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The Plastics Crisis



PSYCHIATRY & SOCIETY

A Neuropsychiatric Problem Hidden in Plain Sight

Elizabeth Ryznar, MD, MSc; Elizabeth Haase, MD; and Margo Lauterbach, MD

The impact of plastics on health is an area of increasing concern. Plastics specifically affect brain health and development, which is why psychiatry must pay attention to the growing plastics crisis.

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Agitation Assessment in Acute Settings

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Do Psychiatric Diagnoses Cause Symptoms?

Ronald W. Pies, MD; and Mark L. Ruffalo, MSW, DPsa

Imagine that you and your traveling companion are touring the ruins of the ancient city of Pompeii. Your historically uninformed companion asks you, “So, what caused the destruc-

tion of Pompeii?” You reply that an erupting volcano in 79 AD was the cause, and you go on to describe its features: the expulsion of gases, rock fragments, and molten lava spewing from within the Earth through a vent onto the Earth’s surface. Your companion strenuously objects,

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In This Issue

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Publisher's Note
Celebrating Silver

We recently celebrated the 25th anniversary of MJH Life Sciences, marking our success in improving health care via medical education among numerous specialties, including psychiatry.

The innovations in health care have been nothing short of miraculous over the past 25 years. Together, we have witnessed significant advances that have cured diseases, alleviated pain, and improved quality of life. We have also navigated challenges, including a global pandemic, new technology and ways of practicing medicine, and economic fluctuations. Many of these challenges significantly affected your practices, some of which have caused more work for you, the clinician. Through it all and into the future, MJH is committed to providing high-quality information to support you and your patients in the best of times and during the most difficult storms.

Although MJH started with a single publication in 1 field, we now serve many specialties and educate professionals via articles, videos, podcasts, and events. In 2019, we had the pleasure of adding

Psychiatric Times to our list of top publications.

Next year, Psychiatric Times will celebrate an even more impressive anniversary—40 years of being the most read psychiatric publication in the US. Since John L. Schwartz, MD, started the journal, it has covered important topics that are written by your colleagues, from clinical insights, meaningful conversations, and CME, to lively debates and point/counterpoint pieces pushing the envelope to get to the core of the issues. We look forward to looking back together! (If you have old copies of the publication or memories you would like to share, please email us at PTEditor@mmhgroup.com.)

In the meantime, we invite you to enjoy this month's issue, which includes compelling clinical pearls on challenging cases, new research discussions, and thoughtful commentaries. And as always, we welcome you to share article ideas, suggestions, and feedback. ■

Mike Hennessy Jr
President and CEO, MJH Life Sciences®

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From the Editor

Meditation Is Not What You Think

John J. Miller, MD Editor in Chief Dr Miller is Medical Director, Brain Health, Exeter, New Hampshire; Editor in Chief, *Psychiatric Times*; Staff Psychiatrist, Seacoast Mental Health Center, Exeter; Consulting Psychiatrist, Insight Meditation Society, Barre, Massachusetts.



You may have seen “Meditation Is Not What You Think” on a bumper sticker. It would be a great name for a college course on philosophy because it evokes such a wide range of important discussions and debates. The word *meditation* conjures up different images and practices depending on an individual’s exposure to the context in which this word is used. Meditation is often discussed and taught as a self-directed practice to enhance attention and relaxation, but my very first published article reviewed the unveiling of traumatic memories and emotions during the practice of mindfulness and concentration meditation.¹

Generally speaking, there are 2 basic subtypes of meditation: concentration and mindfulness. The practice of concentration meditation is essential before embarking on the practice of mindfulness. Concentration practices—such as focusing one’s attention on the inbreath and the outbreath, which occurs in the present moment and is devoid of thought—allow our conscious self to have a neutral object to serve as an anchor to reinforce the mind pattern of being grounded and aware.

Once the meditator is able to keep their attention on the breath for an extended period of time without distraction, shifting to mindfulness meditation becomes possible. With mindfulness, while grounded with a concentrated mind, the task is to be aware of whatever intrudes into our experience that is trying to pull us away from the quiet stillness of the present moment. The challenge is to maintain concentration and simply observe the distraction with the intention of learning about our mind through this process. Often what distracts us is an uncomfortable sensation in our body, a conflicted memory from the past, or an unresolved emotion letting us know it is still waiting to be processed and then integrated into our biographical memory with resolution, rather than lurking in our primitive amygdala, waiting for us to revisit.

A Complex Topic

Often the word *meditation* is used to describe a technique to aid in relaxation, stress reduction, and achieving peace and quiet of the mind. Commonly, the instructions for meditation are to sit in a quiet and comfortable place and pay attention to the inbreath and the outbreath to help counteract the fight-or-flight response that is a common result of our busy and stressful lives. When the mind’s attention is distracted, which it most certainly will be, as soon as we are aware of this distraction we return our attention to breathing.

It sounds pretty straightforward and simple to do, but in reality, for the vast majority of meditators, their minds spend most of the meditative session distracted and involved in internal dialogues of all types. The common result is frustration, discouragement, and the feeling of

being unable to meditate, although these experiences are foundational to the meditative journey. This is why the vast majority of individuals who begin to meditate stop after a short excursion into the process.

In other settings, *meditation* is the word used to describe a religion’s spiritual practice that may involve praying, chanting a mantra, singing, staring at an altar or statue with focused attention, or being silent with oneself while hoping to engage with a higher power. In clinical settings in the United States, meditation has been used as a part of various treatments to ideally facilitate healing. Examples include meditation-assisted psychotherapy,² stress reduction programs,³ meditation while receiving light therapy for psoriasis,⁴ treatment for insomnia or anxiety,^{5,6} mindfulness-based cognitive therapy,⁷ mindfulness as a core part of dialectic and behavior therapy (DBT),⁸ and more.

Meditation Can Include What You Think

Paradoxically, in mindfulness meditation, what is being thought can be the object of the meditation, with 1 important caveat. The conscious awareness that has been developed through both concentration and mindfulness practices is like a large peaceful open space that is equanimous and curious, ready for whatever intrusion tries to pull us from that peaceful space. It could be an itch on our leg, discomfort from sitting, a sound that is offensive, an object passing by if our eyes are open, an unpleasant or pleasant odor, the taste of our last meal lingering in our palate, or a memory or emotion that seduces us away from that mindful open space. With steady concentration and mindfulness, the instructions are to simply observe the intrusion, including the thought itself, for what it truly is: a fleeting experience that only has as much power and control over us as we give it.

Advanced meditators focused on mindfulness often learn a great deal about the structure and content of their mind through this process.

Advanced meditators focused on mindfulness often learn a great deal about the structure and content of their mind through this process, with the possibility of spending more time in the equanimous open space of pure attention and less time ruminating over distractions. In my opinion, the best definition of *mindfulness* was provided by my first meditation mentor when I was a medical student and

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psychiatry resident at the University of Massachusetts Medical Center and the person who introduced mindfulness meditation practices into Western medicine, Jon Kabat-Zinn, PhD. His definition of *mindfulness* is “paying attention, on purpose, in the present moment, in the service of self-understanding.” Dr Kabat-Zinn has authored many books that are considered classics in this area.^{3,9}

Informed Consent

Unlike meditative practices outside of a clinical setting, such as at a monastery, religious gathering, spiritual ceremony, or through self-directed meditation, when any meditative practice is used in the context of a clinical setting—be it meditation-assisted psychotherapy, a stress-reduction program, treatment for insomnia, or DBT—it is important that the clinician have and document a comprehensive risk-benefit discussion with their patient before utilizing meditation as part of the clinical treatment. In my experience, this remains a huge blind spot with the use of meditation in clinical settings.

Although there are no absolutes, some individuals should not meditate or should utilize a modified approach to decrease risks. One example is individuals with a psychotic disorder, which can worsen with many meditative practices. Another example is individuals with a significant history of trauma, either remembered or repressed, because meditation is known to lower a person’s psychological defenses and increase the risk of emotional distress. At the extreme, the meditation may unveil previously repressed memories/experiences that can result in significant emotional distress, regression, and in some cases psychosis.¹

Concluding Thoughts

Meditation is a simple word that is often loosely used but ultimately represents a wide range of meditative techniques that are practiced in diverse settings for very different reasons. Meditation has preceded medical treatments by thousands of years, and it has a rich history in religious, spiritual, and self-guided

inquiry residing in a category and context separate from the application of meditation in a clinical setting. A fair analogy is the historical use of psilocybin in spiritual ceremonies for thousands of years, where it has a well-established cultural acceptance, and it should be respected for its role in these cultures.

However, administering psilocybin in any clinical or medical setting requires the standard evidence-based research with clinical trials approved by ethics boards and ultimately crossing the threshold of general clinical usage based on its demonstrated benefits and safety. Both meditation and psilocybin share a rich history of use over the millennia primarily for spiritual practices that do not require the guide rails that are essential and that we expect in the medical/clinical setting. Once a licensed clinician adds either meditation or naturally occurring drugs such as psilocybin to their treatment toolbox, incorporating comprehensive informed consent, evidence-based treatment protocols, and clinical monitoring for risks and benefits is essential to maintain the integrity of our profession.

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From the Cover

The Plastics Crisis

Neuropsychiatric Effects

Negative health effects emerge at all stages of the plastics life cycle (production, use, and disposal). At the production stage, plastics account for 3.7% of global carbon emissions and contribute directly to climate change.¹ In the United States, plastics companies collectively release carbon emissions equivalent to 116 coal plants each year.² The negative mental health impacts of climate change have been well documented in *Psychiatric Times*.³ The production plants for plastics also emit toxic air pollutants; air pollution is known to worsen neurocognitive and behavioral outcomes in children and to contribute to cognitive decline and dementias such as those associated with Parkinson disease and Alzheimer disease.^{4,5} These factories often abut disadvantaged communities, exacerbating health inequities.

Another component of the plastic production process is the land or marine transport of small pieces of virgin (ie, newly created) plastic polymers called pellets or nurdles to other factories that create the final plastics product. The spillage of plastics pellets and nurdles is a major source of environmental contamination, contributing to plastics eventually making their way into our bodies.⁶ Additionally, transporting the chemicals required to produce plastic polymers can cause environmental health disasters, as occurred with the derailment of the train carrying vinyl chloride (used to make the polymer polyvinyl chloride) in East Palestine, Ohio, in 2023.⁷

At the use stage, plastics enter the human body primarily through inhalation or ingestion.⁸ Fragments smaller than 5 mm are called microplastics and pieces smaller than 1 μm are called nanoplastics.⁴ With normal use, synthetic textiles (clothing, curtains, carpets) and plastic flooring materials release microplastics into the air and are a major source of inhaled microparticles in indoor environments, especially those with poor ventilation.^{9,10} Sources of microplastics in the outdoor air originate from elements such as tire erosion, brake dust, paint, microfilaments from clothing, and general air pollution.¹⁰ In terms of entry of plastics into food and water, aquatic-derived consumables such as seafood and salt contain micro- and nanoplastic particles because of extensive plastics pollution in oceans and water;

animal proteins also have been found to contain microplastics. A 1-L plastic water bottle has 240,000 detectable micro- and nanoplastic particles in the water, and microwaving food in plastic containers or using plastic teabags can release billions of nanoplastic particles.¹¹⁻¹⁵ Oceans and groundwater can be contaminated by plastics at the manufacturing and disposal stages, but plastics also enter the water system at the use stage from personal care products containing microbeads and the washing of synthetic textiles such as polyester or microfiber. Once inhaled or ingested, micro- and nanoplastics can enter the circulation in multiple ways and accumulate in body tissue, including the placenta, amniotic fluid, testes, liver, kidneys, spleen, joints, heart, and brain.^{8,16}

Research into the direct effects of plastics on brain health is still relatively nascent.¹⁷ However, the neurodevelopmental and neurocognitive effects are particularly concerning. It is helpful to consider separately the effects of micro- and nanoplastic particles and the effects of chemical additives. Direct toxicity from micro- and nanoplastics depends on polymer type, shape, size, and charge.^{8,18} Animal models clearly document the transit of microplastics into the brain, with resultant morphologic changes and eventual cell death in microglia, inflammatory changes, and dramatic changes in neurotransmitter expression.¹⁶ Results of preclinical studies in mice show that nanoplastics bind to α -synuclein and promote fibril formation in dopaminergic neurons (**Figure 1**), and that drinking microplastics-contaminated water induced dementialike behavioral and brain changes.¹⁹⁻²¹ Toxicological studies have linked the buildup of nanoplastics in the brains of carp to morphological and behavioral changes, and zebra fish larvae's motor activity is affected by these neurotoxins.^{19,22} In 2020, Prüst et al reviewed the neurotoxicity of micro- and nanoplastics in a variety of species and found that they induced oxidative stress, neuroinflammation, and subsequent changes in motility and behavior.²³ No studies have yet been done on their effect on human brain tissue.

