May was mental health awareness month. On May Day, Gallup released a survey of which we as a profession need to become very aware.

Gallup surveyed 2226 Americans regarding their perception of mental health care (https://news.gallup.com/poll/644144/americans-perceive-gps-mental-physical-healthcare.aspx). That survey included a grading system, which we can read in part at least as an assessment of the mental health professions, which obviously would include psychiatry. The results were as follows: 57% of Americans gave us a grade of F or D. 27% were more generous and gave us a grade of C. Only 8% were willing to give a B and 1% an A. Let’s just translate these numbers again. 99% of Americans are not willing to give us a grade of A. 91% of Americans give us a grade of C or less. Most Americans rate us as failing or near-failing: D or F.

A natural reaction could be to blame others: the insurance companies, the broken health care system, the court system, stigma. And those systemic issues certainly bear part of the blame, but not all of it. We should be able to take some of the responsibility ourselves too. We cannot say without self-deception that we’re fine; everything else is bad.

Indeed the Gallup poll did address these other systemic issues and found them to be relevant. Americans recognize that stigma and affordability are limiting factors for better mental health care.

These systemic issues need to be addressed, but you can make the system as good as you like, if other factors, which are more clinical and scientific, are not fixed, we will still fail our patients. Let me give you an example:

I had a friend in Canada who had a severe depressive episode in his late 60s, the second in his life. He had a happy marriage, financial security, many friends. There was no external cause. He was given sertraline, which made him slightly hyper for a few hours, and the dose was eventually maximized, and other antidepressants were given, and other antipsychotics. Over months his episode waxed and waned, with some suicidal ideation. He went to the emergency room a few times, and was set up with an outpatient psychiatrist, and psychiatric nurses visited him in his home twice weekly. The structure of the care he was given was impeccable: he had his primary care, a specialist psychiatrist, in-home nursing - and all free. His diagnosis and treatment followed DSM definitions and FDA regulations exactly. He just didn’t get better. One morning he awoke, went to the roof of his high rise, and jumped.

I knew him well. I knew that he met the definition of hyperthyroid temperament (mild manic traits as part of one’s personality), which is not in DSM. I knew that his few “hyper” hours were manic symptoms; we talked about it at length, with increased libido, energy, and racing thoughts – the opposite of depression. I knew that those manic symptoms, and his baseline manic temperament represented mixed depression, not “major depression”, which ignores presence or absence of manic symptoms of less than four days duration (without any scientific evidence for that cut-off). I knew that antidepressants make mixed depression worse and increase suicidality in that condition (based on published data). I knew that lithium reduces such suicidality, but he never gave it.

In short, I can provide a strong scientific rationale for why his diagnosis and medications were wrong, but one would have to go outside the DSM box. The exclusion of mixed depression from DSM has never been based on a strong scientific rationale. The insistence of “major depression“ as being legitimate when it includes mixed states with other conditions has never been proven scientifically. These are just decisions made by DSM committees by fiat. The problem is not just that they may be wrong, but that if they are wrong, they can be deadly, as in the case of my friend.

We follow the rules, but we don’t ask enough how well proven those rules are.

A skeptic reader might say that any treatment can fail, and this could just be one of those cases, and that many other people improve. The Gallup poll says otherwise: It tells us that these failures aren’t exceptional. Remember, we get an A only from 1% of the public.
Beyond Pride Month: How to Be a Better Ally Every Day

As another Pride month comes and goes, I find myself pondering on what it means to be an ally. I think most of us, if not all of us, can relate to being in a social situation where someone makes a joke in poor taste, uses an inappropriate word or even bluntly makes a derogatory remark. There may be some awkward laughter involved or more often deafening silence as we try to make sense of ourselves and how to respond to this uncomfortable situation?

I had an experience in the hospital where a nurse felt quite comfortable expressing their discomfort by a male patient’s painted fingernails. This nurse went on to make some off-color comments which shocked and offended me. The comments caught me off guard and I didn’t know what to say or how to react at the moment, especially as a new resident. Luckily, my attending was by my side and was simultaneously empathetic towards the nurse while also redirecting them and suggesting that they keep those comments to themselves in the future. I felt fortunate not only to know that I was not alone in my feelings but also to have my attending lead by example.

For many people, gay bars like the Stonewall Inn served as safe havens where folks could openly be themselves and socialize without fear of condemnation. Stonewall was particularly important because transgender individuals and drag queens were welcomed there as these folks were typically not accepted at other gay establishments. Gay bars were often penalized and shut down as serving alcohol to suspected LGBTQ+ individuals was “disorderly.” To make matters more complicated, many of these gay bars were owned by the mafia and operated without liquor licenses. The mafia would pay off corrupt police officers who would tip off the bars before raids which allowed owners to hide whatever illegal activity that was going on. However, on June 28, 1969 Stonewall was not tipped off and armed police officers raided the bar, assaulted patrons and arrested 13 people including those who isolated the state’s gender-appropriate clothing statute (which was enforced by having female officers check individuals’’ sex in the bathroom). Instead of dispersing, which was the norm, patrons and neighborhood residents fought back which turned into a riot involving hundreds of people. Although the crowd was eventually dispersed, protests continued for 5 days after the event. Interesting fact: the Stonewall Rising was not the first of its kind. Three years earlier and on the other side of the country, police raid of a popular hangout for transgender and queer people in San Francisco called Compton’s cafeteria. When the police were getting rough with the customers they fought back and protesters gathered there the next day. These events are defining moments for LGBT+ political activism.

On the one year anniversary of the Stonewall Uprising, thousands of people marched from the Stonewall Inn to Central Park which became known as America’s first gay pride parade.

One month after the parade, Black Panther Party co-founder Huey P. Newton published a letter in the party newspaper titled “A Letter from Huey to the Revolutionary Brothers and Sisters About the Women’s Liberation and Gay Liberation Movements.” In the letter he recognized gay individuals as an oppressed group and called for recognition of the Gay Liberation Movement. This example of allyship highlights how one can recognize their own privilege and use that to amplify the voices of those from marginalized communities. It also exemplifies the fact that recognizing and addressing the ongoing issues of the past involves education that is understanding and learning and re-evaluating, in which a person in a position of privilege and power seeks to operate in solidarity with a marginalized group. Historically, the term ally has been associated with LGBTQ+ communities. Let’s pause for a brief history lesson.

Many people are familiar with the Stonewall Uprising which to many sparked the start of the gay liberation movement. The Stonewall Inn was a gay bar in New York City’s Greenwich Village. Around the time of the uprising in the late 1960s, gay bars like the Stonewall Inn were frequently subjected to harassment and police raids. Same-sex relations were illegal in New York City as most other places at the time and raids. Same sex relations were illegal in New York City as most other places at the time and raids.

RESIDENT FELLOW MEMBER CORNER

Brianna Rowan, MD

Have we got a career for you!

We have several exciting opportunities to join the Psychiatry Department at Emerson Hospital, a vibrant community hospital located in historic Concord, Massachusetts. We are currently looking for a Medical Director/Department Chair of Psychiatry as well as a full-time physician and moonlighting opportunities.

• Treat patients on our adult inpatient unit
• Collaboration with medical colleagues
• Enjoy a competitive salary and compensation package

Boston, MA

Emerson Health

Inpatient Psychiatry

About Concord, MA and Emerson Health

Emerson Health is a regional health system providing advanced healthcare to more than 300,000 people across 25 towns in Massachusetts. We make high-quality healthcare more accessible to those who live and work in our community at Emerson Hospital in Concord, health centers in Bedford, Groton, Sudbury, Westford, and Concord, and Urgent Care settings in Hudson, Littleton, and Shirley.

Emerson has strategic alliances with several academic centers in Boston, including Mass General Brigham and Massachusetts Eye and Ear Infirmary.

Concord, MA and the surrounding communities are among the best places to live in Massachusetts, with several top-ranked school systems in the state and located just 20 miles west of Boston.

For inquiries, please contact:

Diane Forte Willis
Director of Physician Recruitment and Relations
dfortewillis@emersonhosp.org
Phone: 978-287-3002 | Fax: 978-287-3800

(continued on page 3)
ATTENDING POSITIONS IN PSYCHIATRY AT MASSACHUSETTS GENERAL HOSPITAL

The Massachusetts General Hospital Department of Psychiatry has outstanding attending opportunities in several practice settings. Part- and full-time positions are available in our Primary Care Psychiatry outpatient clinics, on our Substance Use Disorder team, in psychiatric and medical subspeciality outpatient groups, and on our emergency psychiatry service. Opportunities in our affiliated community health centers are also available.

