro-Radiology for the Consult Psychiatrist: What Every C-L Psychiatrist Needs to Know *Chair: Samidha Tripathi, M.D.*

New York and Amsterdam 400 Years Later: Sharing Insights Across the Atlantic Regarding Public Mental Health and Forensic Populations *Chair: Abhishek Jain, M.D.*

Overcoming Shame, Stigma, and Barriers in Addressing Victims of Male Sexual Violence *Chair: Dhruv Gupta, M.D., M.S.*

Peers, Clubhouses, and Psychiatry Residents: A Recovery-Oriented Training Experience *Chair: Arkaprava Deb, M.D., M.P.A., M.P.H.*

Psychogeriatric Outreach: Adapting Outreach to Better Service an Aging Population *Chair: Sarah A. Colman*

Recovery Mapping: A Practical Method to Produce Transformative Outcomes in Team-Based Care *Chair: Shelby Arnold, Ph.D.*

Social Media and Psychiatry: Effects of Social Media on Users, Research, Advocacy, Networking, and Intervention Opportunities *Chair: Mariana Pinto Da Costa, M.D.*

Struggle and Solidarity: Stories of How Americans Fight for Their Mental Health Through Federal Legislation *Chair: Michael Compton, M.D.*

Suicidal Ideation in Teens: Treatment Beyond Inpatient Admissions *Chair: Robert Holloway*

The Birth of SBIRT"H": Incorporating Harm Reduction Strategies Into the SBIRT Model *Chair: Vineeth P. John, M.D., M.B.A.*

The IMG Journey: Snapshots Across the Professional Lifespan *Chair: Muhammad Zeshan, M.D.*

The Psychiatry Research Lab: A Novel Intervention to Promote and Improve Research Literacy and Advocacy in an Inner-City Community Hospital *Chair: Sasidhar Gunturu, M.D.*

Using Financial Incentives to Engage Individuals Experiencing Homelessness and Mental Illness: Stakeholder Perspectives on Impact and Acceptability *Chair: Nadine Reid, Ph.D.*

We Are All in This Together: Expanding Psychiatrists' Responsibility for Reproductive Health Post-*Roe* *Chair: S. Therese Garrett, M.D.*

Word to the Wise: Informing Clinical Decision-Making for Psychosis Using Speech and Language Biomarkers *Presenter: Sunny X Tang, M.D.*

Presidential Session

Education: An Essential Component of Consultation-Liaison Psychiatry *Chair: Philip Aaron Bialer*

Poster Session

Poster Session 14

8 A.M. - NOON

Courses

Course ID: C8097 | Challenges and Opportunities: Forensics and Corrections: What You Need to Know ($) *Directors: Tanuja Gandhi, M.D., Joseph Penn*

Course ID: C3032 | Evaluation and Treatment of Sexual Dysfunctions ($) *Director: Waguih W. IsHak, M.D.*

Course ID: C3009 | Imminent Suicide Risk Assessment in High-Risk Individuals Denying Suicidal Ideation or Intent: Introduction and Training ($) *Director: Igor I. Galynker, M.D., Ph.D.*

Course ID: C8104 | Integrating Technology and Psychiatry ($) *Directors: Steven Richard Chan, M.D., M.B.A., John Luo, M.D.*

Course ID: C3033 | Religion/Spirituality as a Determinant of Mental Health: Assessment and Integration Into Clinical Practice ($) *Director: Alexander Moreira-Almeida, M.D., Ph.D.*

10:30 A.M. - NOON

General Sessions

Advancing Mental Health Service Access Through Equity-Driven Quality Improvement Initiatives *Chair: Lucy Ogbu-Nwobodo, M.D., M.S.*

Applying EDI: Innovating to Improve Child and Adolescent Psychiatry Training in Equity, Diversity, and Inclusion Principles *Chair: Nikhita Singhal*

Birth Trauma Basics: Understanding and Treating Childbirth-Related PTSD *Chair: Christina T. Khan, M.D., Ph.D.*

Centering Psychiatry in Multidisciplinary Chronic Disease Treatment Via Collaborative Care *Chair: Katharina Schneiber*

Changing U.S. Trends in Alcohol, Hallucinogens, Cannabis, and Opioid Overdoses *Chair: Dustin Graham*

Chronic Pain for the General Psychiatrist: A Review of Shared Mechanisms and Treatment Strategies *Presenter: Xavier Jimenez, M.D.*

Climate Change and Mental Health of Older Adults *Chair: Jason Strauss*

Controversies Surrounding the Use of Antipsychotic Medications in Psychotic Disorders *Chair: Awais Aftab, M.D.*

COVID-19 and Higher Education Students' Well-Being: An International Approach *Chair: Tyler L. Frank, M.S.*

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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 result are disorders like depression that are highly likely to be biologically heterogenous.