In addition to direct neuronal toxicity, micro- and nanoplastics affect other organ systems that can impact brain health. First, microplastics have been documented in human placentas, raising the question of their impact on fetal brain development, given the link between placental health and future risk of neuropsychiatric conditions.^{24,25} Second, microplastics accumulate in the heart and blood vessels. New research is emerging on how microplastics affect cardiovas-

cular health, which in turn affects brain health. A recent prospective study in *The New England Journal of Medicine* assessed outcomes in patients who underwent carotid endarterectomy

sive expertise in environmental health research, Grandjean and Landrigan hypothesized that BPA and other plastics chemical additives are neurotoxic and that their increased presence accounts for the increasing prevalence of autism, attention-deficit hyperactivity disorder, and cognitive impairments in children.³² BPA can also disrupt the blood-brain barrier, making it a potential environmental risk factor for Alzheimer disease.³⁰ New research has recently been funded to investigate BPA and blood-brain barrier disruption in patients with Alzheimer disease.¹⁹

In the disposal stage, most plastics end up littered or in landfills. Physical erosion and UV radiation degrade the macroplastics into micro- and nanoplastics, which ultimately leach into the environment, where they become sources for human ingestion and inhalation. A small percentage of plastics end up incinerated with other trash. Incineration produces more air pollution, which impacts brain health as described earlier, and can leave up to 100,000 pieces of microplastics in the residual ash per metric ton of waste, making it a potential source of environmental

microplastics pollution.³³

A Growing Problem

Unfortunately, the environmental and health burdens of plastics will only increase due to the sheer scale of plastic use. Annual global plastics use has grown from 72 million tons in 1980 to 445 million tons in 2020 and is projected to double by 2040 and triple by 2060 under current policies and regulations (**Figure 2**).¹ Single-use plastics will account for a significant part of that increase, underscoring the importance of advocating for its reduction and supporting rigorous and effective

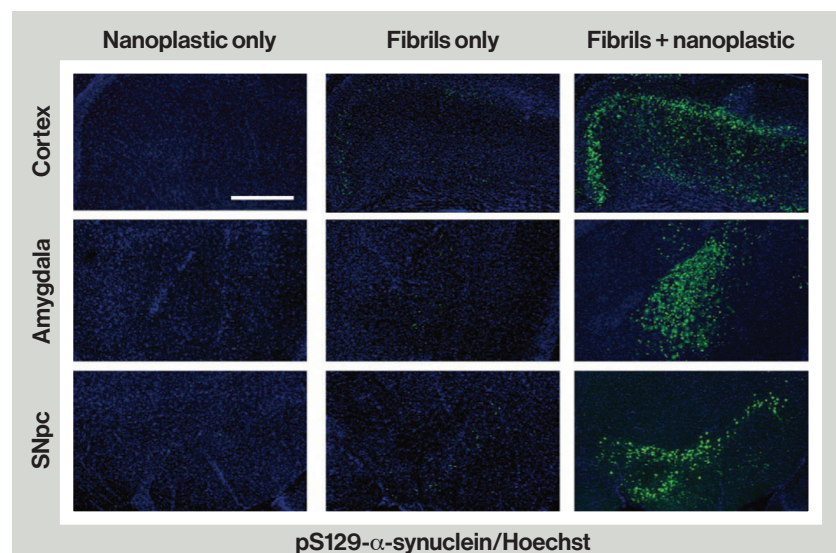


FIGURE 1. Reproduction of Figure 9B from Liu et al,²¹ captioned, “Anionic nanoplastic contaminants in the brain synergize with α -synuclein fibrils to increase the deposition of pathology in the cortex, amygdala, and substantia nigra in nontransgenic mice.” In this experiment, mice received intracranial injections of nanoplastics only, α -synuclein fibrils only, or both nanoplastics and fibrils. Two months later, brain tissue samples were collected and immunofluorescence staining of α -synuclein pathology (pS129- α -synuclein, green) was performed in each cortex, amygdala, and substantia nigra pars compacta (SNpc). Scale bar, 0.5 mm.

for asymptomatic disease.²⁶ Plastic polymers were detected in the removed plaques of 58% of patients, and these patients had a dramatically higher composite risk of myocardial infarction, stroke, or all-cause death over a 34-week follow-up period (HR, 4.53; $P < .001$). Third, the interaction between gut and mental health is of increasing focus in psychiatry, and ingestion of microplastics has substantial effects on gut function and the human microbiome.²⁷ Microplastics in the gut cause disruptions in endothelial tight junctions, accumulate in gut endothelial cells, change the composition of the microbiome, and cause bacteria to produce biofilms.¹⁶ These changes in permeability and dysbiosis lead to elevation of inflammatory cytokines and markers of oxidative stress, damage to the gut reflected in cracked villi and small vessel proliferation, and many other changes.¹⁶

A separate but related body of research has investigated the effects of chemical additives in plastics. For example, bisphenol-A (BPA), which can be found in food and beverage containers and baby bottles, among many other sources, has been implicated in neurodevelopmental, mood/anxiety, and neurocognitive disorders.²⁸⁻³⁰ Results of initial research that followed a small cohort of children starting at gestation suggest that prenatal BPA exposure is associated with anxiety and depression in boys.³¹ Based on their exten-

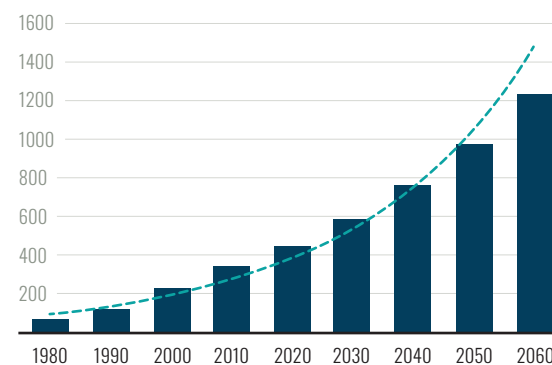


FIGURE 2. Global Plastics Use in Million Tons Values calculated from data provided by the OECD! Values from 2020 and later are projections based on continuation of plastics policies and regulations in the year 2019.

regulation across the globe. Recycling is not a panacea: Between 1950–2015, humanity has produced 8.3 billion metric tons of plastics in total, of which 30% is still in use, 9% is incinerated, and 60% has accumulated as litter or landfill; overall, only 9% has been recycled.³⁴ Increasing recycling rates would not solve the problem because many plastics, especially single-use plastics, cannot be recycled. Plastics are necessary for certain aspects of modern life, most notably in health care; however, many plastics are unnecessary and can be replaced with eco-friendly alternatives that are reusable or made from truly recyclable materials.

Looking Forward

Some jurisdictions have made progress toward eliminating plastics waste. Several US states have started addressing plastics pollution with bag bans, food container restrictions, and extended producer responsibility programs. At the federal level, the Break Free From Plastics Pollution Act was introduced in Congress

in 2020 and 2023, though it was not passed in either year.³⁵ Internationally, the United Nations is negotiating a binding Global Plastics Treaty.³⁶ However, the fossil fuel and plastics companies, as well as their lobbying group, the American Chemistry Council, have pushed back forcefully.³⁷ The petrochemical industry needs plastics as an alternative source of revenue, given the push for clean energy, and is actively hampering legislative progress.³⁸

So what can psychiatrists do to address this problem and advocate for brain health? As individuals, we can contact our representatives at the local, state, federal, and international levels; advocate for the reduction of plastics in our workplaces^{39,40}; and commit to reducing unnecessary plastics in at least 1 aspect of our personal lives. The Plastic Free July website, a key initiative of the Plastic Free Foundation, has many suggestions, including reducing single-use plastics for food and drinks and avoiding fast fashion and synthetic textiles such as polyester.⁴¹

As a field, psychiatrists need to assess how our health care systems and professional organizations are using plastics and contributing to plastics waste. The goal is not to eliminate *all* plastics but to eliminate unnecessary plastics. We can also encourage research funding in this area to obtain more definitive findings about the neuropsychiatric impacts of plastics. However, we ought not wait for the outcome of these research studies to begin taking immediate action. There are countless examples of public health mistakes that could have been prevented if early warning signs were heeded.^{42,43} The preliminary evidence warrants urgent intervention in the plastics crisis. Let's act to safeguard brain health before it is too late, especially for future generations.

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WHAT ARE PLASTICS?

Most plastics are fossil fuel–derived hydrocarbon polymers that are compounded with chemical additives that imbue desired physical properties (eg, durability, color, oil or water repellency). Industrial applications of plastics include packaging and single-use plastics (accounting for 31% of all plastics), buildings/construction (17%), transportation (14%), textiles (10%), and consumer/institutional products including medical products (10%).¹

Two properties of plastics are critical to understanding their impacts on health. First, plastics products contain chemical additives that are loosely embedded in the hydrocarbon polymer matrix. Examples of chemical additives include formaldehyde, phthalates, bisphenol A, polyvinyl chlorides, and per- and polyfluoroalkyl substances such as perfluorooctanoic acid and perfluorooctane sulfonate. In a study from 2021, researchers estimated that more than 10,000 chemical substances can be added to plastics, of which 24% have data indicating medium or high concern for human hazard—carcinogens, endocrine disruptors, or organ toxins—and 39% lack any data on possible health effects.² A more recent comprehensive report funded by the Norwegian Research Council identified more than 16,000 possible chemical additives; at least 25% are of concern for effects on health, and only 6% are subject to regulation.³ Accordingly, any discussion of plastics needs to consider the impacts not only from the hydrocarbon polymers but also from the chemical additives.

Second, once produced, plastics persist in the environment and do not biodegrade. Over time, they break down into smaller and smaller pieces of hydrocarbon polymer with embedded chemicals. Fragments smaller than 5 mm are called microplastics and pieces smaller than 1 μm are called nanoplastics.⁴ These tiny pieces readily disperse in the air, water, and soil and are ubiquitous in the environment, found everywhere from the top of Mount Everest to the deepest oceanic trench.⁵ Moreover, their quantity is hardly insignificant: one study estimates that the ocean floor contains 14 million tons of microplastics.⁵ Importantly, micro- and nanoplastics are small enough to be bioactive at the cellular level.



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From the Cover

Do Psychiatric Diagnoses Cause Symptoms?

“No, no! All you did was describe the observable features of a volcano. I want to know the *cause* of Pompeii's destruction!” At that point, you might be puzzled, or a bit annoyed, and reply that you have just identified the cause.

Perhaps your friend was trying to pose a deeper question, such as, “What is the cause of volcanoes?” You see the problem: You were answering by invoking 1 level of causal explanation (level 1), whereas your friend was seeking a level 2 causal explanation. The latter is a perfectly legitimate and laudable mode of inquiry—but it remains the case that the destruction of Pompeii was indeed caused by an erupting volcano. There is nothing wrong with the level 1 explanation, incomplete though it is. Often, in science and medicine, that is the best we can do in our present state of knowledge.

Now, transposing the argument into the realm of psychiatric diagnosis: We often hear critics argue that psychiatric diagnoses are “purely descriptive” and are “currently defined only by symptoms. That is, they do not refer to any known pathophysiological processes or specific causes.”¹

It is simply not the case that the *DSM* diagnostic categories are defined only by symptoms...

These critics argue that *DSM* diagnoses are merely “agreed-upon labels—a kind of shorthand—for describing symptoms...”² This claim often leads to the charge that psychiatric diagnoses are little more than exercises in circular logic. Why? Because, the argument goes, “a purely descriptive diagnosis cannot be the cause for its symptoms, because it merely describes them: [for example], depression cannot be the cause of depressed mood.”¹

As one critic put it²: “Here is the circular logic: How do we know a patient has depression? Because they have certain symptoms. Why are they having these symptoms? Because they have depression.”

The argument then expands to allege that “misleading circular causal claims” are potentially harmful, because they may lead the public “to misunderstand the nature of mental health problems.”¹

To be clear: We acknowledge many problems and inadequacies in current *DSM-5* psychiatric diagnostic categories, including, but not limited to the *DSM's*

rejection of diagnostic hierarchies and the problematic heterogeneity of the “mental disorder” construct.³ Nevertheless, we believe the critics’ circularity argument is ill-founded, misleading, and fallacious.

To put it simply, these critics are insisting on a level 2 causal explanation while discounting the (admittedly limited) value of a level 1 causal explanation. We will show presently why diagnoses such as schizophrenia or bipolar disorder, properly made, are neither circular nor uninformative nor lacking in explanatory value, despite the absence of “known pathophysiological processes” as part of their diagnostic criteria. The critical phrase here is “properly made.” First though, we need to clear away some rhetorical underbrush that often obscures the reality of psychiatric diagnosis.

Misunderstanding the DSM-5

In our experience, very few US psychiatrists and psychotherapists have taken the time to read the first 25 pages of the *DSM-5*; ie, the Introduction and Use of the Manual sections. This has led to several mistaken beliefs about the nature, scope, and purpose of the diagnostic categories—and, more important, of the diagnostic process.

Firstly, it is simply not the case that the *DSM* diagnostic categories are defined *only* by *symptoms*, understood as the patient’s subjective report of what he or she feels or experiences.⁴ On the contrary, many psychiatric diagnostic categories include a variety of *signs* as part of their criteria set; ie, objective features that can be clinically observed and measured.⁵ Examples include significant weight loss (in major depressive episode, anorexia nervosa); psychomotor agitation or retardation; stereotyped movements; distractibility (during evaluation), avoidance of eye-to-eye gaze (in autism); and, of course, numerous objectively measurable deficits in cognitive function, such as impaired recent memory and inability to calculate. We would also classify observable features such as pressured speech, loose associations, and markedly elevated or depressed affect as *signs*—not symptoms.

Secondly, to make a valid *DSM-5* diagnosis, the clinician must, yes, must devise a case formulation based on biopsychosocial factors⁶: “...that may have contributed to developing a given mental disorder. Hence it is not sufficient to simply check off the symptoms in the diagnostic criteria to make a mental disorder diagnosis.”

In our experience, this *DSM-5* requirement is rarely appreciated, much less satisfied, by most US clinicians. This is unfortunate, as the case formulation very clearly provides substantive, explanatory content for the patient’s condition, not merely a recitation of the patient’s symptoms.⁷

Finally, the diagnostic process of the *DSM-5*—apart from its diagnostic criteria—requires a series of rule outs before a final diagnosis can be

made. For example, a diagnosis of schizophrenia (criterion E) requires that “...the disturbance is not attributable to the physiological effects of a substance...or another medical condition.”⁶ In clinical practice, this requires the psychiatrist to consider and rule out a variety of neurological, endocrine, and infectious conditions, ranging from complex partial seizures to “myxedema madness” (severe hypothyroidism) to tertiary syphilis—causes of so-called “secondary psychosis.”⁸

The Circularity Fallacy

Critics who claim that psychiatric diagnoses are merely tautologies do not seem to realize that what the patient does not have is just as important, and as informative, as what they do have. As our colleague, Awais Aftab, MD, has pointed out⁹: “An important thing about diagnoses in medicine is that they don’t just identify something, they also typically exclude other things. For example, to say ‘you have *unipolar* depression,’ also implies, ‘I don’t think you have *bipolar* depression.’ To say, ‘you have generalized anxiety disorder’ also means ‘I don’t think your anxiety is secondary to psychotic symptoms.’ In this sense, to say, ‘Your anxiety is *caused by* generalized anxiety disorder’ can be interpreted as ‘The way I understand your anxiety, it seems to be best described as generalized anxiety disorder rather than major depressive disorder with anxious features, or as panic disorder... We sometimes colloquially use ‘caused by’ with the meaning of ‘this is how it best makes sense’ or ‘this is how it is best described.’”