In addition to clinical work, there are teaching and research opportunities at Mass General and Harvard Medical School (HMS) for the appropriate interested candidate. Qualified applicants are strongly encouraged to apply for a faculty appointment at HMS in Psychiatry at the rank of Instructor or above. Candidates should be board certified/eligible in Psychiatry and have (or be able to apply for) a Massachusetts medical license. Additional board certification and/or fellowship training in relevant subspecialties, as well as a record of scholarly productivity, are highly desirable but not required.

Interested individuals should apply to Jeff Huffman, Associate Chief of Psychiatry for Clinical Services (jhoffman@partners.org).

We are an equal opportunity employer and women and minorities are highly encouraged to apply. All qualified applicants will receive consideration for employment without regard to race, ethnicity, religion, sex, national origin, disability status, protected veteran status, gender identity, sexual orientation, pregnancy and pregnancy-related conditions, or any other characteristic protected by law.

Cambridge Psychiatric Services

Interested in flexible, competitive pay rates, and a schedule that fits your needs?

Qualified psychiatrists, residents, and psychiatric nurse practitioners wanted to provide overnight, weekend, and holiday moonlighting coverage at a Boston area psychiatric facility. Shifts can vary from weekly to monthly based on your desire and availability. Shifts are scheduled typically 3 or more month in advance to accommodate work and life demands. Total compensation ranges between $900-2300, with additional pay per admission.

For more information please call Jessica D’Angio at (617)864-7452 or at jdangio@northcharles.org

MPS Bulletin - July/August 2024

Massachusetts General Hospital

Child Psychiatrist Opportunity, Near Boston, MA

Mass General Brigham Salem Hospital has an exciting opportunity for a child psychiatrist to join a thriving and growing psychiatric service in Salem, MA. Salem Hospital is part of the prestigious Mass General Brigham health care system, and the Department of Psychiatry is closely aligned with Massachusetts General Hospital (MGH).

The position is based in the outpatient department, providing care for children and adolescents and collaborating with primary care providers and psychotherapists. In addition to direct care the physician will have a role in the Massachusetts Child Psychiatry Access Program (MCAP), providing consultation to pediatricians as well as evaluations of their patients.

Salem Hospital provides a full spectrum of psychiatric care, including a 35-bed child and adolescent inpatient unit, adolescent partial hospitalization program, child and adolescent ED consultations, as well as similar services for adults. Inpatient care is provided at the Epstein Center for Behavioral Health, a spectacular, newly renovated facility that provides unique outdoor recreational space for patients. We have a vibrant educational program, and teaching opportunities and an academic appointment are available. Physicians in the department enjoy a collegial and supportive practice environment.

Compensation is very competitive. The call schedule is very reasonable and requires no in-house coverage.

Salem is located on the North Shore of Massachusetts, only 15 miles north of Boston. This region features all the advantages of proximity to a wonderful metropolitan area.

Interested candidates should forward their CV to Louis Caliguiri, Executive Director of Physician Recruiting at lcaliguiri@partners.org.

Salem Hospital, a member of Mass General Brigham, is an affirmative action/equal opportunity employer. Minorities and women are strongly encouraged to apply. The position is eligible to participate in the federal Public Service Loan Forgiveness Program.

Cambridge Psychiatric Services

Interesting in flexible, competitive pay rates, and a schedule that fits your needs?

QUALIFIED PSYCHIATRISTS, RESIDENTS, AND PSYCHIATRIC NURSE PRACTITIONERS WANTED TO PROVIDE OVERNIGHT, WEEKEND, AND HOLIDAY MOONLIGHTING COVERAGE AT A BOSTON AREA PSYCHIATRIC FACILITY. SHIFTS CAN VARY FROM WEEKLY TO MONTHLY BASED ON YOUR DESIRE AND AVAILABILITY. SHIFTS ARE SCHEDULED TYPICALLY 3 OR MORE MONTH IN ADVANCE TO ACCOMMODATE WORK AND LIFE DEMANDS. TOTAL COMPENSATION RANGES BETWEEN $900-2300, WITH ADDITIONAL PAY PER ADMISSION.

FOR MORE INFORMATION PLEASE CALL JESSICA D’ANGIO AT (617)864-7452 OR AT JDANGIO@NORTHCHARLES.ORG

RESIDENT FELLOW MEMBER

35th Annual Psychopharmacology Update Conference
Saturday, November 2, 2024 (virtual)

Psychotherapy Conference
Saturday, November 16, 2024 (virtual)

SAVE THE DATES

As a resident, I understand the difficulty of being a learner and a teacher simultaneously. Training other people how to be allies while you are learning to be one can be quite effective! A good friend of mine published research on allyship in residency. They provide a didactic presentation outline on medical allyship for graduate medical trainees. It’s worth the read and consideration to replicate the workshop across all residency specialties.

I hope this serves as a beginning friendly guide on how to be an ally. There are other roles of allyship including changing system-wide issues that promote inequality and oppression as well as supporting organizations that do such work. However, I think the basics are fundamental and easy to work on day-by-day. Please remember that allyship is a process with an end-all-be-all. Misakes are bound to happen but we can give ourselves permission to be vulnerable, sit with the uncomfortable, and grow.

References:


What I raise in this example involves two matters I mentioned in my first column: first, the fact that the DSM system of diagnosis is mostly false, i.e., it has not been validated or it has been in fact invalidated; and second, that our medications are mostly symptomatic in effect, like Tylenol for pain, and not disease-modifying. These two features differentiate us from the rest of the general medicine, in a bad way. Let me explain.

We speak about parity. There is no parity, partly because of stigma, but not entirely. Another reason there might not be parity may have to do with outcomes. Now that statement will be challenged by many colleagues, and there are claims against it in the scientific literature, a point which I could criticize. But putting aside what you or I think, it matters what our patients think, what the public thinks, and there too the Gallup poll shows that most Americans think that our provision of psychiatric doesn’t much up to our colleagues in general medicine.

To quote the poll: “Overall, 38% of U.S. adults think mental health issues are handled ‘much worse’ and 37% ‘somewhat worse’ than physical health issues, while 15% say they are dealt with ‘about the same.’ 8% think mental health issues are treated ‘somewhat better,’ with 1% saying ‘much better.’” Let’s restate the numbers once again: 75% of Americans feel that psychiatric care is provided worse than physical health care, and only 15% say they are similar. Only 5% of Americans believe that mental health issues are handled better than physical health issues.

It doesn’t matter if we disagree; our patients are telling us what they experience, and we need to listen to them.

So what’s the problem? There are the systemic issues, as mentioned, and MPS has been and will continue to be active on those fronts.

But there are clinical and scientific issues, about which the APA and our profession has been in denial, and I would like MPS to be at the vanguard of honesty, finally admitting where we are failing.

It doesn’t matter if we disagree; our patients are telling us what they experience, and we need to listen to them.

So what’s the problem? There are the systemic issues, as mentioned, and MPS has been and will continue to be active on those fronts.

Back to my two points: DSM and our drugs.

DSM is mostly invalid. This should not be a controversial statement. It was stated by the makers of DSM-III themselves: they claimed reliability and admitted invalidity. They just hoped validity would improve over time. It has not, because the dictionary, as I think, has become a Bible, and we refuse to change it. We still use definitions, like MDD, almost exactly as defined in 1980 based on limited evidence of validity, and despite decades of research proving aspects of that diagnosis to be false.

Our drugs are symptomatic. Look at all the drug trials. How much do depressive symptoms improve in 8 weeks, or psychotic symptoms in 3 months, or PTSD symptoms in a few months? The drugs are developed to reduce symptoms in the short-term. That’s what they do. Nothing more. Compare it to Tylenol; it won’t be transformative because it’s just doing more of the same. It’s not fixing anything, it’s just a different form of the same, faster, nothing different.

Academic researchers and the FDA tomorrow could join together to demand disease-modifying clinical trials, not symptomatic ones, and the pharmaceutical industry would be forced to do so, as it does for every other medical specialty. Within a decade, we would have amazing new effective drugs. Instead, we have mere psychedelic drugs that just improve symptoms more quickly and more more, advocates say, without any proof (meaning randomized studies) of true long-term improvement of the course of any illness.

I recently attended the American Society of Clinical Psychopharmacology annual meeting, the main Congress bringing together the pharmaceutical industry, academic clinical trial researchers, and the FDA. The vast majority of presentations were on psychiatric drugs and their variations. I came away with the unhappy feeling that we were hustling toward a dead end. The pharmaceutical industry knows it can make billions providing these me-too psychiatric drugs, and the gullible public and profession hope for a miracle from it. There will be no miracle, because super-Tylenol is still Tylenol; it won’t be transformative because it’s just doing more of the same, faster, nothing different.