"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." **PN**

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COVID-19: Clinical Neuropsychiatric Manifestations in Patients and Wellness Interventions for Health Care Workers *Chair: Laura T. Safar, M.D.*

DEI for *DSM-5-TR*: Exploring Cultural, Ethnoracial, Gender, and Social Determinant Revisions *Chair: Christopher E. Hines, M.D.*

Evolutionary Psychiatry: How an Evolutionary Framework Increases Patient Engagement, Treatment Effectiveness, and Clinician Well-Being *Chair: Cynthia M. Stonnington, M.D.*

Gastroentero-Psychiatry: Nutritional Influences on Developmental Mental Health in a Growing Crisis *Chair: Bhagwan A. Bahroo, M.D.*

How About a Drink? Addressing Prenatal Alcohol Exposure and FASD *Chair: Sherry Ann Nykiel, M.D.*

Implementing an Arts and Humanities Curriculum in a Psychiatry Residency: A One-Year Investigation *Chair: Christopher Rogers*

Integrated Gender-Affirming Services in California State Prisons: Re-Thinking Our Therapeutic Interventions *Chair: Christine Osterhout*

Is It All in My Head? Subjective Cognitive Impairment in Neuropsychiatry *Chair: Omar Ghaffar, 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.*

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: Jeffery 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.*

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 Musher*

Beyond Race, Sex, and Gender: Intersectionality, Intersex, and Nonbinary 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. Rosenfield, 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*

New Tech: New Treatments, New Psychiatrists *Chair: Saba Afzal*

"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 Fattal, 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 Thuy 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 Brewerton, M.D.*

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

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

Virtually Represented: The Impact of Social Media Usage on Trainee Wellness *Chair: Carisa Maureen Kymissis, 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.*

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

General Sessions

A New Paradigm for Suicide Prevention: Recovery-Based High Risk Treatment Programs *Chair: Robert J. Gregory, 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: Yavar Moghimi, M.D.*

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

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

Clinical Effects and Indications of

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Testosterone Therapy in Men With Depression *Chair: George Grossberg, M.D.*

Creating Psychodynamic Psychiatrists *Chair: Sherry Katz-Bearnot, M.D.*

Diagnosing and Treating Internet Gaming Disorder (IGD): An Interdisciplinary and Interspecialty Approach *Chair: Ramon Solhkhah, M.D.*

Free Will in Psychiatry: A Clinical Introduction *Chair: James Alexander Scott*

From Collaboration to Innovation: How Two Local Hospitals Are Working Together to Provide Physicians Access to Barrier-Free Mental Healthcare *Chair: Joseph David Varley, M.D.*

From Fearing the Other to Annihilation: A Primer on the Psychology and Sociology of Hate and Genocide *Chair: Aliya Saeed*

"I'd Rather Die Than Eat": An Examination of Ethicolegal Conflict in Three Cases of Severe Anorexia Nervosa *Chair: Lauren Ashley Schmidt, M.D.*

Identifying Ageism: Moving Toward Addressing Gaps in Mental Health Care for Older Adults *Chair: Daniel Carl Dahl, M.D.*

Improving Mental Health Care Outcomes in LGBTQ+ Populations: Challenges, Solutions, and Applications to the General Population *Chair: Christine Marchionni, M.D.*

Innovative Care Pathways: Integrating Equitable Screening and Treatment for Substance Use Disorders in Primary Care *Chair: Lorin Michael Scher, M.D.*

Inspiring Motivation and Collaboration Through Social Justice Education in the General Hospital *Chair: Diana Robinson*