Thus, when we provide the patient with a psychiatric diagnosis, we are simply hypothesizing the existence of a condition that “best makes sense” of the patient’s presenting signs and symptoms. This is very close to what philosophers of science call “inference to the best explanation.”¹⁰ In so doing, we are not making any metaphysical claims, or reifying the condition by positing some essence, substance, or thing residing inside the patient—akin to, say, a burst appendix.

Indeed, we recognize that psychiatric (and medical) diagnoses are in large measure socially constructed, but that does not render them in any sense unreal, metaphorical, or tautological. (The concept of health is also socially constructed, but few would argue that health is thereby rendered mythical, metaphorical, or in some sense nonexistent.)

Aftab pointed out that there are some diagnoses—perhaps we should call them pseudo-diagnoses—that embody so little descriptive or causal content as to be trivially nonexplanatory. He gives the example of “fever of unknown origin” (FUO). As he put it⁹: “Imagine saying to a patient, ‘Your fever is caused by FUO.’ That makes no sense at all. We know that this specific fever has some unidentified cause, yet that cause is so abstract, so distant, steeped in so much ignorance, that the mere knowledge that there has to be some cause doesn’t make it so that the mere use of the term

offers us some causal explanation.”

We would argue that the conditions often termed serious mental illnesses do not fit the FUO paradigm.¹¹ On the contrary, debilitating afflictions such as schizophrenia, bipolar disorder, and melancholic/psychotic forms of

Poetry of the Times

Ficus Lyrata

Richard M. Berlin, MD

One September morning,
the day I started medical school,
I placed a two-foot specimen
in my sunny south window.
Then Chicago froze into fall
and reams of lecture notes
swelled into huge white drifts,
the heart-shaped ficus leaves
dropping like sad notes from
a Spanish song, and by finals
nothing remained except
rough brown scars
on cracked dead stems.

Today, on her own
September morning,
my daughter starts medical school
while I scratch my bald head
and wonder why she chose
to follow my old ambition.
I wish I knew the way
to protect her from the avalanche
of facts and nights on call,
but all I can do is ramble around
the house, checking our plants
for aphids, feeding them
all the Miracle Grow I can find.



Dr Berlin has been writing a poem about his experience of being a doctor every month for the past 26 years in *Psychiatric Times* in a column called “Poetry of the Times.” He is instructor in psychiatry, University of

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major depression have so many external validators—eg, family history, course of illness, characteristic biomarkers, genetic risk factors, and typical response to treatment—that it makes sense to speak of these conditions as causing symptoms. The Substance Abuse and Mental Health Services Administration (SAMHSA) notes¹¹: “Bipolar disorder is a brain disorder that *causes* intense shifts in mood, energy, and activity levels...[and] schizophrenia is a chronic and severe mental disorder that *causes* people to interpret reality abnormally.” [italics added]

There is nothing circular or tautological in SAMHSA’s statements. Essentially, SAMHSA is invoking what we have called level 1 causality, cognizant that we do not know the precise pathophysiological processes that explain bipolar disorder or schizophrenia (level 2 causality). It is just as reasonable to state that “Smith’s command auditory hallucinations and paranoid delusions are caused by his having schizophrenia” as it is to state that “The destruction of Pompeii was caused by an erupting volcano.” The truth of the first claim is not dependent on knowing the etiopathology of schizophrenia.¹² The truth of the second claim is not dependent on any knowledge of shifting tectonic plates in the genesis of volcanoes.

Ironically, the paper by Kajanoja and Valtonen demonstrates how the circularity charge collapses under its own weight. They write (footnote 3) that¹ “...it is logically circular to say that depression caused the person’s depressed mood, [but] *it is not circular to say that depression caused the person to not attend an event.*” [italics added]

We completely agree. But this is precisely where the circularity charge falls apart. For if the depression itself can *cause* a person to “not attend an event,” then, ipso facto, depression itself necessarily has *causal efficacy*; ie, it can itself act on individuals to produce clinical or behavioral *effects*. Consequently, there is no reason in principle why depression could not also cause the person to sleep poorly, eat poorly, feel guilty or suicidal, or experience psychomotor slowing. And importantly: *None of these facts requires us to have a complete or even a partial understanding of the pathophysiology or etiopathology of depression itself.*

Historical Identification of Disease

Critics alleging the circularity of psychiatric diag-

nosis seem to have limited understanding of the identification of disease states through the ages. Indeed, the history of medicine is replete with examples of diseases first identified long before their underlying physiological mechanisms—their etiopathology—were known. In 1817, when James Parkinson described a well-defined constellation of signs and symptoms he called “the shaking palsy,” he had in fact identified a disease state that caused the patient’s signs and symptoms,

and what would later become known as Parkinson disease. Importantly, he did so without knowing anything at all about what caused the disease that would bear his name. It would be absurd, on that basis, to say that Parkinson disease did not exist—or was not the cause of parkinsonian symptoms—until its etiopathology was discovered in the 1950s and 60s. In fact, the French neurologist Jean-Martin Charcot (1825-1893) explicitly referred to the condition as Parkinson *disease* as early as 1888, decades before its etiopathology was uncovered.¹³ This fact flatly contradicts the position that just conditions with known and identified pathophysiology count as bona fide diseases.

Finally, to be clear: In

asserting that some psychiatric diagnoses can legitimately be said to be causative of symptoms, we are not claiming that psychiatric disorders arise solely from constitutional-biological factors. On the contrary: We recognize that powerful psychological and social forces often set in motion a pathological process that results in the manifestation of symptoms. This fact reaffirms the importance of the case formulation and its biopsychosocial orientation.

Concluding Thoughts

Causality is not a simple, single-layered concept. Aristotle, for example, recognized 4 types or levels of causation, which he called material, formal, efficient, and final.¹⁴ Similarly, in our response to Aftab,¹⁵ we described 3 alternate uses or senses of the term causality (Table).¹⁶

To be sure, our current psychiatric nosology leaves much to be desired. One of us (RP) has quipped that the *DSM-5* is “by far the worst diagnostic framework psychiatry could have chosen—except for all the rest.”¹⁷ Of course, we all wish that psychiatry were at the point of invoking level 2 causality in our diagnoses, and research continues to yield important knowledge in the realm of pathophysiology.¹⁷ But our incomplete

understanding does not mean that our diagnostic categories are merely short-hand labels for a bunch of symptoms—or empty, acausal tautologies. When arrived at carefully, including a biopsychosocial case formulation, a psychiatric diagnosis can explain a great deal about the patient’s presenting problem and remains the royal road to effective treatment.

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TABLE. Three Alternate Senses of the Term Causality

- **Etiopathological causation:** This refers to the biological and physico-chemical mechanisms through which a disease process develops.
- **Clinical causation:** This refers to the clinician’s identification of a good fit between the patient’s presenting signs and symptoms, and a recognized clinical entity.
- **Causation in ordinary language:** This refers to the way the average person often uses the term “cause,” or its derivative, “because” (by cause). For example, “The doctor said that Joe gets palpitations, dizziness, and sweating *because* Joe has panic disorder.” And as the philosopher Ludwig Wittgenstein observed, “Ordinary language is all right.”¹⁶



DEATH & DYING SPECIAL REPORT

Death Is No Enemy

Sidney Zisook, MD
Special Report Chair

“Death is no enemy of life; it restores our sense of the value of living. Illness restores the sense of proportion that is lost when we take life for granted. To learn about value and proportion we need to honor illness, and ultimately to honor death.” —Arthur W. Frank¹

As mental health clinicians, we often confine our conversations about death and dying to recognizing suicide risk and preventing suicide. And for good reason. Suicide is the 11th leading cause of death in the United States, the 3rd leading cause for individuals aged 15 to 24 years, and the 2nd leading cause for individuals aged 25 to 34 years.² Every suicide is a tragedy that affects not only the deceased’s immediate and extended family, but also friends and acquaintances, health and mental health professionals, clergy, police, firefighters, funeral directors, coroner’s office staff, and others who may be involved in discovery or processing activities related to the death. The estimated suicide rates may be only the tip of the iceberg. The Centers for Disease Control and Prevention (CDC) estimates that 4.8% of adults in the US have thought about suicide, 1.6 million have attempted suicide, and more than 50%

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ONLINE ONLY
Treating Prolonged
Grief Disorder:
Innovations and
Future Directions

have been affected by suicide in some way.²

Far less attention is paid by mental health clinicians to other aspects of death and dying. But we are human, first and foremost, and coping with a host of issues related to the end of life is inextricably bound to both our professional and personal lives. Like it or not, death is part of life. We, as mental health clinicians, are not always as prepared as we would like to be to help ourselves, our loved ones, our patients, and their loved ones deal with loss, dying, death, and bereavement. For many physicians, 1 or 2 hours in medical school and perhaps another few hours during residency are all the training we receive in these complex and challenging clinical issues.^{3,4} This *Psychiatric Times* Death and Dying Special Report helps fill some of that gap. The special report features 4 timely articles highlighting novel approaches to help support patients and their families in these most challenging periods.

Chochinov provides a clinician’s guide for “being with” dying patients. He offers ways of providing intensive caring to enhance empathy, respect, connectivity, and hope, and to make the experience of a dying patient more tolerable than it otherwise might be. Since reading the first draft of this manuscript, I have utilized his Patient Dignity Question, which asks, “What do I need to know about you as a person to take the best care of

you possible?” on several occasions with gratifying results for both the patient and me.

Druck provides a road map for clinician self-care that also can be offered to patients and families to help them navigate the process of death and dying. He shares the tragedy of losing his daughter to sudden and unanticipated death and illuminates his guidelines with personal vignettes and examples. He also provides pragmatic guidelines for honoring one’s loved one after they have died, and he discusses what clinicians should—and should not—do, as well as what to share with family members, friends, neighbors, coworkers, and other mental health professionals.

In the coordinating CME, Yager et al focus on caring for individuals with psychiatric disorders at the end of life. They make a point that is rarely discussed in psychiatric circles: Some psychiatric disorders can themselves result in terminal conditions, such as sometimes seen in patients with anorexia nervosa. Absent effective treatments, clinicians are still morally obligated to care for these patients. Yager et al describe some of the roadblocks to transitioning to palliative care and guidelines for providing it when appropriate. They also introduce the controversial and divisive topic of medical aid in dying (MAiD) for patients with intractable symptoms attributed to their mental disorders. Although there is no consensus on if or when MAiD is indicated, it is a topic that cannot be ignored.

Finally, in an article available online, Spencer-Laitte et al describe an evidence-based treatment for a common, serious, and distressing clinical condition: prolonged grief disorder (PGD). PGD has only recently been formalized by the *ICD* and *DSM* and is relatively underappreciated in most clinical settings.⁵ PGD is particularly prevalent in certain populations, such as those bereaved by suicide. Prolonged grief therapy (PGT) is robustly effective for PGD,⁶ including for those who have lost someone to suicide.⁷ There is reason to believe that treating someone with PGD with PGT following suicide-loss may be an effective prevention technique.⁸ Now that we have compelling evidence that PGT is highly effective for PGD, this article focuses on the all-important next step, which is how to implement PGT and/or other evidence-based treatments in clinical settings.

It is time to put education and training on death and dying on the front burner for health students, trainees, and mental health clinicians. The topic has been taboo for too long, perhaps especially in the medical culture in the US. We hope this special report provokes further conversation, debate, and dialogue.

Dr Zisook is a distinguished professor of psychiatry at UC San Diego in California.

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PSYCHOSOMATICS

Suffering Revisited Tenets of Intensive Caring

Harvey Max Chochinov, MD, PhD, FRCPC

Patients approaching death experience many losses, including losing a sense of self.¹ This is perhaps one of the most substantive existential challenges dying patients face, as they find the essence of who they are—along with who they were or who they want to be—under assault. This notion of disintegration² or fractured sense of personhood³ often lies at the heart of human suffering, which Eric Cassell, MD, MACP, defined as a person’s severe distress at a threat to their personal integrity. Although suffering can often lead to feelings of hopelessness and therapeutic nihilism⁴ for patients and health care professionals, it is important for those of us who care for the dying to understand the nature of suffering and how to be most responsive and therapeutically effective.

Tenets of Intensive Caring

An approach coined *intensive caring* offers an empirically informed way of responding to suffering, which can be used to guide clinical practice (see **Table**).⁵ The first tenet of intensive caring is nonabandonment. Health care professionals are inclined to withdraw from clinical encounters they anticipate will leave them feeling ineffective or therapeutically impotent. There is good evidence that abandonment renders patients more vulnerable to desire for death and even overt suicidality.^{6,7} This affirms the assertion by Dame Cicely Saunders, founder of the modern hospice movement, that “suffering is intolerable when nobody cares.”⁸ Nonabandonment assures patients they will be accompanied, no matter what course their illness follows, until the end.

A steadfast connection with patients goes hand in hand with the next tenet of intensive caring: taking an interest

in who they are as individuals. Doing so affirms that they are more than their illness and that who they are as individuals is recognized and appreciated. This aligns with the work of Robert Butler, MD, and his research on reminiscence in older adults.⁹ Engaging individuals in telling their stories and allowing them to give voice to what matters to them provides benefits in multiple ways. It demonstrates another person values them and cares about their unique history and perspective; it affirms, despite their despair, that someone sees them as having continued worth; it fulfills possible generativity needs, knowing another person will carry their memory into a future of which they will not be a part¹⁰; it gives them a safe and reflective space to integrate and share their life story within a cohesive and meaningful narrative. According to Erik H. Erikson, failure to achieve this late-life developmental goal is a harbinger of despair.¹¹

Placing personhood on the clinical radar can be achieved in multiple ways, including by using the Patient Dignity Question (PDQ), which asks, “What do I need to know about you as a person to take the best care of you possible?”¹² Multiple studies in various practice settings (eg, palliative care, patient oncology, rural hospice) demonstrate the utility of this approach and how summaries of these short conversations, when placed on the patient’s chart, enhance a sense of empathy, respect, and connectedness between patients and their health care professionals, correlating with enhanced job satisfaction for those who avail themselves of these summaries focused on personhood.¹²⁻¹⁴ The PDQ appears to be highly valued by patients and families, and helps health care professionals clarify goals of care.¹³

The next tenet of intensive caring is holding or containing hope.⁵ Suffering casts a long and menacing shadow.