The Department of Psychiatry at Salem Hospital has an outstanding opportunity for a full-time or part-time adult inpatient psychiatrist.

**ADULT INPATIENT PSYCHIATRIST POSITION**

A MASSACHUSETTS GENERAL FACILITY

The Department of Psychiatry at Salem Hospital is an outstanding opportunity for a full-time or part-time BC/BE adult inpatient psychiatrist.

The Epstein Center for Behavioral Health is a 120-bed inpatient facility established in affiliation with Massachusetts General Hospital (Mass General) that includes two adult units, one child and adolescent unit, and one geriatric unit, embedded in a full-service medical center. Each unit includes a team of social workers and a psychiatric Nurse Practitioner to support physicians, optimize workflow, and improve patient care.

Other clinical opportunities involve possibility of participating on the Consultation-Liaison service or in the Adult Outpatient Department.

Salaries are extremely competitive. Evening and weekend call are very reasonable and provide significant additional compensation. Salem is located on the North Shore of Massachusetts, only 15 miles north of Boston. This region features all the advantages of proximity to a wonderful metropolitan area.

Interested individuals should send their CV and letter of interest to Louis Caligiuri, Executive Director of Physician Recruiting at caligiuri@partners.org. Salem Hospital is an affirmative action/equal opportunity employer. Minorities and women are strongly encouraged to apply. Pre-employment drug screening is required. The position is eligible to participate in the Federal Public Service Loan Forgiveness Program.
Two New Books from Ronald W. Pies, MD

The Ennoved Mover is a novallet recounting an un-speakable school tragedy and its traumatic aftermath. The journey from trauma to love and redemption is the heart of this gripping work.

The Anatomy of Gratitude is Dr. Pies's survey of this cen-tral ethical and psychological value, in six of the world's great spiritual traditions. Both works have immediate relevance for our patients, our loved ones, and ourselves. Available from Amazon.com

Chandler Psychological Services

Board Certified psychiatrist(s) in Massachusetts (and possibly Rhode Island) to provide as needed 2nd opinions for applicants not qualified for police, corrections, and fire service positions. Also, to provide psychiatric evaluation/opinion of police, corrections and fire service personnel undergoing Fit-For-Duty assessments. The psychiatrist will be a member and have the support of a senior, multidisciplinary team. Training/orientation will be provided. Flexible schedule. Once acclimated, telehealth utilization is possible. Competitive fee. Friendly collegial environment.

Please visit our website at chandlerpsychologicalservices.com, email at chandlerpsychologicalservices@gmail.com or call us at 508-757-7430.

References


MPS Mentorship

Thanks to the efforts of the Antiracism Committee, the Early Career Psychiatry Committee, the Retirement Committee and many others we have had a successful first year. We have approximately 45 members who are participating as mentors and mentees. Our networking event last fall was well received and we hope to do this another year.

Mentoring is crucial for growth, development, support and networking. This is especially true early in our careers or at any time we seek to make a change or to expand our horizons. It also helps us to stay on track with all the challenges we navigate in psychiatric practice.

Mentorship for BIPOC members of MPS has been identified as an important need in our discussions in the Antiracism Committee. Though Massachusetts continues to be a strong advocate for LGBTQ+ and Women’s rights there remain many challenges and the need for mentorship.

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MPS is pleased to welcome the following New Members

General Members:
- Ying Cao, MD
- Margo Funk, MD
- Katherine Goodwin, MD
- Jennifer Greenwald, MD
- Ambika Kathla, MD
- Kendra Kobrin, MD
- Susan Mahler, MD
- Destiny D. Pogram, MD
- Samuel Sheffield, MD
- Susan Szulewski, MD

Resident Fellow Member:
- Mark Kalinich, MD
- Khalid Katzar, MD
- Aashima Sarin, MD

Transfer In:
- Natasha Boleinisky, MD
- Christopher Magoon, MD
- Huseyn Bayazit, MD

For any questions, or to discuss the program contact Marie Hobart MD, coordinator at mariehobart@icloud.com

Are you interested in applying for Fellow status?

Visit the APA at www.psychiatry.org

Your application must be submitted to the APA on or before September 1, 2024.
I plan to appoint four presidential task forces this year on the following topics: social media, suicide, DSM, and the Goldwater Rule. The task forces will be asked to discuss these topics and then decide if they have consensus on any statement or action, which then can be presented to the Executive Council for its review and approval. I do not presume that all the task forces will complete their work in this presidential year, between now and next May. Nor do I presume that they will reach a consensus in all cases, nor that the Council will approve whatever they recommend. Even if one or two task forces succeed in their efforts, it will be better than nothing.

I present here some basic ideas about what the task forces could consider, and I will encourage them to discuss these issues. If you would like to be part of a task force for constructive discussion, please contact me through MPS headquarters. As the membership and chairpersons become identified, I will notify the membership and keep them updated on the activities of the task forces.

1. Social media – I will ask this task force to discuss the harmful effects of social media on depression, anxiety and negative emotions, especially in teenagers and young adults. We live in an era of a new kind of depression, a digital depression, and we have yet to come to terms with it. How should psychiatrists understand it? How is it similar or different from other depressive states? What should we recommend to parents and to schools? Is there legislation that we would support?

2. Suicide – I will ask this task force to go beyond the usual discussions on the multifactorial nature of suicide, and reach conclusions about what we might implement. One obvious but ignored intervention is lithium, which is the only drug proven to prevent suicide, and it may do so at very low doses which could be given without notable clinical risk. The task force should examine this and other interventions that we could recommend to patients at risk, such as veterans and people with mood illnesses. New medications that reduce suicidal ideation, like ketamine and its derivatives, should be discussed as well in their potential benefits and their limitations, such as the fact that they may reduce suicidal ideation but that benefit may not translate to actual suicide reduction.

3. DSM – As discussed in this month’s column, DSM perpetuates the practice of our profession, but it does not receive any cogent critique from inside the profession. Many from outside the profession attack it and many other things in their overall opposition to psychiatry. But such outside criticism should not keep us from internal analysis of what is right and what is wrong with our status quo. A benefit of DSM has been reliability, a common language; a harm has been lack of validation, or not being true. The invalidity of many DSM constructs may impair good clinical practice. We need to be more honest about this problem, and discuss the whys and wherefores. How much of a problem is validity in DSM? What should we do next? How can we do better? APA makes DSM, so our perspectives here can have a direct impact, as members of APA. I propose this a larger and more complex matter at the national level, but nothing stops a district branch from discussing it and providing its opinions.

4. The Goldwater Rule - This topic has to do with how much our profession should be active in public life. We have a vision at MPS of being a mental health advocate for the public, but to do so, we need to engage with the public, including the media and legislature and other groups. The Goldwater Rule is made by the APA as a means to restrict psychiatrists from commenting on public figures in relation to psychiatric diagnosis. It was made at a time, before DSM-III, when psychiatric diagnosis is even worse; it is now, with APA’s reliability or validity. Thus psychiatrists used terms like schizophrenia wrongly and harmfully. But the rule applies a general censorship about discussing any public figure almost in any way. This excessive restriction keeps us from providing our legitimate expertise about valid diseases to the general public when needed. The majority of APA members and psychiatrists oppose the Goldwater Rule, but the APA national organization has taken a strict and hard-line stance on it. Again, I realize that psychiatrists are sometimes more complex matter at the national level, but nothing stops a district branch from discussing it and providing its opinions. Do we think it is fine as it is? Are there ways in which it is too restrictive? Are there harms in our public role that flow from it? What would be alternatives? I have picked topics of importance for our profession, but which are either being ignored or not discussed with sufficient urgency. I do not know how much will we achieve this year. It is ambitious to move forward on all these topics. But we will start the process and see what we can achieve.

I hope I can count on the support of members to move these task forces forward and put MPS at the vanguard of state branches of the APA in trying to move our national organization, and our whole profession, forward. Again, if you would like to be part of a task force for constructive discussion, please contact me at the MPS headquarters.

Nasir Ghaemi, MD, MPH, DLFAPA
President, Massachusetts Psychiatric Society

UMass Memorial Health and the University of Massachusetts Chan Medical School currently have openings within the Department of Psychiatry.

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 groups(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.

Facility Medical Director (Cape Cod and Islands Mental Health Center, Pocasset, MA) - Provides administrative and clinical oversight for the DMH-operated and contracted state hospital and community support programs.

Facility Medical Director (Brockton Hospital, Brockton, MA) - Provides administrative and clinical oversight for the DMH-operated and contracted state hospital and community support programs.