Involuntary Celibates (Incels), Violence, and Mental Disorder: Recommendations for Best Practice in Risk Assessment and Clinical Intervention *Chair: Jonathan Hafferty*

Livin' on a Prayer: Mental Health Challenges Facing Transitional Age Muslims After COVID-19 *Chair: Sarah H. Arshad, M.D.*

Mental Health Meets Social Innovation: The How Matters *Chair: Rick Peter Fritz Wolthusen, M.D.*

Navigating Complex Systems of Care for Individuals With Intellectual and Developmental Disabilities: A Systems Approach for Treatment in New York City *Chair: Scott Stiefel*

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This American Psychiatric Life: Podcasting for Psychiatrists *Chair: Blake Novy*

Through the Wire: An Exploration of Sequential Intercept Mapping *Chair: Marcus Hughes* **PN**

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**

The 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 completed. The surveys assessed both parent and child race/ethnicity; parental education and employment; parental hardship (such as not being able to afford rent); and total family income, among other variables.

"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."

The participants' neighborhood disadvantage was assessed using the Area 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.

"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."

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., Kerry 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.

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.

see **Adversity** *on page 42*

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**

The 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.

Art Walaszek, M.D., says that the slowing of decline seen in patients who took lecanemab is similar to that of medications such as donepezil; the key question is whether the improvements are longer-lasting than current therapies.

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 $26,500, 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 shortcoming 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."

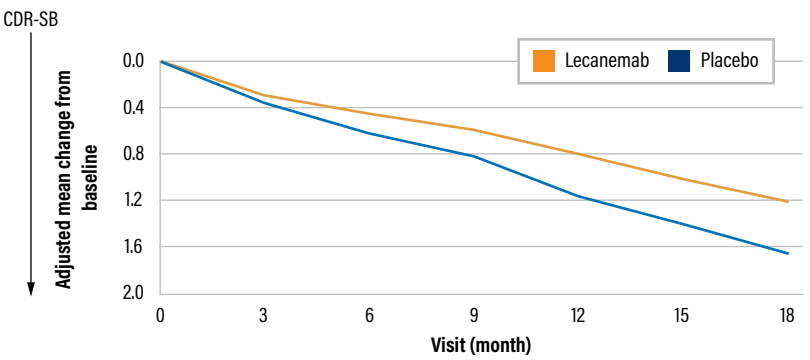
There are also important ethical questions to consider, said Kostas Lyketsos, M.D., the Elizabeth Plank Althouse Professor for Alzheimer's Research at Johns Hopkins Medicine. Lyketsos was not involved in the development of lecanemab but has received past research support and consulting fees from Eisai.

"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

Lecanemab Appears to Slow Cognitive Decline

The cognitive scores of adults with early Alzheimer's who took lecanemab declined at a slower pace over an 18-month period than those who took placebo. The primary measure used in the trial was the score on the Clinical Dementia Rating–Sum of Boxes (CDR-SB).



Source: Christopher H. van Dyck, M.D., et al., *New England Journal of Medicine*, January 2023.

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.

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 Children, Adolescents, and Their Families. Those policies must take a public health approach, though. Even if the number of child and adolescent psychiatry fellowship slots doubled tomorrow, he said, there would still be a shortage in the near future. He pointed to the Collaborative Care Model as an opportunity to more quickly increase access to child and adolescent psychiatrists in communities across the country.

"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 analyzed 81,051 ED visits at 205 Illinois hospitals. Visits for suicidal ideation accounted for $785 million in charges and 145,160 days in the hospital over 66 months. Further, ED visits for suicidal ideation increased 59% from the 2016-2017 study period to the 2019-2021 study period. There were significant spikes in the number of visits during both the fall of 2019 and the fall of 2020. 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

see **Youth** *on page 40*

KEY POINTS

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.

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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but that means they will also spend longer in the more disabling stages later on." At some point, the question will arise on whether lecanemab is prolonging a life worth living.

In addition, since lecanemab is associated with a subtle slowing of cognitive decline rather than a noticeable cognitive improvement, it may be difficult to assess if an individual is benefitting from using the medication, Lyketsos continued. Patients with mild impairment typically do not have enough documented history of decline for predicting their expected trajectory, he noted.