Being caught within that darkness can render health care professionals hopeless and unable to see viable therapeutic pathways forward. Holding or containing hope means appreciating what is still possible for patients and their families and helping them realize that potential. Those possibilities span vigorous pursuit of symptom management; enabling families to spend time together; facilitating meaningful conversations, such as expressing feelings of love, gratitude, regret, or remorse; and seeking reconciliation, forgiveness, or saying goodbye. These are among myriad ways patients and families prepare themselves and each other for impending separation by death.¹⁵ Just as health care professionals help families follow a path of least regret, they also enable patients to model how to die. In doing so, patients create a lasting imprint, shaping the way those who bear witness will one day face the inevitability of their own death.¹⁶

Some elements of intensive caring are not reliant on what one does or says to patients. For instance, *dignity-affirming tone* and *therapeutic presence* describe ways of manifesting certain characteristics to convey deep and steadfast caring. These include being compassionate, empathic, respectful, nonjudgmental, genuine, trustworthy, fully present, valuing the intrinsic worth of the patient, mindful of boundaries, and emotionally resilient.¹⁷ Words frequently fall short in response to suffering, which is why individuals struggle to come up with “the right thing to say.” Embodying a dignity-affirming tone conveys the appropriate sentiment without having to utter a single word.

The final tenet of intensive caring is therapeutic humility, which recognizes dimensions of human suffering whose remedy exceeds our grasp. This means shifting from a traditional medical paradigm—primarily focused on examining, diagnosing, and fixing—to a more holistic one that relinquishes the need to fix while affirming our commitment to presence, holding hope, and affirming patients’ worth as persons. Therapeutic humility also means accepting uncertainty because the patient’s course and how intensive caring might bend the arc of suffering are unknowable. This tenet requires trust in the process and mindfulness of its potential to deliver suffering patients and families to a better place.

Concluding Thoughts

Life often reveals elements of human experience that defy notions of being fixed. Intensive caring offers a way of addressing suffering designed to better meet the needs of patients and families. It also invites those who practice medicine to revisit how they approach suffering. By expanding their therapeutic repertoire and redefining expecta-

TABLE. Elements of Intensive Caring⁵

Nonabandonment

- Committed, quality connection
- Ongoing support

Taking an interest in the patient as a person

- Enhance empathy, respect, connectedness
- Affirm worth of who they are, were, or tried to be and what they achieved or tried to accomplish

Holding/containing hope

- Finding hope for psychological, spiritual, and physical comfort
- Hope for minimal suffering and a peaceful death
- Finding meaning and purpose in
 - Relationships
 - Imparting words/sentiments that need to be shared, such as reconciliation, forgiveness, love, affirmation of feelings
 - Modeling how to die
- Guiding families toward viable opportunities
 - Time
 - Connection
 - Comfort
 - Forgiveness
 - Goodbyes

Dignity-affirming tone of care/therapeutic presence

- Being compassionate and empathic
- Being respectful and nonjudgmental
- Being genuine and authentic
- Being trustworthy
- Being fully present
- Valuing intrinsic worth of the patient
- Being mindful of boundaries and being emotionally resilient

Therapeutic humility

- Tolerate clinical ambiguity
- Accept and honor the patient’s expertise
- Trust in the process
- Avoid the need to fix

Table reprinted with permission from the American Society of Clinical Oncology.⁵

tions, intensive caring allows health care professionals to embrace their traditional role as healers.

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Guidelines for Supporting the Dying and Their Families

Ken Druck, PhD

There are few subjects that most of us, including those who work in mental health, avoid more than death and dying. Meeting the needs of the dying and their families requires a deep and clear understanding of competent and compassionate care for health care professionals and caregivers.

Since the death of my 21-year-old daughter several decades ago, I have had the honor and privilege of helping countless individuals, families, and communities that have suffered losses. I have also been given the opportunity to teach and train mental health professionals and developed several programs and guidelines for supporting the dying and their families.

MY TOP 7 GUIDELINES TO SHARE WITH PATIENTS AND THEIR FAMILIES ARE AS FOLLOWS:

1 Show up.

Whether and how we show up for life's most unspeakably difficult end-of-life moments says it all. We all do the best we can to care for, comfort, and console those who are dying, each other, and ourselves. When my mom was dying at age 92, my sister, brother, and I joined our children and spouses at her bedside, holding her hands and letting her know how much we loved her. On her last day, my mother's favorite song, "Over the Rainbow," came on, and we all gathered in a circle around her. Mom took her final breath with all of us singing, "Away above the chimney tops, that's where you'll find me" and holding hands. We were all left feeling proud about the way we showed up to be by my mother's side in such a meaningful way when she passed.

2 Establish agreements, ground rules, and set a tone of cooperation and civility.

Death can bring out the best and/or worst in us as human beings and families. As uncomfortable as it might be, the following plans need to be discussed in advance: practical and logistical matters; decisions about what the patient wants to happen after they die; agreements between family members; plans for the estate; and a celebration of life, funeral, burial, or cremation. Decisions involving the parents, children, siblings, and family members with the dying person's estate planning attorney need to be worked out well in advance of last-minute, 11th-hour gatherings. Open communication with a loved one who is dying to confirm their final wishes and among family members in the time leading up to (and following) their death helps get everybody on the same page about what will and will not happen. Families wishing to avoid unnecessarily stressful chaos, conflict, and confusion—and give themselves the time and conflict-free closeness with their family—will make time to do this.

Family communication is not always possible

for a variety of reasons. Things can sometimes become painfully chaotic. For example, a little girl with terminal cancer I had been helping for several years called me at 12:30 AM, approximately 2 nights before she died. She was sobbing as her divorced parents screamed profanities at one another in the background and the neighbors called the police. Her dad had come to the house drunk and gotten into a heated argument with his ex-wife, and both allowed things to escalate into a full-scale argument.

3 Get professional help from skilled and trustworthy counselors and confidants.

There are times when calling in a skilled and trustworthy third party to help us through the moment is necessary. Meeting with an experienced confidant, clergyperson, family therapist, or experienced counselor to calm and slow things down, de-escalate conflicts, and move toward constructive agreements is in the best interests of the dying individual and their family.

4 Make time with lawyers, financial advisers, and clinicians to prepare for what is coming.

Families that take the time to understand what is to come give themselves the opportunity to summon newfound courage, clarity, strength, and faith. Advance planning also allows us to begin making the necessary mental, physical, logistical, and spiritual adjustments to go on. It is important to sit down with trusted family advisers to decide best-case scenarios for who will oversee logistical matters at the end of life also helps ensure that the dying individual's final moments are as peaceful and uncomplicated as possible.

5 Take time to calm fears and anxieties about death and dying.

Most of us have fears and anxieties about death, and this often changes as we get older or lose loved ones. The ideal time to deal with these feelings is not when a loved one is passing. Working through your persisting fears, anxieties, discomforts, and

A Few Guidelines for How to Go On and Clear the Path Forward After a Loved One Dies

Those who wish to honor a loved one after they have passed might find these 8 Honorings to be valuable guideposts for how to go on.

THE FIRST HONORING: *Survive their death by taking exceptionally good care of yourself in the hours, weeks, months, and years to come. Clear the path forward by allowing grief, patience, loving kindness, compassion, support, encouragement, self-care, and deep sorrow. Say yes to the things that help you and no to the ones that do not.*

THE SECOND HONORING: *Do something good in their name. Whether this is as simple as lighting a candle, or donating to a cause, or as complicated as helping another family, or starting a not-for-profit foundation, find ways to give your love for them expression in the world.*

THE THIRD HONORING: *Cultivate a spiritual relationship with them. You may not know the true nature of life and death with 100% certainty, but you can still give yourself permission to tell them you love them, listen to them, and share the unbreakable bond you have for one another.*

THE FOURTH HONORING: *Embody and cultivate some special quality that they possessed. If they were kind, become the kinder version of yourself. If they were playful, become more like that.*

THE FIFTH HONORING: *Take the high road in dealing with family members and friends who may not know exactly what to say or do. Treat others kindly and patiently in the rawness of your grief.*

THE SIXTH HONORING: *Summon newfound courage to slowly begin writing new chapters of life.*

THE SEVENTH HONORING: *Speak to and treat yourself with self-compassion and kindness rather than self-criticism, condemnation, or impatience.*

THE EIGHTH HONORING: *Find ways to balance your sorrow and despair with joy, hopefulness, rest, and exercise.*

Some Do's and Don'ts of Grief Support

Working in the field of grief literacy (a term I coined) and over 45 years of assisting the dying and their loved ones, I have discovered a few do's and don'ts of grief support that I invite family members, friends, neighbors, coworkers, and mental health professionals to consider.

DO

1 Be patient, kind, and gentle with yourself. Working with individuals who are dying and their loved ones takes courage, compassion, patience, and strength. Give yourself time to acquire the skills and temperament to work with those who are dying. Give yourself permission to not always know what to say or do, or when to be silent, hold someone's hand, tear up, feel sorrow, and be human.

2 Become a trusted confidant who knows how to quiet your own mind enough to tune in carefully and patiently to what a dying patient has to say. Repeat their words back to them and leave them confident that you are willing and able to listen and understand what they are going through. There is an old saying: "People don't care what you know until they know that you care."

3 Share the ground rules and guidelines for how you would like to work with them. Find out if they are OK with it and ask if there is anything else they would like to be a part of your work together.

4 Ask the dying patient or their family open-ended questions free of hidden messages. Hidden messages may be interpreted as critical, instructional, or judgmental and can diminish the trust, safety, and confidence that they need to find some measure of peace.

5 Stop trying to fix, heal, or change the dying person. By listening, asking open-ended questions, and being a calm and healing presence, you are affording them an opportunity to find the answers within. Leave them feeling listened to and understood. This helps them feel supported at a time when they might otherwise feel utterly alone.

6 Help them open up, unburden themselves, deliberate their options, make important decisions, and take action. This helps to counter feelings of helplessness.

7 Once they have gained greater clarity about what they want, help them consider concrete action plans such as writing or saying goodbyes to loved ones, leaving clearer instructions for what they wish to happen after they die, rendering apologies to those they have hurt, and taking care of legal/financial matters to reduce the possibility of chaos and conflict.

8 Be a safe person, resource, and advocate with whom the dying patient and their loved ones can be 100% honest about their brokenheartedness, fear, anxiety, guilt, anger, remorse, and unfinished business—or their deep gratitude, appreciation, blessings, and peace.

9 Talk with them about what they are doing or could be doing to find some measure of peace. Discuss books, music, audiobooks, podcasts, mental health resources, and programs that can help them and their loved ones find peace.

10 Show respect and sensitivity by asking for permission to bring up an issue. Be a safe, caring, patient, respectful, and trustworthy resource.

DON'T

1 Do not say or do anything that leaves a dying patient or family member feeling that they should not be feeling the way they are feeling.

2 Do not use clichés, anachronisms, scripture, canned poetry, or pop psychology to try to heal faster, feel better, be more positive, or have faith.

3 Do not take it personally if they do not follow your advice, directions, prescriptions, beliefs, and suggestions. Meet their resistance and reluctance to follow your lead by accepting acknowledgments about things being too difficult, too uncomfortable, or not helpful, and get back on track by following their lead.

4 Do not try to convince them that you understand what they are going through before having a deep discussion with them. Citing examples from your own life and experience alone is not going to win their trust.

5 Do not inadvertently begin to rush them through their grief by overcongratulating them on their progress or commenting on how long it takes for them to grieve. Do not pathologize their grief or introduce terms like closure and recovery when what they are going through is natural and normal.

6 Do not give unsolicited, impractical advice by telling them what to say or do. Do not resort to a "circle of life," "going to a better place," or "grief closure and recovery" talk unless you have been invited to comment. Bite your tongue and listen.

7 Do not take things personally, become defensive, get into arguments, lose your cool, or become contentious.

8 Do not ambush, surprise, embarrass, or startle the patient by reintroducing a new issue or bringing up an issue from the past.

9 Do not try to be the mental health expert who has all the answers. Familiarize yourself with other grief resources and share the wealth.

sorrows and giving yourself time to deal with these emotions can be enormously helpful for dealing with your own death and/or that of a loved one. Talking to a trained grief and loss therapist, counselor, coach, or clergyperson; getting grief literacy training; or reading/listening to a good book about loss can be enormously helpful.

6 Find good quality palliative or hospice care.

There are some very good palliative and hospice care doctors, nurses, and doulas. Do your research on who they are and interview the most highly recommended candidates to make sure they are a good fit for your loved one. Having caring, qualified, and communicative end-of-life caregivers ensures that they will receive the care they need.

7 Honor the wishes of the dying person and their family.

The dying individual will need time to put their house in order, including the legal, financial, and psychological matters. This can pay off in countless ways for the patient and their family. A skilled and trustworthy estate planning attorney can help handle potentially complicated matters before death. Professionals trained in end-of-life care can be there to support the family following the death. Answering impossibly difficult questions with family members, doctors, and lawyers belatedly is too often a formula for unnecessary confusion, chaos, and conflict.

Following these 7 simple guidelines does not take away the uncertainty, fear, and uncertainty that can come with the end of life. They can, however, help the patient and their loved ones avoid unnecessary complications and share in the sacred moments of unconditional love, gratitude, trust, affection, and faith that can be a part of life coming to an end.

Concluding Thoughts

Facing the end of our own lives, going through the death or dying of a loved one, or working with someone who is dying and their family requires a rare blend of personal and professional skill, strength, confidence, and courage.