Facility Behavioral Health Director, Brockton Hospital, Brockton, MA - board-certified psychiatric-mental health nurse practitioner (PMHNP-BC)

Full-Time and Part-Time Psychiatrists, Brockton Multi Service Center, Brockton, MA - inpatient and outpatient positions

Full-Time Psychiatric, Worcester Recovery Center and Hospital (WRCI) - inpatient position

Full-Time Clinical Psychologist, Student Counseling Service, UMass Chan Medical School

UMass Chan Medical School

Geriatric Psychiatrist, Health Alliance-Clinical Hospital, Clinton, MA - inpatient position

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

Kimberly A. Younkers, MD
4/e Krystal Bergeron
Krystal.Bergeron@umassmemorial.org

Apply directly at:
http://jobs.jobvite.com/umassmemorialmedicalgroup/phycicians/search/?q=gd-Psychiatry

For more information about the Department of Psychiatry: https://www.umassmed.edu/psychiatry/dop/
committee at large this upcoming year, while we meet more regularly to prepare in the background and discuss upcoming meetings. Primarily, we are interested in revising the membership, adjusting the meeting time to what suits the majority, consider a partial switch back to in-person meetings to allow for networking and in-person discussions, all starting with a meeting in September to introduce interested residents to the forensic psychiatry fellowships and the application process.

Psychotherapy Committee – Margaret Tuttle, MD & Stephen McDermott, MD

The Psychotherapy Committee meets on Zoom 4-5 times a year. We are a small, dedicated and collegial group of members who share an interest in the power of psychotherapy as part of psychiatric practice. Despite our small number, we have been productive. We hosted an informal presentation and discussion on “Using a Psychotherapeutic Lens to Move Cases Forward.” We were pleased to see the Psychotherapy Training Database we started a few years ago grow into a national database that is now being used by residencies and psychiatrists throughout the country.

We have also been busy planning this fall’s Psychotherapy CME Conference on “New Developments in Psychotherapy,” to be held on Zoom on Saturday, November 16, 2024. Topics will include a proposed new integrated psychotherapy curriculum for residents, psychotherapy with psychedelics (with emphasis on the psychotherapy), an innovative IOP for youth at risk for suicide (covered by insurance!), and psychotherapy in diverse communities (presented by Kevin Simon, MD, Chief Behavioral Health Officer for Boston, appointed by Mayor Wu).

All MPS members are welcome to attend our meetings, and we hope to attract some new active members! Participating in the networking, camaraderie, and creativity in our committee can be one of the joys of being a member of MPS.

Public Sector Committee – Hanaan Larsen, MD & Marcus Vercari

The Public Sector Committee meets every 2 months with a mission to advocate for policies and systems that promote mental well-being and ensure equitable access to comprehensive mental health and substance use care by collaborating with community partners, advancing legislation, providing education, and supporting monitoring the psychiatric workforce. In the past year, we held a forum to reflect on the first year of Community Behavioral Health Centers, collaborated with the Antiracism Committee on a talk by health economist and primary care physician Ben Sommers, MD/PhD reviewing the current state of Medicare and Medicaid; and welcomed MPS Legislative Liaison Lisa Simonetti to coach us on more effective advocacy. We have been following pending state legislation on crisis care, gun violence prevention, harm reduction, prior authorization, and assisted outpatient treatment. We contributed input to Mass Medical Society’s list of suggested screening tools for Behav- rioral Health Wellness exams and to the APA’s position statement on long-acting injectable antipsychotics in early psychosis. To promote sustainable careers in public sector/community psychiatry, we are collaborating with the Early Career Psychiatry Committee to host a networking and membership event in September that will feature a panel of psychiatrists with long and diverse public sector psychiatry careers. We welcome all of those with an interest in public sector work and advocacy to join us at an upcoming meeting (next: July 18 at 7pm).

Retirement Committee – Joseph McCabe, MD & Marris Stember, MD

The Retirement Committee continues to meet by Zoom three or four times a year to discuss issues that include retirement planning, closing practices, and early and later post-retirement concerns. Our next meeting will be in the fall.

We welcome all MPS members. We send out invitations to be on the committee mailing list yearly to all MPS members turning 65, and every 5 years to all members not on the mailing list who are between the ages of 70 and 75.

Since the last report, Burns Woodward resigned as cochair, and Mandy Stambler took his place. We have held four Zoom meetings since last year’s report.

Meeting 11/16/24

The topic was “Making Decisions About Retirement. What gets in the way?” Discussants were Dr. Jim Sabini, who has successfully negotiated the process, and Dr. Carl Salzman, who is “in the middle of the struggle.”

Meeting 12/14/23

The topic was “Downsizing.” Dr. Gene Fieman and Dr. Henry Schniewind, who has moved to Brookhaven, a retirement community, were discussants. Most of the discussion centered on Dr. Schniewind’s experience. There was discussion of alternatives to moving into a retirement community.

Meeting 3/13/24

The topic was “Aging in Place.” Dr. Dan Shaw has researched resources available for “Aging in Place.” Dan described services provided by the Senior Center in Newton. He recommended consultation with an Aging Life Care Professional, also known as a Geriatric Care Manager, and having one in place in case of sudden unexpected need. Other services for elders were discussed.

Meeting 5/16/24

The topic was “Working after Retirement.” Dr. Judy Feldman described her nonprofit consulting work and discussed her involvement with the Brandeis (BOLL) education program and the benefits of these activities.

Sexual Disorders – Paul Norosin, MD & Fabian Selah, MD

We, the members of the Sexual Disorders Committee, have been meeting on a regular basis. During these meetings we discuss both clinical and forensic issues, involving individuals presenting with problematic sexual behaviors and/or various forms of sexual dysfunction. We hope to have our next meeting in Sept of 2024. We may invite an outside speaker for our next meeting.

Women in Psychiatry Committee – Naomi Dworkin, MD

The Women in Psychiatry committee meets monthly on the first Monday of the month from 7:85pm, with some variations around holiday dates. The group provides a forum for peer supervision and for the exchange of information about resources for the practice of psychiatry. We also have invited speakers from time to time. We held one joint session with the Retirement Committee and that was very well received with many additional members attending. We welcome new members to join the group. Please feel free to email or call Naomi Dworkin (naomidworkin@gmail.com, 781-721-8375) if you would like to introduce yourself or have any questions about or suggestions for speakers for the committee.
Alcoholism and the Addictions – John Renner, MD, Carly Carlin, MD & Vanessa Reguitti, MD

The Alcoholism and the Addictions committee has hosted several early career speakers this academic year, including Dr. Alexis Derwa, primary care physician and addiction specialist at Boston Medical Center who spoke about international approaches to overdose prevention and substance use care. We were fortunate to host Dr. Fabiola Arbelo-Cruz from Yale School of Medicine who spoke about emerging overdose trends in Latinx communities.

This year, the MPS Addiction Committee also joined efforts with the MPS Consultation Liaison Committee to host Dr. Lisa Vercollone, Medical Director of Addiction Medicine at Brigham and Women’s Faulkner Hospital, who presented on pain management in the setting of opioid use disorder in both the hospital and outpatient settings. Our most recent speaker event this spring featured Dr. Joji Suzuki, Director of the Division of Addiction Psychiatry at Brigham and Women’s Hospital, who spoke about emerging research in ketamine treatment for substance use disorders.

The committee will continue in their leadership for 2024–2025 through the handoff of Dr. Vanessa Reguitti from BIDMC and Dr. Carly Carlin from BMC. We are actively recruiting speakers for the upcoming academic year and already have a few lined up for September and October and look forward to new opportunities to continue growing our educational network in psychiatry and addiction treatment.

Anticrime Committee – Hannah Larsen, MD & Destegn Pagm, MD

The MPS Anticrime Committee was established in 2020 and has remained committed to our mission to inspire and facilitate individual, organizational, and systemic action to dismantle racist structures and advance equity, promote equity and socioeconomic justice within psychiatry and our communities. We meet on the 1st Thursday of every month and have enjoyed engaging active members. We look for the past year to be building partnerships with others engaged in anticrime, promote equity within MPS, and advance the political economy of criminalization, mentorship and support of colleagues of diverse backgrounds and identities. In collaboration with the Early Career Psychiatry committee, we have continued to hold our mentorship kick-off event at member Sally Remyninger’s home. We launched our Spotlight On educational series, “Spotlight On a Career in Global Health,” a curated series of readings and discussions on the topic of the criminal justice system and mental health, led by Adeliza Olivero and Ruqi Tang. Marie Hobart collaborated with the Public Psychiatry Committee to host a talk entitled “Current Issues in Medical & Medicare: Improving Affordability, Addressing Inequities” and we continue to support the MPS Strategic Plan via the direct involvement of Adeliza Olivo and feedback and suggestions from the broader committee. We have actively followed the work of the Health Equity Compact in Massachusetts and are exploring ways that we might support their efforts. We continue to actively seek nominations for MPS members who feel you would be deserving of the following Outstanding Psychiatrist Awards for 2025:

• Early Career Psychiatry
• Lifetime Achievement
• Psychiatric Education
• Public Sector Service
• Research

If you have a nomination, please submit the name of the MPS member, including a brief description of how they exemplify these values. We look forward to recognizing them. You should also include a CV summarizing their work. Nominations should be sent to the attention of the MPS Awards Committee by January 31, 2022 at update@mms.org.