So, while there is a consensus on when antibody therapy should be started—in the earliest stages of disease—there are no data on when to stop. Looking ahead, Lyketsos thinks Alzheimer's drug trials will need to include more quality-of-life data for both patients and their caregivers.

In the meantime, the developers of both aducanumab and lecanemab are conducting additional trials that can offer more clinical details. A third antibody that targets amyloid, named donanemab, was recently denied accelerated FDA approval despite positive phase 2 data (the FDA indicated there were not enough patients who stayed on the medication for at least a year); Eli Lilly is continuing with a phase 3 trial and hopes to resubmit a traditional approval.

"I've been researching Alzheimer's for more than 30 years, and the first 20 were often discouraging," van Dyck said. "But in the past decade, we have seen steady progress into early detection and early intervention for Alzheimer's." **PN**

"Lecanemab in Early Alzheimer's Disease" is posted at https://www.nejm.org/doi/full/10.1056/NEJMoa2212948. The FDA announcement on lecanemab is posted at https://www.fda.gov/news-events/press-announcements/fda-grants-accelerated-approval-alzheimers-disease-treatment.

iStock/MivPiv

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.**

It 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 avoidance of objectifying nouns 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.

see **Psychotherapy Needs** *on page 42*

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.

Psychedelic Renaissance: Clinical Health Justice, Patient Safety, and Equity Need to Be Put First

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., M.P.H., 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 "psychedelic" 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 *Neuropharmacology* identified key challenges about novel ethical and policy issues related to psychedelics, including informed consent, underground use, commercialization, and questions around regulation and legalization. Major hurdles are ahead, such as the legal reclassification 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 eventuality that evidence-based psychedelic treatments become FDA approved, we must recognize the inherent training gap, which will limit rapid practical implementations for needed patients.

Jacques Ambrose, M.D., M.P.H. 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.

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 ethnoracial 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. **PN**

The *Neuropharmacology* article, "Novel Ethical and Policy Issues In Psychiatric Uses of Psychedelic Substances," is posted at https://www.sciencedirect.com/science/article/abs/pii/S0028390822002246?via%3Dihub.

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 imperiled.

As a longtime 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 (*Psychiatric News,* https://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 protect and 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 therapy, but further to get involved: in the APA Caucus on Psychotherapy, in teaching therapy to trainees and young practitioners, and in advocating for psychotherapy. **PN**

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. **BY NICK ZAGORSKI**

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.

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.

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 *AJP* 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. **PN**

"An 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.

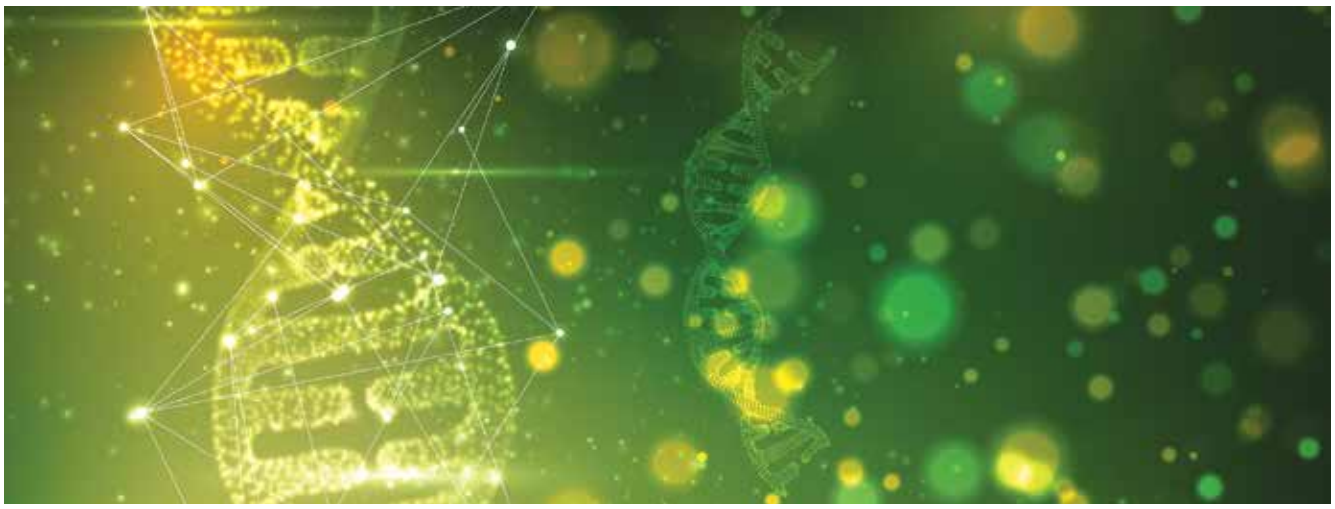
There are several bills pending in Congress that would make such investments. The Investing in Kids' Mental Health Now Act (S 4747) would incentivize states to increase Medicaid reimbursement for mental health and substance use disorder treatment services for youth, providing direct support to the pediatric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