Dr Druck is the author of *How We Go On: Self-Compassion, Courage, and Gratitude on the Path Forward* and a leading expert on grief and loss. Since losing his daughter, Jenna, in a tragic accident in 1996, he has been a lifeline to countless families after 9/11, Sandy Hook, and Columbine, providing road maps for how to go on after life's most difficult losses, challenges, changes, and opportunities. A renowned speaker, coach, consultant, and author, Dr Druck lives in Del Mar, California, and can be reached at www.HowWeGoOn.com and www.kendruck.com. ■

PREMIERE DATE: September 20, 2024
EXPIRATION DATE: March 20, 2026

This activity offers CE credits for:
1. Physicians (CME)
2. Other

All other clinicians either will receive a CME Attendance Certificate or may choose any of the types of CE credit being offered.

ACTIVITY GOAL

To inform readers of how best to provide end-of-life care to patients with psychiatric disorder.

LEARNING OBJECTIVES

1. Describe and discuss the nature and causes of hastened death in patients with psychiatric disorders, including foreseeably hastened death.
2. Describe potential roles for palliative care in psychiatric patients with treatment unresponsive late-stage psychiatric disorders.

TARGET AUDIENCE

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

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PEER REVIEWED

End-of-Life Care for Patients With Psychiatric Disorders

Joel Yager, MD; Jonathan Treem, MD; and Thomas B. Strouse, MD

Caring for psychiatrically healthy individuals at the end of life is typically emotionally taxing and burdensome. Caring for individuals with psychiatric disorders at the end of life is often considerably more challenging.

Most individuals aspire to a “good death,” typified by being free from physical pain, lucid, in dignified circumstances, attended by loved ones, surrounded with flowers and family photos, leaving a legacy, anticipating a positive obituary, experiencing few regrets, and having prepared a will and a prearranged funeral.¹ Practically speaking, fewer individuals probably experience such good deaths than not,² and such good deaths are undoubtedly less frequent among patients with psychiatric disorders.

Individuals with psychiatric disorders frequently have foreshortened lives. Average life expectancies are often a decade or 2 shorter than population averages. Among individuals with mental disorders, approximately 67% of deaths are due to natural causes, 18% to unnatural causes, and the remainder to other or unknown causes (Figure 1).³⁻⁵ Added burdens include adverse medication effects, poor social conditions, greater difficulties accessing health care, poor self-care, alienation from or contentious relations with families, increased rates of accidents and homicides, and, at times, repeated self-harming behaviors.

In contrast to individuals with psychiatric disorders who die “with” their disorders but from natural causes such as cardiovascular diseases or cancer, some individuals die “from” their psychiatric disorders, documented as immediate causes on death certificates.⁶ Whereas many patients with psychiatric disorders are beset by conditions that indirectly contribute to their deaths (eg, obesity), other processes contribute more directly (eg, tobacco, alcohol, and other substance use disorders) or are directly consequential (eg, inescapable, persistent suicidal ruminations or command auditory hallucinations leading to suicide) (Figure 2). Although specific causes of death in psychiatric patients have been categorized in detail, trajectories leading to these deaths have been less well delineated, particularly toward the end of life.

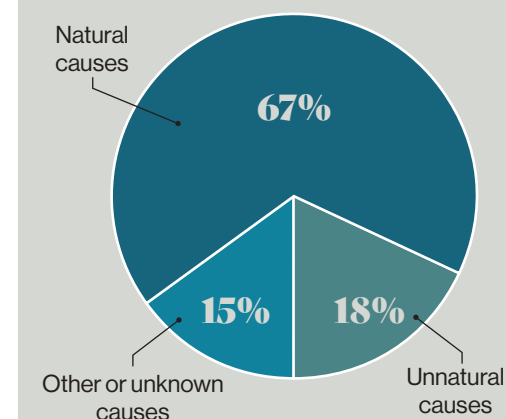
Some individuals who die from their psychiatric

disorders face predictably foreshortened lives, such as those with persistent severe difficult-to-treat alcohol and other substance use disorders, unrelenting suicidal impulses, and severe and persistent eating disorders. Some of these individuals manifest trajectories characterized as “slow suicides.”⁷⁻⁹ These patients have often been told or have said to themselves, “If you continue to act this way, you are going to die.” Too often, they are correct. These difficult-to-treat conditions sometimes result from patients not responding to available treatments and sometimes from rejecting treatment. Despite some clinicians' reluctance to acknowledge that psychiatric disorders can themselves be the cause of death, at end of life some psychiatric disorders clearly result in terminal conditions, as sometimes seen in patients with anorexia nervosa.^{10,11}

Individuals demonstrating foreseeably foreshortened lives have been tentatively characterized as manifesting “likely fatal trajectories” (LFTs), which sometimes culminate in “end-stage psychiatric disorders.”¹¹ Individuals with psychiatric disorders on an LFT demonstrate the following characteristics¹¹:

1. Relentlessly or cumulatively self-destructive behaviors, no single one intended or likely to be lethal, but which at some point may result in a lethal episode (ie, the straw that broke the camel's back). Examples: escalating alcohol use, substance use, slow starvation or gorging,

FIGURE 1. Cause of Death Among Individuals With Mental Disorders³⁻⁵



extreme risk-taking or other self-injurious behaviors, repeated injection with unknown substances.

2. Intermittently or consistently showing attitudes of despair, hopelessness, loss of dignity, sometimes accompanied by self-destructive thoughts indicating that, at least momentarily, they no longer care about whether they live or die—about what happens to them (“Who cares?!”).
3. Characteristics irrespective of legal status or decisional capacity; irrespective of active, ineffective, intolerable, inaccessible, or refused treatment; and irrespective of whether the individual expressly indicates a wish to die.

Despite best efforts by families and professionals to intervene and reverse these downward courses, these processes sometimes accelerate to the point where patients’ death trajectories are highly unlikely to be reversible. At these points, patients could be considered to be dying “from” their psychiatric disorders, entering end stages of LFT.

End-Stage Psychiatric Disorder

- The individual demonstrates a clinical status and persistent behaviors increasing in intensity and/or severity, associated with deteriorating psychiatric disorders and increasing frailty. These conditions clearly can lead directly, inevitably, and at times irreversibly to hastened natural or unnatural death. These can be seen in individuals with severe anorexia nervosa whose BMIs fall precipitously and who nevertheless refuse to eat or accept treatment, in individuals with alcohol use disorder who continue to drink alcohol despite suffering from severe liver failure and cirrhosis, and in individuals with treatment nonresponsive psychotic illness who repeatedly follow command hallucinations to throw themselves down on the ground, resulting in devastating and eventually fatal neurologic injuries.
- Absent (or sometimes, despite) major changes in treatment acceptance/adherence/efficacy, clinical opinion estimates that death is likely to occur within months to no more than several years.
- These characteristics are present irrespective of legal status or decisional capacity; irrespective of active, ineffective, intolerable, inaccessible, or refused treatment; and irrespective of whether the individual expressly indicates a wish to die.

Caring for Patients at End of Life

Specific guidance regarding how to care for patients with psychiatric disorders at the end of life has received insufficient attention, particularly for those with foreseeably foreshortened lives. For patients who are not agreeable to participating in treatment, much remains to be learned about whether and when restrictive interventions might be effective, legally permissible, and ethically justified.¹¹ These interventions are always difficult to effect and may cause patients and stakeholders considerable iatrogenic traumas, distress, and loss of dignity.

Absent effective treatments, clinicians are still morally obligated to care for these patients and minimize their suffering. Both mental health and

general medical clinicians involved in long-term care with these patients are likely to understand the importance of their ongoing relationships; these clinicians would be disinclined to simply stop all care despite a patient who is uncooperative or refuses disease-modifying treatments. In some instances, unless suitable and meaningful referrals are made, clinicians’ withdrawal from treatment could constitute abandonment. These circumstances offer opportunities to introduce palliative approaches.

As its primary aim, palliative care prioritizes quality of life, providing care consistent with a patient’s goals, and preventing and relieving suffering.¹² Palliative care approaches have been deemed appropriate for patients with psychiatric disorders at certain points of clinical care, usually when patients have stopped responding to and/or stopped participating in recovery-oriented care but still hope to mitigate suffering from their disorders and circumstances. Diagnoses suitable for such care mentioned by scholars include refractory schizophrenia, bipolar disorders, major depressive disorders, and anorexia nervosa.¹³⁻¹⁵ Exactly when palliative approaches can be instituted depends on patients’ clinical status, skills of clinicians in describing and implementing care plans, and patients’ acceptance of these approaches.

The mainstay of palliative care is an interdisciplinary, whole-person therapeutic assessment and care plan that emphasizes physical, social, emotional, spiritual, and relational health; privileging therapeutic alliance; compassionate witnessing; and quality of life. When aptly applied, palliative care improves quality of life, caregiver burden, and end-of-life care outcomes, and decreases acute care use and costs.^{16,17} When patients become debilitated and demonstrate limited life expectancy, goals focus on spiritual wholeness and peaceful death. Wherever possible, compulsory interventions are avoided.

Eligibility for hospice care under Medicare can be established when a person has a 6-month or less expected survival resulting from the expected progression of their qualifying illness. In practice, end-of-life care, including hospice care, is often instituted when patients are days to weeks away from death.¹⁸ Most studies show that patients dying from psychiatric disorders are less likely to receive palliative or hospice care and more likely to die alone or in nursing homes than in the presence of their families.¹⁹⁻²⁵ For example, studies from Australia, New Zealand, and Canada suggest that patients with serious mental illness are 2 to 4 times less likely than others to access palliative care services in the last months of life.²⁴ Rather

than “death with dignity,” patients dying from psychiatric disorders are more likely to experience “death with indignity.”

These factors underscore the importance of developing palliative and hospice care providers specially trained on issues that might be anticipated in caring for patients with psychiatric disorders and their families, and for empowering nonspecialists who are comfortable providing meaningful palliative care.²⁶⁻²⁸

Accordingly, as patients with psychiatric disorders approach end of life, wherever possible caregivers are advised to engage patients and their families in developing patient- and family-centered care plans so that patients’ and families’ physical, social, and psychiatric needs can be recognized and addressed, to assist coping and reduce suffering. Advance care planning should address preferences concerning palliative and hospice care, including attempts to address where patients wish to die. Hospice services should be provided at home, nursing homes, hospitals, or other facilities. Although assuring “good deaths” can be challenging, system-

atic efforts can assist patients with psychiatric disorders to achieve deaths with dignity rather than indignity.

Contemporary discussions concerning end-of-life issues of patients with psychiatric disorders also raise considerations of medical aid in dying (MAiD) for patients with intractable suffering attributed to their disorders.²⁹ The Netherlands, Belgium, Luxembourg, and Switzerland currently permit MAiD for patients with intractable suffering due to psychiatric disorders, and Canada is now scheduled to follow suit in 2027.³⁰ Over time, public opinion in these countries has shifted toward increasing acceptance of such interventions.³¹ However, no jurisdiction in the US authorizes MAiD for such purposes. Numerous, fraught, and divisive cultural and ethical considerations are at play.³² Some distinguished American psychiatrists have objected to any considerations of MAiD for patients with psychiatric disorders. Their objections have been based on religious, historical, and cultural arguments, all of which have influenced contemporary ethical formulations by professional societies. Controversially, they often claim that all patients with psychiatric disorders are so vulnerable that they cannot be granted the agency or decisional capacity necessary to make autonomous decisions involving MAiD. Nevertheless, we can anticipate learning a great deal from the European and Canadian experiences, observing how opinions concerning these issues evolve among various American subpopulations, and seeing what transpires if permissive legislation is passed in 1 or more states.

FIGURE 2. Conditions that contribute to death in patients with psychiatric disorders

Indirectly

- obesity

Directly

- tobacco
- alcohol
- other substance use disorders

Directly consequential

- inescapable
- persistent suicidal ruminations
- command auditory hallucinations leading to suicide

Case Study Example

This case study is adapted from reference 33. “Ms Adams” was a 30-year-old woman who presented to clinic, referred by her primary care physician, for help managing her psychiatric medications. Her weight was 64 pounds (body mass index [BMI] of 10.9). Ms Adams suffered anorexia nervosa, binge-purge subtype, and obsessive-compulsive disorder (OCD), first diagnosed at age 19. She described multiple episodes of prior treatment, including 2 attempts at residential eating disorder programs, a 2-year inpatient certification, and several more years of participation in an eating disorders day hospital program. She limited herself to no more than 300 calories daily, ran up to 2 hours every day, and had multiple exercise rituals. She participated in several months of medication management, supportive therapy, and case management in the clinic, during which time she incurred repeated injuries due to passing out, hitting her head, and dangerous falls while exercising. Consequently, she was involuntarily hospitalized.

Ms Adams refused eating disorders treatment, and no eating disorder program would accept her on an involuntary status. All the local, highly experienced eating disorder experts who had worked with Ms Adams extensively over the past 10 years were consulted. They all considered her anorexia nervosa to be refractory to treatment with any currently available method.

The medical center’s ethics committee was consulted but had no experience or points of reference regarding how to manage this patient, who was chronically a danger to herself, unwilling to engage in further treatments, and unresponsive to all prior attempts to treat her involuntarily. Hospital attorneys opined that Ms Adams would most likely not meet criteria for court ordered guardianship. The patient’s family, overwhelmed and burned out, refused to assume guardianship.

Given her history, treatment, and resource limitations, and in the opinion of hospital attorneys, there were no legal grounds for prolonged forced intervention. The treatment team and the ethics committee determined that her impairments were likely to lead to her death. At the request of staff and with the patient’s consent, the palliative care team met with the patient, the patient’s family, and the outpatient treatment team, including psychiatry and internal medicine, to discuss shifting Ms Adams’ care to a palliative treatment stance.