CME – Margaret Tuttle, MD

The Continuing Medical Education Committee continues to review and approve CME programs. After being my co-chair for the past year, Dr. Renner has chosen to step down. However, he will remain on the committee as a valuable member.

Since the last Chair and Council meeting, we reviewed and approved through April 2024 the 24th Annual Meeting of the American Psychiatric Association which was held on Tuesday, November 4, 2023 and had 158 attendees, as well as the Annual Risk Avoidance & Risk Management conference which was held on Saturday, March 9, 2024 and had 194 attendees. All requests for CME for the fall months must be received by July 8 for review at the July 15 meeting. Please note that all requests for CME programming that is not one of our approved annual programs must be shared with Debbie Brennan and leadership prior to presentation to keep our peers and program approval to ensure we have the allocated resources and of course prepare our attendees.

The CME committee has been charged with a needs assessment survey of the membership which we will be working on and sending out soon. We hope all members will participate in the survey to help us enhance our programming and ensure we are meeting your educational needs.

Consultation/Liaison – Cristina Montalvo, MD, Elliott Baker, MD & Katherine Crist, MD

The Consultation-Liaison Psychiatry Committee is led by chair Dr. Cristina Montalvo and representative, Dr. Monte Hernandez. We have continued to collaborate with the Massachusetts Psychiatric Society Committees (Alcoholism and the Addictions) and other fields including Global Mental Health and Cultural Psychiatry into career practice, and psychiatric practice in the critical care setting. We have continued to send out our annual spotlight series on a variety of topics and encourage broad participation in the election process and to fully represent our membership.

Early Career Psychiatry – Saffie Adamian, MD & Christopher Lebe, MD

The Early Career Psychiatry (ECP) group seeks to engage residents and fellows in the broader psychiatry community. We continue to provide opportunities for early career psychiatrists to connect and engage in career learning together. This past year, we hosted our annual “Disaster Psychiatry: Readiness, Evaluation, and Treatment” conference which received great interest by early career psychiatrists and provided useful but disrupted by the HP-Tufts merger. Greg Harris keeps us posted on events at Blue Shield, and we are grateful. To encourage broad participation in the election process and to fully represent our membership, early career psychiatrists, let me know.

If you have any ideas about ways we might be more useful to the membership, particularly early career psychiatrists, let me know.

Nominating – John A. Fromson, MD & Jhilam Biswas, MD

Each year the MPS elects members to leadership positions for the next term beginning April 30, 2025. The Nominating Committee will consider nominations of committee members and will send out the call to the membership for the next open positions.

Positions for Nomination:

• President-elect (3 years total – President-elect, President and Immediate Past President)
• Treasurer (2-year term)
• APA Representative (2 positions - 3-year term)
• MPS Councilor (2 positions - 3-year term)
• Nominating Committee (2 positions - 2-year term)

Watch your emails in September when we begin the process and be sure to share nominations with leadership.

Psychiatry & Law – Margarita Daou, MD, Adeliza Olivero, MD & Jane Poleci, MD

The Law and Psychiatry committee co-chairs met for the first time in May to plan for the year ahead. We will be working in different settings this year, so please feel free to reach out to us with ideas and suggestions on how we can best share with a bigger group, spanning from trainees to seasoned forensic psychiatrists. We are aiming to have quarterly meetings, if possible, to continue growing our educational network in psychiatry and addiction treatment.
Alcoholism and the Addictions – John Renner, MD, Carlylin Carlin, MD & Vanessa Reguitti, MD

The Alcoholism and the Addictions committee has hosted several educational talks this academic year, including Dr. Alexander Walley’s primary care physician and addiction specialist at Boston Medical School who spoke about international approaches to overdose prevention and substance use care. We were fortunate to host Dr. Fabiola Arbelo-Cruz from Yale School of Medicine who spoke on addressing opioid use disorders in Latinx communities.

This year, the MPS Addiction Committee also joined efforts with the MPS Consultation Liaison Committee to host Dr. Lisa Vercollone, Medical Director of Addiction Medicine at Brigham and Women’s Faulkner Hospital, who presented on pain management in the setting of opioid use disorder in both the hospital and outpatient settings. Our most recent speaker this spring featured Dr. Jordan Suzuki, Director of the Division of Addiction Psychiatry at Brigham and Women’s Hospital, who spoke about emerging research in ketamine use for substance use disorders.

The committee will have continuity in their leadership for 2024-2025 through the co-chairship of Vanessa Reuquitti from BHMC and Carlylin Carlin from BMC. We are actively recruiting speakers for the upcoming academic year and already have a few lined up for September and October and look forward to new opportunities to continue growing our educational network in psychiatry and addictions treatment.

Antiracism Committee – Hannah Larsen, MD & Desteyn Pegram, MD

The MPS Antiracism Committee was established in 2020 and has remained focused on our mission to inspire and facilitate individual, organizational, and systemic action to dismantle racist structures and advance equity. We are promoting equity and socioeconomic justice within psychiatry and our communities. We meet on the 1st Thursday of every month and have enjoyed engaged and active membership. Our goals for the past year were to build partnerships with other organizations and support the work of our committee to the MPS Strategic Plan via the direct involvement of Adeliza Pineda from the Public Sector Committee to host a talk entitled “Current Issues in Medicaid & Medicare: An Update”.

Career Psychiatry – Hannah Larsen, MD & Destiny Pegram, MD

• Early Career Psychiatry
• Lifetime Achievement
• Psychiatric Education
• Public Sector Service
• Research

If you have a nomination, please submit the name of the MPS member, who should have current details of their involvement with the committee. You should also include a CV summarizing their work. Nominations should be sent to the attention of the MPS Awards Committee by January 31, 2022 at update@mms.org.

CME – Margaret Tuttle, MD

The Continuing Medical Education Committee continues to review and approve CME programs. After being my co-chair for the past year, Dr. John Renner has chosen to step down. However, he will remain on the committee as a valuable member.

Since the last Chairs and Council meeting, we reviewed and approved CME programs for the 34th Annual Psychopharmacology Update which was held on Saturday, March 9, 2024 and had 194 attendees. All requests for CME for the fall months must be received by July 8 for review at the July 15 meeting. Please note that all requests for CME programming that is not one of our approved annual programs must be shared with Debbie Brennan and leadership prior to its presentation to keep our peers and participants informed of resources and of course prepare us to meet the requirements of our members who are eligible to be nominated for DF status (current Fellows, other names on boards of directors, and oftentimes interested by interested friends and members and others). After discussion, the Committee made its decision about whom we will invite to apply, and how best to move each application forward. The Committee will review the completed application by email during the second week of June and at that time the Committee will select the candidates that it will support and forward to the APA for its consideration by July 1.

Ethics – Don Condilie, MD

The MPS Ethics Committee currently does not have any open calls for cases or meetings available for members. If you have any ideas about ways we might be more useful to the membership, particularly early career psychiatrists, let me know.

Nominating – John A. Fronos, MD & Jhulan Blows, MD

Each year the MPS elects members to leadership positions for the next term beginning on April 30, 2025. The Nominating Committee will be soliciting nominations for candidates who will serve in 2025. We encourage broad participation in the election process and to fully represent the diverse membership of our organization.

Positions for Nomination:

• President-elect (3 years total – President-elect, President and Immediate Past President)
• Treasurer (2-year term)
• APA Representative (2 positions – 3-year terms)
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• Nominating Committee (2 positions – 2-year terms)

Watch your emails in September when we begin the process and be sure to share nominations with leadership.

Psychiatry & Law - Margarita Daou, MD, Adeliza Oliveira, MD & Beverly Piccillo, MD

The Law and Psychiatry committee co-chairs met for the first time in May to plan for the year ahead. We are all well in different settings but are happy to be able to share with a bigger group, spanning from trainees to seasoned forensic psychiatrists. We are aiming to have quarterly meetings with the committee and will meet as soon as we do to one another, on ways of dealing with prior authorizations, telepsychiatry, coding, and good suggestions and tips. And, if early career psychiatrists work for clinics, we predict that those who work for larger organizations will, sooner or later, find it helpful to use unionization, or the threat of same, to improve the quality of care.