"Trends in Suicidal Ideation-Related Emergency Department Visits for Youth in Illinois: 2016–2021" is posted at https://publications.aap.org/pediatrics/article/150/6/e2022056793/189943/Trends-in-Suicidal-Ideation-Related-Emergency. "Association of Youth Suicides and County-Level Mental Health Professional Shortage Areas in the US" is posted at https://jamanetwork.com/journals/jamapediatrics/fullarticle/2798887.

Rare Neuropsychiatric Variants Present in 1% of Individuals



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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 issues," said senior investigator Christa L. Martin, Ph.D., the chief scientific officer at Geisenger, 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. Geisenger, for example, has created a library of over 1,500 variants that may be linked with neurodevelopmental and psychiatric disorders.

Geisenger 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.

Geisinger's Autism and Developmental Medicine Institute

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.

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**

"Prevalence and Penetrance of Rare Pathogenic Variants in Neurodevelopmental Psychiatric Genes in a Health Care System Population" is posted at https://ajp.psychiatryonline.org/doi/full/10.1176/appi.ajp.22010062.

APA Election

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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. Friedrich, D.O., M.B.A., M.S., chief resident at Jefferson Health's Albert Einstein Medical Center in Philadelphia, and Sarin Pakhdikian, 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.

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 have argued that the experience of racism is a form of trauma itself that can lead to posttraumatic stress disorder. Barch is the Gregory B. Couch Professor of Psychiatry and chair of the Department of Psychological & Brain Sciences at Washington University School of Medicine in St. Louis. Luby is the Samuel and Mae S. Ludwig Professor of Psychiatry and director and founder of the Early Emotional Development Program at Washington University School of Medicine in St. Louis.

The study "is an important step towards understanding how [social determinants of health] impact brain development in youth as a potential pathway to risk for mental health challenges," Barch and Luby wrote.

Wilson, a child and adolescent psychiatrist, said the study provides a deeper context for better understanding youth, especially those from disadvantaged backgrounds. "When we have youth in our offices who have been exposed to many of the adversities included in this study, we need to understand the stressors they have been through and remember how it may impact their brain development," he said.

The study should also be an important reminder that patients are intimately impacted by the environments in which they grew up, Wilson said. When youth are having trouble regulating their emotions, psychiatrists should investigate what resources the families or the communities need.

"Children are vulnerable, and they are at the mercy of larger community and societal problems that are out of their control, but that trickle down to them," he said. "A child does not need to be fixed; the communities need to be fixed."

Harnett hypothesized that the brain differences identified in the study may only accelerate as the children become adults. "That is a terrifying proposition," he said, and it impacts the psychiatric care they might need. "Some individuals who are from racialized backgrounds are constantly exposed to threatening situations as a result of individual and structural racism," he continued. "How do we work with them to address that? Those threats aren't going away. They experience constant pressure to be vigilant and ready to respond to very real potential threats. How do we conceptualize classical approaches to treating psychiatric disorders with these individuals' experiences in mind?"

The study was supported by grants from the National Institute of Mental Health. **PN**

"Racial Disparities in Adversity During Childhood and the False Appearance of Race-Related Differences in Brain Structure" is posted at https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.21090961. The editorial, "Understanding Social Determinants of Brain Health During Development," is posted at https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.20220991.

IMG Track

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Almari Ginory, D.O., Farooq Mohyuddin, M.D., and Vineeth P. John, M.D., M.B.A., will share practical strategies to increase the chances of successfully matching, understand the common challenges in the match process, the role of a mentor in navigating these hurdles, and identification of ways to strengthen one's application for the residency match.