The clinicians explained that Ms Adams would receive no further involuntary treatment for her eating disorder. If she chose to pursue treatment, she would be assisted, but the staff would not

force her into any involuntary placements or impose any treatment she did not want. There would be no weigh-ins, no calorie or exercise monitoring, no intramuscular medications, and no required therapy sessions. She would be offered outpatient therapy only as she felt desirable and necessary. Psychiatric medications would be prescribed as the patient deemed necessary to help manage depression, anxiety, and insomnia. The patient would receive weekly visits from a palliative care nurse, who would work with her to manage her symptoms and keep her comfortable. The palliative care team eventually agreed to work with Ms Adams and agreed to provide her with support regardless of her belief that she was not likely to die from her condition. She was discharged from the hospital weighing 85 pounds (BMI of 14.6).

Immediately upon discharge, Ms Adams resumed her strict caloric restriction and exercising, leading to new stress fractures. During 1 emergency department visit, she weighed 55 pounds (BMI 9.4), with blood pressure of 40/30. Given her precarious weight and ongoing self-destructive behaviors, the treatment team prognosticated that her life expectancy would be short, and home hospice services were offered. After several weeks of palliative care and further emergency department visits, Ms Adams eventually became so weak that she was moved to an inpatient hospice, where she died 3 weeks later.

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CLINICAL REFLECTIONS

New-Onset Racism or Psychosis?

Rimsha Arif, MD; Vikas Manjunath, MD; Bhavana Muppavarapu, BSc; and Andrew J. Lancia, MD

Racism is not usually considered a psychotic symptom and therefore it is not often considered in the diagnosis of schizophrenia. Typically, early signs of schizophrenia consist of negative symptoms, such as social withdrawal, decreased capacity for conversation, and neglect of daily living activities. Development of negative symptoms may precede the emergence of positive symptoms, such as hallucinations and delusions, by several years, in what is often called the prodromal phase of schizophrenia.

The ideas that a person is exposed to during the prodromal phase can influence the later delusions.¹ Regardless, initial treatment remains largely the same: the initiation and titration of antipsychotic medication, with regular assessments for reduction of symptom burden as well as improvement of insight. Delusions are notoriously difficult to treat, often requiring prolonged treatment with incomplete resolution of symptoms. As insight improves, patients may become candidates for cognitive behavioral therapy adapted for psychosis, in which rational challenges of psychotic symptoms may be attempted.² However, the goal of treatment remains the reduction of symptom burden rather than the complete resolution of the delusions.

Little research has been done on the development of racist and sexist beliefs as a manifestation of a developing psychotic illness. Thus, this case study serves as an exploration of the similarities and differences between more typical prejudicial beliefs vs prejudicial beliefs developed as manifestations of psychosis. It is particularly relevant given the prominence of race and gender issues in cultural and medical discussions. The prominence of these topics suggests we may see more cases of psychosis involving similar delusions in the near future.

CASE STUDY

“Vishwa” is a 31-year-old Indian woman who presented to the emergency department (ED) in a mid-western city for evaluation of homicidal ideations and bizarre thoughts. Vishwa had no significant prior psychiatric or medical history. Vishwa’s parents reported that for the past 3 years, their daughter had been working in a large city in a southern state as a consultant after completing an engineering degree from a top-ranked US university followed by a master’s degree from a top-ranked US business school. Her long-term relationship ended 6 months prior to presentation, and her employment had ended approximately 3 weeks prior. The circumstances surrounding both events remained unclear, with Vishwa indicating that her employment ended due to her workplace not recognizing her talent. She had moved back in with her parents in their home in the Midwest after the end of her employment.

Vishwa’s parents reported that 3 weeks prior, she made statements that women are inferior and that Black men and women are slaves. Vishwa’s parents insist that such ideas have never been espoused in their home, family, or community. Her mother noted that Vishwa had previously commented on the introduction of diversity, equity, and inclusion initiatives in her workplace in the past year and thought Vishwa developed these beliefs about women and Black individuals in response. Her father hypothesized that Vishwa had a negative experience with women or Black individuals while working at her last job, possi-

bly having been passed over for a promotion in light of her comments about her unrecognized talent. Her parents also reported that she had become more withdrawn and blunted in the past 6 months.

A first-break psychosis workup was unremarkable. In the ED, she refused to speak with or accept treatment from Black or female staff. She expressed wanting Black individuals and women killed due to their inferiority, and she used derogatory and dehumanizing terms such as “rapist,” “baboon,” and “whore.” She emphasized that she would only speak to and cooperate with “white-enough men,” which included White men.

There were minimal symptoms present suggestive of depression, mania, anxiety, posttraumatic stress disorder (PTSD), or substance use. Vishwa did not have a history of paranoia or hallucinations. However, throughout the course of her acute illness, her expression of prejudicial delusions was constant and consistent, with no significant amenability to rational challenges. In defense of her delusions, Vishwa appealed to concepts from genetics. When the logic of her arguments was challenged, she became simpler in her assertions and did not engage. She did not appear to be responding to internal stimuli. She did not have pervasive disorganized speech or behavior except for when she intermittently spoke in short, agrammatical phrases to communicate demands to staff. She did exhibit blunting of affect consistently.

Vishwa was initiated on risperidone 0.5 mg twice

daily for 3 days. Her family had concerns about the risk of tardive dyskinesia while she was on risperidone. Therefore, with her family’s input, the medication was changed to olanzapine 5 mg nightly and titrated up to 10 mg twice daily. She continued her racist and sexist commentary, such as “females and Black males are unclean.” She disrespectfully commanded Black males, telling them to bring her the dinner tray, have the bathroom cleaned, and clip her fingernails, saying, “Go ahead, slave.” She was verbally abusive toward women, using the phrases “heinous woman,” and “dirty female rapist.”

The delusions and behaviors did not improve on olanzapine; thus, Vishwa was cross-titrated onto paliperidone. Significant improvement in her interactions with staff was noted once she was taking paliperidone 9 mg. She was willing to speak with her clinician, a White woman, after refusing to do so since the beginning of the admission. Her thought process became more logical about why she referred to individuals as “rapists.” Departing from the standard definition, she explained her use of the term referred to those she deemed responsible for causing her mental and emotional abuse.

After reaching a target dose of paliperidone 12 mg daily, Vishwa became more future oriented and appropriate in her interactions. She began inquiring about her treatment plan and was motivated for discharge. She spoke to staff members respectfully and no longer referred to anyone by derogatory terms. Vishwa stated that she did not recall her behaviors throughout admission, and she was surprised to hear of how she spoke with staff members, noting that she does not think about individuals based on race and gender and would never speak to others in such a manner. However, she continued to have a blunted affect, and certain bizarre beliefs persisted, such as her insistence that her mother was “sinless” and that her father was “White,” despite her family being of an Indian ethnic background.

Discussion

Vishwa’s delusions centered on race and gender. She used derogatory terms and expressed homicidal ideations with no fear of consequence or concern for her actions. This change in behavior in a 31-year-old woman in conjunction with the development of negative symptoms suggests a diagnosis of schizophrenia. Her symptoms did not respond to olanzapine 20 mg daily. As an adequate dose of paliperidone was reached, she had complete resolutions of prejudicial delusions and improvement of negative symptoms, but she continued to have bizarre delusions regarding her parents.

The way Vishwa expressed her delusional and bizarre thinking was unique; she was absolute and unyielding in her thinking when it came to Black individuals and women. She remained fixated on her disdain even in situations where passive cooperation would have benefited her personally. She persisted in her beliefs and maintained her superiority despite her and her family members falling outside of the demographics that she deemed to be acceptable. Her commitment to these beliefs despite their contradictions with her own personal and professional experiences raises the question: What was driving the specific content of Vishwa's delusional beliefs?

Notably, Vishwa's delusions focused on members of minorities that have been prominent in recent discussions in the media. Her delusions regarding race and gender seemed to align with extremist views that tend to surface in response to efforts to promote racial and gender diversity in society, paralleling nonidiosyncratic beliefs held by many individuals without a diagnosed mental illness. Although the full clinical picture of Vishwa's behaviors suggests she was exhibiting delusions related to psychotic illness, the prevalence of similar beliefs in the public makes it unclear how many of her espoused beliefs she was sympathetic to prior to developing psychosis vs the beliefs being a result of exposure during the period of heightened vulnerability as she was developing psychosis.

Racial biases have been discussed through the lens of psychiatric illness and psychotherapy by researchers going as far back as the 1940s, after World War II. Three cases demonstrated examples of prejudicial ideations against ethnic minorities with relevance to classically recognized psychiatric illness.³ One case described a patient who developed prejudicial beliefs as a type of negative alteration in cognition and mood, suggestive of PTSD. The prejudicial beliefs diminished with behavioral modification therapy of the trauma-related symptoms. Another case discussed a patient who underwent a similar trauma with development of PTSD, but instead he held related prejudicial beliefs prior to undergoing the inciting traumatic experience, and, in contrast, these beliefs did not diminish with similar treatment. The third case described a scenario where outgroup bias resulted in significant impairment of social functioning, and the patient's prejudicial behaviors also did not respond to psychotherapy. These cases suggest it may be prudent to distinguish new-onset prejudicial ideations from preexisting ideations as a relevant prognostic factor.

In the aforementioned cases, prejudicial ideations were delineated by therapists in the course of the patients receiving treatment for previously diagnosed psychiatric disorders.

There have been proposals for new psychiatric disorders that would identify prejudicial ideations as constitutive of psychopathology,

typically in the family of personality and anxiety disorders rather than psychotic disorders. Such classifications would be expected to have major cultural implications, as highlighted by Pouissant, who proposed the concept of "extreme racism" as a type of delusional disorder in response to a period of several publicized racially motivated killings.⁴ He wished to oppose the legitimization of such behaviors by pathologizing the paranoid thinking that motivated many of these killings.

On the other hand, the ramifications of considering racial prejudice within the realm of psychiatric disorders must be considered.⁵ Firstly,



to consider a collection of symptoms as constituting a disorder, there is the general standard that it must cause clinically significant suffering and/or incapacity. In Vishwa's case, there was a clear case for incapacity. However, suffering is a much more subjective criterion that may be controversial to establish in many cases of racial prejudice. Nonetheless, efforts are being made to develop tools to measure such suffering, such as the Outgroup Hostility Scale.⁶ Additionally, one must consider the effect of such a classification on the criminal justice system, given the disparate way we address hate crimes vs crimes related to manifestations of psychiatric illness.

Efforts to target racial prejudice have been explored in several research studies. Different interventions to target these biases have been studied including implicit bias training, diversity and inclusion training, cognitive behavioral therapy, and exposure therapy. The general trends show a reduction in expression of racial bias and implicit gender bias through training.⁷⁻¹⁰ However, when outcome measures are untethered to more direct measures of suffering or incapacity, it is unclear to what degree these interventions are genuinely promoting well-being vs successfully training individuals to express more socially acceptable sentiments. However, in cases where expression of nonsocially acceptable sentiments causes significant friction between individuals and the social systems they interface with, a case can be made that decreases in such expressions is indeed therapeutic.

Other factors relevant to the treatment of racial prejudice include cognitive functioning. Studies show individuals with higher cognitive abilities such as Vishwa may not respond to treatments designed to reduce prejudicial beliefs with the same reliability as the general populace. This may be understood as being due to a greater ability to create and maintain rationales supporting their preexisting beliefs.¹¹ Also documented are studies demonstrating there is resistance to changing falsely held beliefs despite being presented with contradicting evidence, suggesting that such beliefs are prone to a sort of inertia that resists correction.¹²

Concluding Thoughts

In summary, this case highlights a patient's delusion of racism that was treated appropriately with antipsychotic medication leading to resolution of symptoms. It is important to realize that individuals express racist thoughts and views but would not be considered to have delusions. In instances where, for example, patients admitted to the psychiatric unit make racist remarks, the treatment plan does not shift to ensure that the patient no longer is racist. In this case, Vishwa's parents say that the racist remarks were new, warranting further evaluation of these symptoms.

Vishwa's appropriate response to the medication treatment also supports that racism was a part of her psychosis and not an inherent part of her racial biases.

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How to Integrate Psychopharmacology and Foster Sustainable Addiction Recovery

Hyong Un, MD

In the evolving landscape of substance abuse and addiction treatment, the integration of psychopharmacological interventions is a pivotal, yet underutilized, strategy for fostering sustainable recovery. As the medical community increasingly recognizes addiction as a complex and chronic brain disorder, we must progress beyond general acknowledgment. Psychiatric clinicians should manage substance use disorders with integrated psychosocial and pharmacologic approaches.

Contextualizing Medication

Understanding the synergy between medications and psychosocial approaches enables us to better address barriers and advocate for a paradigm shift toward comprehensive care for addiction. The use of medication-assisted treatment (MAT) represents a fusion of medical and psychological interventions tailored to address the complex nature of addiction. It encompasses a spectrum of medications approved by the US Food and Drug Administration (FDA) designed to mitigate the neurobiological effects of substance use disorders (SUDs).

It is crucial to acknowledge that medication alone does not constitute comprehensive treatment; rather, it should complement other evidence-based therapeutic interventions. Personalized care that factors into patient preference needs to be considered when tailoring treatments that may be based on abstinence or harm reduction.

Promoting Sustainable Recovery

When integrated with psychosocial therapies, MAT is a foundation for SUD treatment and offers a path to successful sustained recovery. By increasing patient survival rates, enhancing treatment retention, and mitigating the risk of relapse or overdose, MAT addresses addiction with similar clinical efficacy afforded to other chronic diseases.

MAT not only improves patient survival but also increases retention in treatment programs, lowers the risk of relapse or overdose, and enhances patients' ability to gain and maintain employment, fostering their reintegration into

society and familial connections. Moreover, MAT interacts synergistically with counseling, community, and peer support, amplifying its efficacy.

It is encouraging to see emerging evidence that supports this approach. Recent data from the Recovery Centers of America (RCA) care model show a 20% reduction in readmissions when patients use MAT, which is a higher rate of reduction than the national average.¹

Empowering Patients

Too often, patients with addiction are met by others with blame and dismissal rather than with empathy and support, like a patient with cancer or diabetes might receive. It is assumed by some that SUD is episodic and that a patient should recover and move on. In reality, SUD requires ongoing management and support.