Each of us has spent time on the roles of mental health in crisis and the use unionization, or the threat of same, to improve the quality of care.
The Retirement Committee continues to meet by Zoom three or more times a year. We are a small, dedicated and collegial group of members who share an interest in the power of psychotherapy as part of psychiatric practice. Despite our small number, we have been productive. We hosted an informal presentation and discussion on “Using a Psychotherapeutic Lens to Move Cases Forward.” We were pleased to see the Psychotherapy Training Database we started a few years ago grow into a national database that is now being used by residency and psychiatrists throughout the country.

We have also been busy planning this fall’s Psychotherapy CME Conference on “New Developments in Psychotherapy,” to be held on Zoom on Saturday, November 16, 2024. Topics will include a proposed new integrated psychotherapy curriculum for residents, psychotherapy with psychedelics (with emphasis on the psychotherapy), an innovative IOP for youth at risk for suicide (covered by insurance!), and psychotherapy in diverse communities (presented by Kevin Simon, MD, Chief Behavioral Health Officer for Boston, appointed by Mayor Wu).

All MPS members are welcome to attend our meetings, and we hope to attract some new active members! Participating in the networking, camaraderie, and creativity in our committee can be one of the joys of being a member of MPS.

Public Sector Committee – Hannah Larsen, MD & Marcus Vi-eari

The Public Sector Committee meets every 2 months with a mission to advocate for policies and systems that promote mental well-being and ensure equitable access to comprehensive mental health and substance use care by collaborating with community partners, advancing legislation, providing education, and supporting mentoring of the psychiatric workforce. In the past year, we held a forum to reflect on the first year of Community Behavioral Health Centers, collaborated with the Antiracism Committee on a talk by health economist and primary care physician Ben Sommers, MD/PhD reviewing the current state of Medicare and Medicaid; and welcomed MPS Legislative Liaison Lilia Sennott to coach us on more effective advocacy. We have been following pending state legislation on crisis care, gun violence prevention, harm reduction, prior authorization, and assisted outpatient treatment. We contributed input to Mass Medical Society’s list of suggested screening tools for Behavioral Health Wellness exams and to the APA position statement on long-acting injectable antipsychotics in early psychosis. To promote sustainable careers in public sector/community psychiatry, we are collaborating with the Early Career Psychiatry Committee to host a networking and membership event in September that will feature a panel of psychiatrists with long and diverse public sector psychiatry careers. We welcome all of those with an interest in public sector work and advocacy to join us at an upcoming meeting (next: July 18 at 7pm).

Retirement Committee – Joseph McCabe, MD & Marris Stamber-ler, MD

The Retirement Committee continues to meet by Zoom three or four times a year to discuss issues that include retirement planning, closing practices, and early and later post-retirement concerns. Our next meeting will be in the fall.

We welcome all MPS members. We send out invitations to be on the committee mailing list yearly to all MPS members turning 65, and every 5 years to all members not on the mailing list who are between the ages of 70 and 75.

Since the last report, Burns Woodward resigned as cochair, and Mandy Stambler took his place. We have held four Zoom meetings since last year’s report.

Meeting 10/12/23

The topic was Making Decisions About Retirement. What gets in the way? Discussants were Dr. Jim Sabia, who has successfully negotiated the process, and Dr. Carl Salzman, who is “in the middle of the struggle.”

Meeting 12/14/23

The topic was “downsizing.” Dr. Gene Freiman and Dr. Henry Schriein, who has moved to Brookhaven, a retirement community, were discussants. Most of the discussion centered on Dr. Schriein’s experience. There was discussion of alternatives to moving into a retirement community.

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Women in Psychiatry Committee – Naomi Dworin, MD

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I plan to appoint four presidential task forces this year on the following topics: social media, suicide, DSM, and the Goldwater Rule. The task forces will be asked to discuss these topics and then decide if they have consensus on any statement or action, which then can be presented to the Executive Council for its review and approval. I do not presume that all the task forces will complete their work in this presidential year, between now and next May. Nor do I presume that they will find consensus in all cases, nor that the Council will approve whatever they recommend. Even if one or two task forces succeed in their efforts, it will be better than nothing.

I present here some basic ideas about what the task forces could consider, and I will encourage them to discuss these issues. If you would like to be part of a task force for constructive discussion, please contact me through MPS headquarters. As the membership and chairpersons become identified, I will notify the membership and keep them updated on the activities of the task forces.

1. Social media – I will ask this task force to discuss the harmful effects of social media on depression, anxiety and negative emotions, especially in teenagers and young adults. We live in an era of a new kind of depression, a digital depression, and we have yet to come to terms with it. How should psychiatrists understand it? How is it similar or different from other depressive states? What should we recommend to parents and to schools? Is there legislation that we would support?

2. Suicide – I will ask this task force to go beyond the usual discussions on the multifactorial nature of suicide, and think of concrete therapeutic interventions we might implement. One obvious but ignored intervention is lithium, which is the only drug proven to prevent suicide, and it may do so at very low doses which could be given without notable clinical risk. The task force should examine this and other interventions that we could recommend to patients at risk, such as veterans and people with mood illnesses. New medications that reduce suicidal ideation, like ketamine, are on the horizon, and we should be discussing these as well in their potential benefits and their limitations, such as the fact that they may reduce suicidal ideation but that benefit may not translate to actual suicide reduction.

3. DSM – As discussed in this month’s column, DSM perpetuates the practice of our profession, but it does not receive any cogent critique from inside the profession. Many from outside the profession attack it and many other things in their overall opposition to psychiatry. But such outside criticism should not keep us from internal analysis of what is right and what is wrong with our status quo. A benefit of DSM has been reliability, a common language; a harm has been lack of validation, or not being true. The invalidity of many DSM constructs may impair good clinical practice. We need to be more honest about this problem, and discuss the whys and wherefores. How much of a problem is validity in DSM? How does it work? How can we do better? APA makes DSM, so our perspectives here can have a direct impact, as members of APA. I do not see this a larger and more complex matter at the national level, but nothing stops a district branch from discussing it and providing its opinions.

4. The Goldwater Rule - This topic has to do with how much our profession should be active in public life. We have a vision at MPS of being leaders in mental health for the public, but to do so, we need to engage with the public, including the media and legislature and other groups. The Goldwater Rule is made by the APA as a means to restrict psychiatrists from commenting on public figures in relation to psychiatric diagnosis. It was made at a time, before DSM-III, when psychiatric diagnosis is even worse, it is not only without reliability or validity. Thus psychiatrists used terms like schizophrenia wrongly and harmfully. Is the goldwater rule applies a general censorship about discussing any public figure almost in any way. This excessive restriction keeps us from providing our legitimate expertise about valid diseases to the general public when needed. The majority of APA members and psychiatrists oppose the Goldwater Rule, but the APA national organization has taken a strict and hard-line stance on it. Again, I realize that there is a larger and more complex matter at the national level, but nothing stops a district branch from discussing it and providing its opinions. Do we think the rule is fine as is? Are there any other ways in which too restrictive? Are there harms in our public role that flow from it? What would be alternatives?

I have picked topics of importance for our profession, but which are being ignored or not discussed with sufficient urgency. I do not know how much we will achieve this year. It is ambitious to move forward on all these topics. But we will start the process and see what we can achieve.

I hope I can count on the support of members to move these task forces forward and put MPS at the vanguard of state branches in this. We will put together a list of people interested in serving on these task forces. I will make sure I do not force, constructive discussion, please contact me at the MPS headquarters.

Nassir Ghaemi, MD, MPH, DLFAPA
President, Massachusetts Psychiatric Society

The MPS Executive Committee, Council and staff wish you a safe and happy summer!!!

UMass Memorial Health and the University of Massachusetts Chan Medical School currently have openings within the Department of Psychiatry.

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 child and adolescent psychiatry and forensic psychiatry. 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

Faculty Medical Director (Cape Cod and Islands Mental Health Center, Pocasset, MA) - Provides administrative and clinical oversight for the DMH-operated and contracted state hospital and community support programs.

Facility Medical Director (Brockton Hospital, Brockton, MA) - Provides administrative and clinical oversight for the DMH-operated and contracted state hospital and community support programs.

Facility Behavioral Health Director, Brockton Hospital, Brockton, MA - board-certified psychiatric-mental health nurse practitioner (PMHNPC-B)

Full-Time and Part-Time Psychiatrists, Brockton Multi Service Center, Brockton, MA - inpatient and outpatient positions

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

Full-Time Clinical Psychologist, Student Counseling Service, UMass Chan Medical School

Full-Time Researcher, Implementation Science and Practice Advances Research Center (ISPARC), UMass Chan Medical School

Geriatric Research, Psychologist/Psychiatrist, UMass Chan Medical School

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

For more information: https://www.umassmed.edu/psychiatry/dop/

As the leading employer in the Worcester area, we seek talent and ideas from individuals of varied backgrounds and viewpoints.
Two New Books from Ronald W. Pies, MD

The *Embraced Mover* is a novelette recounting an un-speakable school tragedy and its traumatic aftermath. The journey from trauma to love and redemption is the heart of this gripping work.