- **Navigating Career Paths for IMGs: Charting Your Successful Future:** Choosing a career path can be challenging for IMGs and American medical graduates alike, making this an interesting session for any resident fellow member or early career psychiatrist wondering "What next?" This session will delve into career paths in academic psychiatry, public psychiatry, and private practice. Our panelist and session chair, Toni Johnson Liggins, M.D., will identify the pathways and barriers to the development of a successful career in academic psychiatry. Leon Ravin, M.D., will discuss challenges and advantages of providing psychiatric care in state-operated systems and highlight opportunities for influencing health care policies, participating in government task forces and community stakeholder-driven work groups, working with law enforcement, and consulting with state legislatures. Vikas Malik, M.D., will present on different types of private practice models and the challenges in starting and running a successful private practice.

We are excited about these sessions and look forward to seeing our IMG colleagues there! **PN**

Psychotherapy Needs

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- Understand that for many incarcerated individuals, social injustice has affected their placement in a correctional institution and their experience of mental illness. In conjunction with this, consider that some individuals may be labeled as having mental illness due to the effects of social injustice (a fact that is known to be true historically).

- Learn basic criminology and examine your own attitudes toward criminal behavior and even the more general concepts of good and evil (see *The Anatomy of Evil* by Michael H. Stone, M.D.)

- Examine your countertransference to your patients, but don't confuse sympathy (which you may find unlikely) with empathy (which you should never lose). **PN**

"Outcomes of Psychological Therapies for Prisoners With Mental Health Problems: A Systematic Review and Meta-Analysis" by Isabel A. Yoon et al. is posted at https://psycnet.apa.org/fulltext/2017-23969-001.html. "A Meta-Analysis of Outcome Studies Comparing Bona Fide Psychotherapies: Empirically, 'All Must Have Prizes' " by Bruce Wampold, Ph.D., et al. is posted at https://psycnet.apa.org/doiLanding?doi=10.1037%2F0033-2909.122.3.203.

Heather McGhee

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nization 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 country to try to understand what it is that everyday Americans believe about each other.

"Ultimately, I learned that the reason we don't have nice things is because of this zero-sum mentality we have about race in America: The idea that if people of color gain something, then white people have to lose something," she said. "This kind of thinking has led this country to drain the pools … of resources for all of us."

"I know racism always hits its intended target—people of color—first and worst. … But I don't think we've really come to understand how much racism costs everyone," she continued. "This country's economic dysfunction, the poverty wages, the collapsing bridges, health care that's out of reach, [and] underfunded schools come from our inability to share the pool—to really see ourselves as one people worthy of investment."

The Sum of Us traces the history of how Americans arrived at this place of great division and disparity; examines who benefits from sowing the seeds of the zero-sum narrative; and tells the story of everyday Americans who refuse to buy it and instead are coming together to demand more from their government, their jobs, and each other.

"It may not look like it and you may not be hearing about it, but there's a groundswell happening all over this country, often under the radar of the big national news: [O]rdinary people in overlooked parts of America are owning up to what racism has cost us," McGhee said. "Even though we're in an era of intense division, I've learned that when we truly see each other, have honest conversations and do the tough and sometimes messy work of crossing boundaries to build solidarity, then we can win solutions to the problems that are keeping most of us up at night."

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 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.

McGhee has also adapted *The Sum of Us* for youth. *The Sum of Us (Adapted for Young Readers): How Racism Hurts Everyone* was released last month.

McGhee has a B.A. in American Studies from Yale University and a J.D. from the University of California at Berkeley School of Law. She is a distinguished lecturer of Urban Studies at the City University of New York's School of Labor and Urban Studies. She is also the chair of the board of Color of Change and also serves as the trustee emeritus at Demos and a board member of the Rockefeller Brothers Fund and the Open Society Foundations' US Programs. Her writings have appeared in such outlets as *The New York Times*, *The Wall Street Journal*, *Politico*, and National Public Radio. **PN**

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. **PN**

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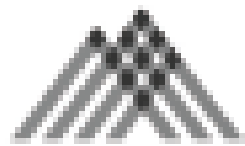

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