By developing comprehensive recovery plans tailored to individual needs, fostering accountability, and cultivating a supportive network of patients' peers, families, and caregivers, psychiatric clinicians can enable long-term recovery and transformation in patients' lives. At RCA's 11 inpatient and outpatient treatment centers across the US, this includes holistic approaches ranging from recovery support fellowship to stress management techniques to peer support that complement MAT by addressing the interconnected dimensions of recovery.

Providing these resources and treating the *whole person* is working, and we are seeing positive outcomes using the Brief Addiction Monitor questionnaire. During inpatient care, protective scores (improvements in recovery-oriented behavior to protect against relapse such as spirituality, attendance at self-help programs, and confidence in sobriety) increased by 13%, whereas risk scores (reductions in risky relapse-related behaviors such as sleeping issues, cravings, and feelings of depression/anxiety) decreased by 59%.¹

Overcoming Barriers

To catalyze a paradigm shift in addiction treatment, psychiatrists must confront prevailing misconceptions and be more proactive in looking for signs of substance abuse. By destigmatizing addiction, fostering open dialogue, and integrating MAT into routine clinical practice, clinicians

TABLE. Integrating MAT Into Routine Clinical Practice

- **Regular screening:** Psychiatrists should consistently screen patients for substance and alcohol use disorders.
- **Early interventions:** Where appropriate, brief interventions advising patients to cut back on their use or misuse can be effective. This facilitates ongoing conversation with the patient and, where appropriate, early referral to treatment.
- **Address stigma:** Despite the effectiveness of MAT in improving patient outcomes, pervasive stigma and barriers such as access and cost impede its widespread adoption. Overcoming these hurdles requires a concerted effort to educate stakeholders and cultivate a supportive ecosystem around MAT implementation.
- **Supportive system of care:** Once in treatment, patients need a system of care, from provider teams to family and friends, for the best chance at lasting recovery. Supporting patients' ability to stay in treatment and sustain recovery will make these patients better family members, employees, and contributors to society.

can promote sustainable recovery (**Table**).

Approaching addiction as a chronic disorder will enhance the effectiveness of existing treatment. When psychiatrists fully embrace psychopharmacological interventions as integral components of addiction treatment, patients can begin a journey toward sustainable recovery. By combining medication for the treatment of addiction with psychosocial interventions, clinicians offer individuals with addiction new avenues for healing and hope. We must navigate this evolving landscape with compassion, innovation, and a commitment to the overall well-being of our patients.

Dr Un is the chief medical officer at Recovery Centers of America.

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With MDMA on Hold, What's Next for Psychedelics?

Heidi Anne Duerr, MPH

In what could have been a landmark approval, the US Food and Drug Administration instead issued a complete response letter (CRL) for midomafetamine (MDMA)-assisted psychotherapy (MDMA-AT) for posttraumatic stress disorder (PTSD), requesting an additional phase 3 trial to examine safety and efficacy.¹ (*For complete coverage of the decision and reactions, please visit [psychiatrytimes.com](https://www.psychiatrytimes.com).*)

As this issue went to press, Lykos Therapeutics told *Psychiatric Times* that they were seeking a meeting with the FDA and were committed to finding a path forward. Lykos has asserted that the requests and questions could be addressed “with existing data, post-approval requirements or through reference to the scientific literature.”¹

More in the Pipeline

As Lykos and the FDA continue their tango, other psychedelic compounds are proceeding with trials for psychiatric conditions. Hot on the heels of the MDMA-AT announcement, Atai announced positive preliminary results from their phase 1b trial of VLS-01/VLS-01-BU, an oral transmucosal film formulation of *N,N*-dimethyltryptamine (DMT) indicated for treatment-resistant depression (TRD). Previous research has indicated that intravenous DMT, a partial agonist of the 5-HT_{1A/2A/2C} receptors, can result in rapid-acting and durable antidepressant effects in patients with major depressive disorder (MDD). The company expects the buccal film formulation to be as effective as IV administration, with the added convenience of not needing a needle.²

The phase 2 study is anticipated to start at the end of 2024. It will consist of 2 treatment periods and will be a randomized, double-blind, placebo-controlled trial assessing the safety, efficacy, and durability of response of repeated doses.

Numinus is also pioneering psychedelic-assisted therapy. Following the FDA’s CRL decision, Payton Nyquvest, Numinus Founder and CEO, told the press, “While this is a blow to all the incredibly positive and encouraging work that has been done to advance safe access to psychedelic therapy... we remain unwavering and committed to doing all we can to make these important therapies available for all those suffering who need it most.”³

Numinus recently announced it will be a study center for a phase 3 trial of Cybin’s CYB003, a proprietary deuterated molecule related to psilocybin that was granted breakthrough therapy designation for the treatment of moderate to severe depressive disorder.⁴

Meanwhile, COMP360, a synthetic form of

psilocybin, is being investigated for several psychiatric disorders. In May, Compass released results of an open-label multicenter phase 2 study of PTSD, which found “early and clinically meaningful improvement,” improvement over time, and met the primary safety endpoint.⁵

“We are pleased to see the strong signal in PTSD, which, along with our prior data in treatment-resistant depression, lead us to believe that COMP360 has the potential to become an important treatment option for patients across a broad set of mental health conditions,” Kabir Nath, CEO of Compass Pathways, said in a statement.⁵

Similarly, MindBio is studying MB22001, a proprietary titratable form of lysergic acid diethylamide (LSD) available in microdoses.⁶ They completed a successful phase 2a clinical trial for MDD earlier this year. MB22001 is also in clinical trials for premenstrual dysphoric disorder and distress/depression associated with cancer.

As part of their goal “to deliver on the therapeutic potential of psychedelics and other novel compounds,” MindMed completed a phase 2 multicenter randomized, double-blind, parallel-group dose finding trial of MM-120 (LSD D-Tartrate) for the treatment of generalized anxiety disorder (GAD).⁷ They expect to initiate a phase 3 clinical trial program for the orally disintegrating tablet version of MM-120 for GAD this year.

“Few treatment options have shown robust activity in GAD,” Daniel R. Karlin, MD, MA, MindMed Chief Medical Officer, said in a statement.⁸

They also are examining MM120’s potential for treating MDD. That study is expected to start in 2025, with data available in late 2026.

In August, Awakn screened its first patient in the MORE-KARE phase 3 trial of AWKN-001 for severe alcohol use disorder. Participants in the blinded trial will be randomized to receive different doses of ketamine infusion and a form of psychosocial support. The largest study of ketamine-assisted therapy, MORE-KARE follows a successful phase 2 trial that found an 86% abstinence rate.⁹

These are just the tip of the iceberg. A search of clinicaltrials.gov found 185 clinical studies on psilocybin, 104 for MDMA, and 58 for LSD.

Lykos Makes Moves

Meanwhile, all eyes remain on Lykos and the FDA to see what’s next for MDMA-AT. The company has undergone a reorganization, which included reducing their workforce by 75% as well as focusing remaining staff on the issue at hand. As part of the plan, David Hough, MD, was newly appointed as

senior medical advisor. Hough has roots in psychiatric drug development, having served as compound leader for Invega, Invega Trinza, and Spravato.

“My hope is to build on the strong foundation Lykos has created and leverage my experience in the industry to ensure a productive ongoing dialogue with the FDA and oversee the clinical work that needs to be done to address the Agency’s questions which will allow us to serve patients safely and effectively,” Hough said.¹⁰

In addition, Rick Doblin, PhD, founder of MAPS, exited Lykos. “I can speak more freely as a public advocate by resigning from the Lykos Board,” he told press. “The FDA delays make it more important than ever that I work at MAPS toward developing global legal access to MDMA and other psychedelics for public benefit through MAPS’ multidisciplinary research, education, and drug policy reform.”¹⁰

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Tales From the Clinic The Art of Psychiatry

Series Editor Nidal Moukaddam, MD, PhD

In this installment of *Tales From the Clinic: The Art of Psychiatry*, we discuss agitation and how it can mimic various psychiatric illnesses. Agitation, possibly leading to aggression, is a major issue in emergency centers. The role of psychiatry in acute settings, such as emergency departments (EDs) and consultation-liaison services, often entails managing agitation and diagnosing and then managing underlying mental illness when applicable. This topic was chosen because of the pervasiveness of the issue, the severity of the impact of agitation (believed to cause burnout and turnover in staff and physicians), and the possibility of misdiagnosing an agitated patient with mental illness when the etiology, as in this case, is in fact medical.

Agitation Assessment: The Role of Psychiatry in Acute Settings

Heba Mesbah, MD, PhD

CASE STUDY “Edward” took his wife to the ED, expressing deep concern for abrupt changes in her behavior. He explained that she had been missing for a day and returned at 5 AM, completely naked except for a coat, which was not even hers. Despite being relieved that she was alive, Edward was terrified by her state and was worried that she might have been sexually assaulted. His wife, “Susan,” is a 61-year-old woman with schizophrenia who had been taking her medication as prescribed. However, she had recently babysat her friend’s grandchildren and exhibited unusual behavior by being verbally abusive. She then fought with the child’s mother and left the house at 2 pm. When Susan did not return home by 5 pm as expected, Edward grew concerned and contacted the friend, who did not know her whereabouts. He filed a missing person report.

In the ED, Susan displayed signs of anxiety and agitation and was talking incessantly. She also claimed that her husband was not her husband but confirmed that she had been taking her medication as prescribed. Susan was placed in a psychiatric bed in the ED to wait for medical evaluation and psychiatric assessment. Meanwhile, a patient next to her experienced hallucinations and talked to herself. Susan became agitated and attempted to leave the room, but the nurse was able to redirect her. However, Susan’s agitation worsened, and she began to scream and insisted on leaving. Her nurse activated a security call, and Susan was given medications on an emergency basis and restrained in her bed until the medications took effect. Susan was found to have a urinary tract infection and required parenteral antibiotics. She was then admitted to the medical ward with no subsequent agitation.

Discussion

Aggressive behavior and agitation in patients with a psychiatric disorder are significant challenges in the ED, where medical and traumatic emergencies are routinely managed, and time and space are scarce. The potential for escalation to aggressive behavior—which may put patients, staff, and providers at risk—makes it imperative to address agitated behavior rapidly and efficiently. Time constraints and limited access to psychiatric support have pushed emergency providers to rely on emergency medications and physical restraints, a strategy previously referred to as restrain and sedate,¹ though that term is no longer used or sanctioned.

Patients with borderline personality disorder displayed the highest aggression rate, reaching up to 73%, whereas patients with schizophrenia experienced agitation ranging from 10% to 45% during hospitalization.^{2,3} Patients with bipolar depression, on the other hand, exhibited aggression at a rate of 12.2%.⁴

A nationwide poll conducted by the American College of Emergency Physicians in 2018, which included over 3500 emergency physicians, revealed that almost half of them had experienced physical assaults on the job, with 60% of these occurring within the past year. Furthermore, a 2016 survey of 119 emergency medicine residents indicated that 66% had been physically assaulted by patients, whereas only 16.8% had received prior training in violence prevention.⁵

Agitation affects patients with and without mental illness. It is easy to assume that agitation reflects a mental etiology, though it is often a nonspecific manifestation of disease.⁶ The

TABLE 1. Causes of Agitation

Trauma	• Burns	• Head injury
Infection	• Syphilis • Meningitis, encephalitis	• Sepsis from other infections
Toxicologic	• Adverse drug reaction (including serotonin syndrome, neuroleptic malignant syndrome, and steroid-induced psychosis)	• Overdose or intoxication • Sedative-hypnotic agent withdrawal
Respiratory	• Hypoxia	• Hypercarbia
Cardiovascular	• Shock	• Hypertensive encephalopathy
Thermoregulation	• Hypothermia	• Hyperthermia
Metabolic/endocrine	• Acidosis • Hyper- or hypoglycemia • Electrolyte abnormalities • Hyper- or hypocortisolism • Hepatic or uremic encephalopathy	• Nutritional deficiency (eg, Wernicke encephalopathy) • Thyroid disorders (eg, thyroid storm, myxedema coma)
Nervous system	• Stroke • Tumor • Seizure • Vasculitis	• Hemorrhage • Hydrocephalus • Neurocognitive impairment
Psychiatric	• Psychosis • Mood disorders with psychotic features	• Substance intoxication or withdrawal

evaluation of a patient’s medical condition begins during the initial assessment, when they are assessed for red flags such as abnormal vital signs, trauma, and abnormal neurologic examination results, which indicate life-threatening issues that require immediate attention.⁷ A more comprehensive evaluation is then conducted

once it is safer to do so. Information from outside providers, bystanders, and significant others can be crucial in determining the cause of agitation. The most common life-threatening causes of acute agitation are listed in **Table 1**. The role of the psychiatry team is to assist in management and help elucidate etiology, as well as to guide psychotropic agent choices, especially in patients with underlying mental illness. A collaborative, comanagement approach works best when both teams are involved since a patient's arrival.⁸

Assessing Agitation

The severity of agitation and risk of violence must also be determined using a validated tool to quantify the assessment. Predicting aggression and agitation among patients with psychiatric disorders in busy EDs is difficult. The use of violence risk prediction scores is crucial for decision-making, but the process can be complicated.

Several aggression/agitation scores are available. Although many of these scores have broad applicability, their usefulness in the ED setting may be limited. Furthermore, the number of scores that have been validated in the ED setting is quite small, and their effectiveness and impact on patients are still under study.

We will provide an overview of some established aggression prediction scores used in emergency settings. The Behavioural Activity Rating Scale⁹ is one such score, developed by pharmaceutical companies to evaluate agitation in drug trials. It categorizes patients into 7 levels of agitation: unable to arouse, very sedated, sedated, calm, agitated, very agitated, and dangerously agitated. Although it has been recommended by "Best Practices for Evaluation and Treatment of Agitated Children and Adolescents" and is used to assess agitated patients in the ED, the scale has limitations, including a lack of proven effectiveness in reducing violent incidents, security activations, and the need for mechanical restraints.

The Brøset Violence Checklist (BVC)¹⁰ is a tool designed to predict short-term violence by assessing symptoms such as confusion, irritability, boisterousness, verbal threats, physical threats, and attacks on objects, which are rated as present or absent. The BVC has been further validated through its inclusion in an occupational violence and aggression recognition program implemented in an Australian ED. However, it should be noted that this validation was based on a single study conducted in a single health care system.