The *Anatomy of Gratitude* is Dr. Pies's survey of this central ethical and psychological value, in six of the world's great spiritual traditions.

Both works have immediate relevance for our patients, our loved ones, and ourselves. Available from Amazon.com

Chandler Psychological Services

Board Certified psychiatrist(s) in Massachusetts (and possibly Rhode Island) to provide as needed 2nd opinions for applicants not qualified for police, corrections, and fire service positions. Also, to provide psychiatric evaluation/opinion of police, corrections and fire service personnel undergoing Fit-For-Duty surgeries. The psychiatrist will be a member and have the support of a senior, multidisciplinary team. Training/orientation will be provided. Flexible schedule. Once acclimated, telehealth utilization is possible. Competitive fee. Friendly collegial environment.

Please visit our website at chandlerpsychologicalservices.com, email us at chandlerpsychologicalservices@gmail.com or call us at 508-757-7430.

MPS Mentorship

Thanks to the efforts of the Antiracism Committee, the Early Career Psychiatry Committee, the Retirement Committee and many others we have had a successful first year. We have approximately 45 members who are participating as mentors and mentees. Our networking event last fall was well received and we hope to do this another year.

Mentoring is crucial for growth, development, support and networking. This is especially true early in our careers or at any time we seek to make a change or to expand our horizons. It also helps us to stay on track with all the challenges we navigate in psychiatric practice.

Mentorship for BIPOC members of MPS has been identified as an important need in our discussions in the Antiracism Committee. Though Massachusetts continues to be a strong advocate for LGBTQ+ and Women’s rights there remain many challenges and the need for mentorship.

Please join us, as a mentor, mentee, or both! Fill out the attached mentorship interest form and we will help to connect you.

For any questions, or to discuss the program contact Marie Hobart MD, coordinator at mhealthcare@iscold.com

References


MPS is pleased to welcome the following New Members

General Members:
- Ying Cao, MD
- Margo Funk, MD
- Katherine Goodwin, MD
- Jennifer Greenwald, MD
- Ambika Kattula, MD
- Kendra Kobrín, MD
- Susan Maher, MD
- Destiny D. Pegràm, MD
- Samuel Sheffel, MD
- Susan Szulwes, MD

Resident Fellow Member:
- Mark Kalinch, MD
- Kaushal Katkar, MD
- Aashima Sarin, MD
- Koushik Sengupta, MD

Transfer In:
- Natasha Boleckinsky, MD
- Christopher Magoon, MD
- Huseyin Bayazit, MD

Visit the APA at www.psychiatry.org

Your application must be submitted to the APA on or before September 1, 2024.
(continued from page 1) - FROM THE PRESIDENT

What I raise in this example involves two matters I mentioned in my first column: first, the fact that the DSM system of diagnosis is mostly false, i.e., it has not been validated or it has been in fact invalidated; and second, that our medications are mostly symptomatic in effect, like Tylenol for pain, and not disease-modifying. These two features differentiate us from the rest of the general medicine, in a bad way. Let me explain.

We speak about parity. There is no parity, partly because of stigma, but not entirely. Another reason there might not be parity may have to do with outcomes. Now that statement will be challenged by many colleagues, and there are claims against it in the scientific literature, which I could critique. But putting aside what you or I think, it matters what our patients think, what the public thinks, and there too the Gallup poll shows that most Americans think that our provision of psychiatric doesn’t match up to our colleagues in general medicine.

To quote the poll: “Overall, 38% of U.S. adults think mental health issues are handled ‘much worse’ and 37% ‘somewhat worse’ than physical health issues, while 15% say they are dealt with ‘about the same’ and only 8% that ‘mental health issues are treated ‘some what better,’ with 1% saying ‘much better.’” Let’s rewrite the numbers one more time: 75% of Americans feel that psychiatric care is provided worse than physical healthcare, and only 15% say they are similar. Only 5% of Americans believe that mental health issues are handled better than physical health issues.

It doesn’t matter if we disagree; our patients are telling us what they experience, and we need to listen to them.

So what’s the problem? There are the systemic issues, as mentioned, and MPS has been and will continue to be active on those fronts. But there are clinical and scientific issues, about which the APA and our profession has been in denial, and I would like MPS to be at the vanguard of honesty, finally admitting where we are failing and why.

Back to my two points: DSM and our drugs.

DSM is mostly invalid. This should not be a controversial statement. It was stated by the makers of DSM-III themselves: they claimed reliability and admitted invalidity. They just hoped validity would improve over time. It has not, because the dictionary, the Bible, and we refuse to change it. We still use definitions, like MDD, almost exactly as defined in 1980 based on limited and inadequate evidence of validity, and despite decades of research proving aspects of that diagnosis to be false.

Our drugs are symptomatic. Look at all the drug trials. How much do depressive symptoms improve in 8 weeks, or psychotic symptoms in 3 months, or PTSD symptoms in a few months? The drugs are developed to reduce symptoms in the short-term. That’s it. That’s all. More pointedly, compare it to general medicine: Statins are not measured for their effects on chest pain over time, but rather on their effect on death over weeks, or chemotherapies for their effect on edema over weeks. Those drugs are studied for their effects in modifying the underlying disease, not based on biological measures (statins are not proven based on cholesterol levels nor antihypertensives based on blood pressure reduction), but rather based on clinical measures of long-term improvement in the course of the illness: reduction in frequency of heart attacks or stroke, and decreased mortality. These outcomes are measured over 1-5 years, not 1-5 weeks. We do not develop drugs that way in psychiatry, so the drugs we have do not function that way. They are not disease-modifying. Exceptions are lithium and mood stabilizers, which are the only drugs proven to improve long-term course of illness in psychiatry; I know some will disagree; I have provided the research evidence for this statement elsewhere.

It’s noteworthy in the Gallup survey that the public was more satisfied with the benefits of psychotherapies than with the effects of medications.

So back to our failing grade: The health care system is a mess — true. Stigma is a problem — true. We are not well reimbursed — true. AND: DSM is mostly invalid. And our drugs have mainly short-term symptomatic benefits.

We are trying to fix the first three problems but ignoring the last two, and interestingly, the last two we ignore are the ones we can fix most directly ourselves. We have the power to make things better, but we aren’t trying, on the issues over which we have the most control.

APA could decide tomorrow to drop DSM (but it won’t, for economic reasons since 2/3 of the APA budget relies on DSM income). And our profession could diagnose like every other medical specialty based on the best scientific research found in the journals, end of story. But the APA or the AMA tell us what to think. After DSM, I would predict that clinical practice would improve markedly, as clinicians would be free to think more scientifically about their work, rather than simply following note orders from afar.

Academic researchers and the FDA tomorrow could join together to demand disease-modifying clinical trials, not symptomatic ones, and the pharmaceutical industry would be forced to do so, as it does for every other medical specialty. Within a decade, we would have amazing new effective drugs. Instead, we have me-too psychedelic drugs that just improve symptoms more quickly and more markedly, advocates say, without any proof (even randomized studies) of true long-term improvement of the course of any illness.

I recently attended the American Society of Clinical Psychopharmacology annual meeting, the main congress bringing together the pharmaceutical industry, academic clinical trial researchers, and the FDA. The vast majority of presentations were on psychedelic drugs and their variations. I came away with the unhappy feeling that we are hurtling toward a dead end. The pharmaceutical industry knows it can make billions providing these me-too psychedelic drugs, and the gullible public and profession hope for a miracle from it. There will be no miracle, because super-Tylenol is still Tylenol; it won’t be transformative because it’s just doing more of the same, faster. Nothing much different: it’s a new approach, treating not symptoms of diseases of unquestionable validity, like MDD or “generalized anxiety disorder” (which was completely invented with minimal scientific data in 1980 to find a phrase to replace the older concept of neurasthenia), but long-term clinical outcomes changing the course of proven diseases like manic-depressive illness and schizophrenia.

We can do better, but we can’t, because we don’t admit where we’re failing.