Computer vision is another promising tool that can be used for this purpose. It aims to equip computers with the ability to interpret and comprehend a visual world. One application is human activity recognition, which automatically identifies and analyzes human activities using data gathered from various types of sensors.¹¹

Although no direct evidence exists to suggest that computer vision and cameras can predict aggression in patients, some related studies have

TABLE 2. Psychotropic Medications Used for Agitation

Drug name	Receptors affected	Route of administration	Adverse effects	Possible life-threatening reaction
Haloperidol	D2-D3, σ , α_{11}	Oral (tablets and oral solution), IM, IV	EPS	None
Olanzapine	2-D3, 5-HT _{2A} , 5-HT _{2C} , α_1 , H1, M1-M5	Oral (regular and dispersible tablets), IM	Sedation	Respiratory depression
Risperidone	D2-D3, 5-HT _{2A} , 5-HT ₇ , α_1 , H1	Oral (tablets and oral solution)	Sedation, EPS	None
Benzodiazepines (lorazepam, diazepam, midazolam)	GABA _A (positive allosteric modulator)	Oral (except midazolam), IM, IV	Sedation, paradoxical reactions	Respiratory depression
Aripiprazole	D2-D3 (partial agonist), α_1 , 5-HT _{2A} (antagonist)	Oral, IM	Sedation or akathisia	None
Ziprasidone	5-HT _{2A} , D2-D3, 5-HT ₁ (partial agonist)	Oral, IM	Minor sedation, usually well tolerated	Cardiac arrhythmias
Dopridole	D2-D3	IM, IV	EPS	Cardiac arrhythmias

used cameras and artificial intelligence to detect signs of aggression in hospitals.¹² The system uses video cameras strategically placed in a hospital and employs artificial intelligence to detect indications of aggression. It then connects to the nurse call and alerting system to summon help in cases of conflict, potentially preventing injuries to staff and other patients. Medications used to treat agitation range from sedatives/hypnotics to antipsychotics.¹³ Mechanism of action and possible adverse effects are presented in **Table 2**.

One of the major challenges is that patients with psychiatric disorders are labeled as disruptive or aggressive. Labels can be harmful and stigmatizing and can lead to biased psychological labeling. This can lead to negative feelings toward the patient when the patient returns to the ED. Instead, it is important to focus on identifying the underlying cause of the behavior and addressing it appropriately. This can also lead to burnout in caregivers.

Concluding Thoughts

Agitated patients presenting to the ED can escalate to displaying aggressive and violent behaviors with the potential for injury to themselves, the ED staff, and others. Agitation is a nonspecific symptom that may be caused by, or result in, life-threatening conditions. A standardized strategy to identify patients before agitation would allow this vulnerable population to be treated appropriately while increasing the safety of medical staff. The potential to assess the probability of a patient becoming agitated can be measured using one of many objective risk scores. Although many of the scores have a wide range of applicability, they may have limited utility in the ED setting. Machine learning algorithms in conjunction with computer vision technology can

identify indicators of aggression and promptly notify relevant personnel. Furthermore, computers are not prone to fatigue and can continuously monitor these behaviors.

Dr Mesbah is an assistant professor in emergency medicine at Baylor College of Medicine.

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The Department of Psychiatry is a national leader in addiction, biological, child and adolescent, and public sector, psychiatry, neuropsychiatry, psychosocial rehabilitation, and women's mental health. We integrate our clinical, research, teaching and community partnership activities to help individuals and families transform their lives through recovery from mental illness and addiction. We are the largest provider of psychiatric services in central Massachusetts, with over 400 faculty members and 12 hospitals and community mental health centers in varied settings across the state.

Our residency program trains 7 residents per year, including general psychiatry and specialty tracks for combined adult and child psychiatry and combined psychiatry and neurology. We offer fellowships in Addiction, Adult Developmental Disabilities, Child and Adolescent, Forensic Psychiatry, and Neuropsychiatry.

Diversity, equity, and inclusion are integral to the commitment of the Department and University. Accordingly, the Department seeks qualified candidates who can contribute to racial equity, diversity and inclusion through service, mentorship, teaching and scholarship. Candidates from historically underrepresented group(s) in higher education and medicine are encouraged to apply. Candidates who possess personal characteristics that might be considered as diversifying elements among the clinical team and the larger psychiatry faculty at UMass Chan are invited to identify themselves during the application process.

UMass Chan Medical School

Facility Medical Director (Brockton Multi-Service Center, Brockton, MA)

- Provides administrative and clinical oversight for the DMH-operated and contracted state hospital and community support programs. Clinical Care in our Partial Hospital program.

Attending Psychiatrists, Southeast Area –Brockton, Fall River and Taunton MA

Assistant Director of Psychiatry, Director of Child and Adolescent services, Adolescent Continuing Care Units (ACCU) -provides child and adolescent clinical leadership and comprehensive psychiatric care to adolescents admitted to the ACCU in Worcester, MA

Interested applicants should apply directly at <https://academicjobsonline.org/ajo/UMASSMED/Psych> (J-1 and H-1B candidates are welcome to apply)

Full-Time Attending Psychiatrist, Worcester Recovery Center and Hospital (WRCH)

Full-Time Attending (Forensic) Psychiatrist, Worcester Recovery Center and Hospital (WRCH)

Full-Time Child & Adolescent Attending Psychiatrist, Worcester Recovery Center and Hospital (WRCH)

Forensic Psychologist, Law and Psychiatry Program, Mobile Forensic Evaluation Service, Worcester, MA

For additional information on the above, please contact Brian Daly, MD, Vice Chair, Public Sector Psychiatry
bdaly@communityhealthlink.org

UMass Memorial Health Care

Medical Director- Health Alliance with clinical consultation Part-Time

Medical Director- Community Healthlink Part-Time

Attending Geriatric Psychiatrist – Clinton Hospital provide direct clinical services and work with medical students & residents on this teaching unit Full-Time

Attending Psychiatrist – Inpatient Psychiatric Treatment and Recovery Center Full-Time

Attending Psychiatrist- Inpatient Full-Time

Attending Psychiatrist- Inpatient Consultation-Liaison Full-Time

Attending Psychiatrist- Emergency Mental Health Services Full-Time

Interested applicants should submit a letter of interest and curriculum vitae addressed to Kimberly A. Yonkers, MD c/o Krystal Vincent krystal.vincent@umassmemorial.org Careers (myworkdayjobs.com)

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

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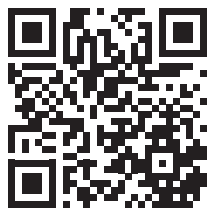
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Hackensack Meridian Health

Department of Psychiatry Physician Opportunities

Multiple Positions & Locations in New Jersey

At Hackensack Meridian Health we're ready to help you advance your career! As the area's premier provider of psychiatric services, Hackensack Meridian Behavioral Health Services has provided comprehensive mental health and substance abuse services to the residents of Monmouth, Ocean, Middlesex, and Bergen Counties for over forty years. Due to continued growth and expansion, we are currently accepting applications for Psychiatrists to join our Mental Health and Addiction Interdisciplinary Teams in the following positions:

- **Addiction Psychiatrist (consult service):** Jersey Shore University Medical Center (Neptune, NJ)
- **Child and Adolescent Psychiatrist (consult service):** Hackensack University Medical Center (Hackensack, NJ)
- **Inpatient:** Hackensack University Medical Center (Hackensack, NJ), Carrier Clinic (Belle Mead, NJ)
- **Outpatient Psychiatrist (addiction fellowship preferred):** Hackensack University Medical Center (Hackensack, NJ)
- **Outpatient (forensic fellowship preferred):** Ocean University Medical Center (Brick, NJ)
- **Outpatient (adult psychiatrist):** Jersey Shore University Medical Center (Neptune, NJ) Ocean University Medical Center (Brick, NJ), Hackensack University Medical Center (Hackensack, NJ)
- **Per Diem Inpatient/CL/EPS Opportunities Available:** Per Diem inpatient/consult opportunities are available at all hospital locations. Send your CV today!

WHAT WE CAN OFFER:

- A dynamic network of experienced physicians, specialists, and support staff who foster a culture of collaboration and mentorship with strong clinical support.
- Eligibility for faculty appointment to the Hackensack Meridian Health School of Medicine.
- Highly competitive compensation package
- Robust benefits package

REQUIREMENTS:

- M.D./D.O. degree from a recognized Medical or Osteopathic School
- BC/BE in appropriate specialty board
- Have or the ability to obtain a New Jersey Medical License, CDS, DEA

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For immediate consideration please contact:
Allison Vogel • Senior Physician Recruiter
Email: Allison.Vogel@hmhn.org
Phone: 908-418-8014

Hackensack Meridian Health School of Medicine is re-defining graduate medical education, research, and clinical practice; reversing the critical physician shortage in both the New York/New Jersey metropolitan area and the nation; and stimulating economic development in northern New Jersey.

The School of Medicine serves as an anchor in the development of a comprehensive health sciences campus that includes research facilities and biotechnology endeavors – all in service of educating tomorrow's doctors, discovering novel therapies, and facilitating compassionate and effective healthcare that will meet the ever-changing needs of tomorrow's patients.

The School of Medicine is the cornerstone of a dynamic venue for the exchange of ideas, the development of healthcare and research thought leaders and practitioners, and the discovery of novel therapies to meet the medical challenges of the future.

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

To learn more, visit us at: www.HackensackMeridianHealth.org.

Hackensack Meridian Health - Keep Getting Better.

California



Psychiatrist Position Excellent Opportunity in California

Imperial County Behavioral Health Services is currently recruiting for full-time or part-time psychiatrists. Imperial County, a rich farming area with a population of 180,000, is located 90 miles east of San Diego, 90 miles south of Palm Springs, 60 miles west of Yuma, Arizona, and just north of the cosmopolitan city of Mexicali, Mexico. San Diego State University maintains a satellite campus in Calexico, and there are several private and public universities located in Mexicali. Imperial County's location and diversity make it the perfect place for any professional.

The position pays a highly competitive salary, including health benefits for you and your family, requires no hospital work and minimal after-hours work, freeing you up for more leisurely activities. As a Psychiatrist with Imperial County Behavioral Health, you will be part of a multi-disciplinary treatment team that includes therapists, nurses and rehabilitation technicians that provide comprehensive support and resources to assist clients in achieving recovery.

J-1 and H1-B Applicants welcome. Our agency is experienced in successfully processing J-1 Waiver and H-1B Visa applicants.

Qualified candidates must have a CA medical license or ability to obtain. Send CV to Imperial County Behavioral Health Services, 202 North 8th Street, El Centro, CA 92243.

For additional information, please contact: Marey Sesma (442) 265-1605
icbhpsychiatry@co.imperial.ca.us



Outpatient Psychiatry Opportunity - San Joaquin County Behavioral Health Services is seeking to fill Outpatient Adult [General], and Sub-Specialty Psychiatry (Child Psychiatry, Geriatric, Forensic, Addiction and Psychosomatic Medicine) positions in a multidisciplinary, recovery-

oriented clinical setting. Services are provided either on-site or using a hybrid model of on-site and tele-psychiatry practice. The positions offer a very competitive salary with a guaranteed base, plus incentive opportunities, board certified Psychiatrists have the potential to easily earn over 300K+ a year; comprehensive health insurance; up to three retirement and pension programs; 35 days of vacation and CME time that increase with tenure. Signing and moving bonuses are also available. Interested J-1 and H-1B candidates are welcome to apply. Fax your CV to 209-468-2399 or email to BHSadministration@sjcbhs.org. EOE

Tennessee



The Quillen College of Medicine's Department of Psychiatry at East Tennessee State University

Psychiatry and Behavioral Sciences – 31560 / College of Medicine Faculty

• Faculty member to serve as a Child Psychiatry Consultation-Liaison Director for a new Child and Adolescent Fellowship.

The candidate should be, or is eligible to be, a Board-Certified Child Psychiatrist who has completed, or is near completion of, a Child Fellowship. Candidate should possess excellent communication and teaching skills.

• Faculty member to serve as an Assistant Residency Program Director.

The candidate should be Board Certified or Board Eligible and possess excellent communication and teaching skills.

Faculty rank and salary commiserate with education and experience. Some appointments may be eligible for tenure.

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MILLERNA2@mail.etsu.edu

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Psychiatry- Assistant Professor - 24000001JR

The Department of Psychiatry at the University of Tennessee Health Science Center is seeking a full-time psychiatrist. The position is at the faculty rank of Assistant Professor or above, and consists of clinical care, clinical supervision of trainees, departmental and university service, and teaching. Primary clinical care responsibilities will be adult outpatient psychiatry and inpatient adult consultation liaison psychiatry.

The Department of Psychiatry at the University of Tennessee Health Science Center is a growing and thriving department that is actively recruiting faculty in several areas.

JOB REQUIREMENTS: MD or DO or equivalent, Board certification or Board eligibility required. Completion of an accredited residency or equivalent as permitted by state law is required and sub certifications/training highly preferred. International Medical Graduates who completed a psychiatry residency abroad may be eligible for faculty

appointment without retraining in the US. At the time of start, current licensure as a Physician in Tennessee, current DEA certification number, eligible for malpractice insurance, relocation is not required, however the work is on-site.

Must be able to work with residents / fellows, medical students, and other trainees.

For benefits information, please visit <https://www.uthsc.edu/hr/benefits/documents/benefits-preview-packet.pdf>

Applicants should have a demonstrated commitment to and knowledge of equal employment opportunity and affirmative action.

Applicants should have a demonstrated commitment to and knowledge of equal employment opportunity and affirmative action. Interested individuals should include curriculum vitae, with names and addresses of two professional references.

Contact: Ronald L. Cowan, MD, PhD, Chair, Department of Psychiatry, UTHSC, 920 Madison Avenue, Memphis, TN 38163
Email: rcowan3@uthsc.edu
EOE

The University of Tennessee is an EEO/AA/Title VI/Title IX/Section 504/ADA/ADEA/V institution in the provision of its education and employment programs and services.

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