In another article in this issue, I am describing four presidential task forces to address some of these ignored problems in psychiatry.
Salem Hospital, a member of Mass General Brigham, is an affirmative action/equal opportunity employer. Proximity to a wonderful metropolitan area. Compensation is very competitive. The call schedule is very reasonable and requires no in-house coverage. Partial hospitalization program, child and adolescent ED consults, as well as similar services for adults. Inpatient care is provided. Care system, and the Department of Psychiatry is closely aligned with Massachusetts General Hospital (MGH). Mass General Brigham Salem Hospital has an exciting opportunity for a child psychiatrist to join a thriving and growing psychiatry team. In psychiatric and medical subspecialty outpatient clinics, on our substance use disorders, and pregnancy-related conditions, or any other characteristic. We are an equal opportunity employer and women and minorities are encouraged to apply. Interested individuals should apply to Jeff Huffman, Associate Chief of Psychiatry for Clinical Services (jhoffman@partners. org). We are an equal opportunity employer and women and minorities are highly encouraged to apply. All qualified applicants will receive consideration for employment without regard to race, ethnicity, religion, sex, national origin, disability status, protected veteran status, gender identity, sexual orientation, pregnancy, and pregnancy-related conditions, or any other characteristic protected by law.

MAGNIFICENT GARDENS AT THE MGH OF ALEXANDER GARDENS

Massachusetts General Hospital provides a full spectrum of psychiatric care, including a 30-bed child and adolescent inpatient unit, adolescent partial hospitalization program, child and adolescent ED consults, as well as similar services for adults. Inpatient care is provided at the Epstein Center for Behavioral Health, a spectacular, newly renovated facility that provides unique outdoor recreational space for patients. We have a vibrant educational program, and teaching opportunities and an academic appointment are available. Physicians in the department enjoy a collegial and supportive practice environment. Compensation is very competitive. The call schedule is very reasonable and requires no in-house coverage. Salem is located on the North Shore of Massachusetts, only 15 miles north of Boston. This region features all the advantages of proximity to a wonderful metropolitan area. Interested candidates should forward their CV to Louis Caliguiri, Executive Director of Physician Recruiting at lcaliguiri@partners.org. Salem Hospital, a member of Mass General Brigham, is an affirmative action/equal opportunity employer. Minorities and women are strongly encouraged to apply. The position is eligible to participate in the federal Public Service Loan Forgiveness Program.

It's worth the read and consider to replicate the workshop across all residency specialties. I hope this serves as a beginner-friendly guide on how to be an ally. There are other parts of allyship including changing system-wide issues that promote inequality and oppression as well as supporting organizations that do such work. However, I think the basics are fundamental and easier to work on day-by-day. Please remember that allyship is a process without an end-all-be-all. Mistakes are bound to happen but we can give ourselves permission to be vulnerable, sit with the uncomfortable, and grow.

References:
RESIDENT FELLOW MEMBER CORNER

Bianna Rowan, MD

Beyond Pride Month: How to Be a Better Ally Every Day

As another Pride month comes and goes, I find myself pondering on what it means to be an ally. I think most of us, if not all of us, can relate to being in a social situation where someone makes a joke in poor taste, uses an inappropriate word or even blantly makes a derogatory remark. There may be some awkward laughter involved or more often deafening silence as we ask ourselves, “How do I respond to this uncomfortable situation?”

I had an experience in the hospital where a nurse felt quite comfortable expressing their discomfort by a male patient’s painted fingernails. This nurse went on to make some off-color comments which shocked and offended me. The comments caught me off guard and I didn’t know what to say or how to react at the moment, especially as a new resident. Luckily, my attending was by my side and was simultaneously empathetic towards the nurse while also redirecting them and suggesting that they keep those comments to themselves in the future. I felt fortunate not only to know that I was not alone in my feelings but also to have my attending lead by example in a complicated and uncomfortable situation. This was not the first nor will it be the last time that a scenario like this occurs in the future. In the future, I want to move beyond my shocked state and take action. So herein lies the question: How do I become a better ally?

Let’s begin with a definition: allyship is “supportive association with another group, specifically members of marginalized or mistreated groups to which one does not belong.” To expand on this definition the Anti-Oppression Network defines allyship as “an active, consistent and arduous practice of unlearning and re-evaluating, in which a person in a position of privilege and power seeks to operate in solidarity with a marginalized group.” Historically, the term ally has been associated with LGBTQIA+ communities. Let’s pause for a brief history lesson.

Many people are familiar with the Stonewall Uprising which to many sparked the start of the gay liberation movement. The Stonewall Inn was a gay bar in New York City’s Greenwich Village. Around the time of the uprising in the late 1960s, gay bars like the Stonewall Inn were frequently subjected to harassment and police raids. Same sex relations were illegal in New York City as most other places at the time and gay liberation movement. The Stonewall Inn

Uprising, thousands of people marched from the lesbian, gay, bisexual, and transgender individuals and drag queens were welcomed there as these folks were typically not accepted at other gay establishments. Gay bars were often personalized and shut down as serving alcohol to suspected LGBTQ individuals was “disorderly.” To make matters more complicated, many of these gay bars were owned by the mafia and operated without liquor licenses. The mafia would pay off corrupt police officers who would tip off the bars before raids which allowed owners to hide whatever illegal activity that was going on. However, on June 28, 1969 Stonewall was not tipped off and armed police officers raided the bar, assaulted patrons and arrested 13 people including those who violated the state’s gender-appropriate clothing statute (which was enforced by having female officers check individuals’ sex in the bathroom). Instead of dispersing, which was the norm, patrons and neighborhood residents fought back which turned into a riot involving hundreds of people. Although the crowd was eventually dispersed, protests continued for 5 days after the event. Interesting fact: the Stonewall Rising was not the first of its kind. Three years earlier and on the other side of the country, police raid- ed a popular hangout for transgender and queer people in San Francisco called Compton’s Cafeteria. When the police were getting rough with the customers they fought back and protesters gathered there the next day. These events are defining moments for LGBT political activism.

On the one year anniversary of the Stonewall Uprising, thousands of people marched from the Stonewall Inn to Central Park which became known as America’s first gay pride parade.

One month after the parade, Black Panther Party cofounder Huey P Newton published a letter in the party newspaper titled “A Letter from Huey Newton: To White America.” In the letter he recognized gay individuals as an oppressed group and called for recognition of the Gay Liberation Movement. This example of allyship highlights how one can recognize their own privilege and use that to amplify the voices of those from marginalized communities. It also exemplifies the fact that [cont. on next page]
May was mental health awareness month. On May Day, Gallup released a survey of which we as a profession need to become very aware. Gallup surveyed 2226 Americans regarding their perception of mental health care (https://news.gallup.com/poll/644144/americans-perceive-gps-mental-physical-healthcare.aspx). That survey included a grading system, which we can read in part at least as an assessment of the mental health professions, which obviously would include psychiatry. The results were as follows: 57% of Americans gave us a grade of F or D. 27% were more generous and gave us a grade of C. Only 8% were willing to give a B and 1% an A. Let’s just translate these numbers again. 99% of Americans are not willing to give us a grade of A; 91% of Americans give us a grade of C or less. Most Americans rate us as failing or near-failing: D or F.

A natural reaction could be to blame others: the insurance companies, the broken health care system, the court system, stigma. And those systemic issues certainly bear part of the blame, but not all of it. We should be able to take some of the responsibility ourselves too. We cannot say without self-deception that we’re fine; everything else is bad.

Indeed the Gallup poll did address these other systemic issues and found them to be relevant. Americans recognize that stigma and affordability are limiting factors for better mental health care.

These systemic issues need to be addressed, but you can make the system as good as you like, if other factors, which are more clinical and scientific, are not fixed, we will still fail our patients.

Let me give you an example:

I had a friend in Canada who had a severe depressive episode in his late 60s, the second in his life. He had a happy marriage, financial security, many friends. There was no external cause. He was given sertraline, which made him slightly hyper for a few hours, and the dose was eventually maximized, and other antidepressants were given, and other antipsychotics. Over months his episode waxed and waned, with some suicidal ideation. He went to the emergency room a few times, and was set up with an outpatient psychiatrist, and psychiatric nurses visited him in his home twice weekly. The structure of the care he was given was impeccable: he had his primary care, a specialist psychiatrist, in home nursing – and all free. His diagnosis and treatment followed DSM definitions and FDA regulations exactly. He just didn’t get better. One morning he awoke, went to the roof of his high rise, and jumped.

I knew him well. I knew that he met the definition of hypertymic temperament (mild manic traits as part of one’s personality), which is not in DSM. I knew that his few “hyper” hours were manic symptoms; we talked about it at length, with increased libido, energy, and racing thoughts – the opposite of depression. I knew that those manic symptoms, and his baseline manic temperament represented mixed depression, not “major depression,” which ignores presence or absence of manic symptoms of less than four days duration (without any scientific evidence for that cut-off). I knew that antidepressants make mixed depression worse and increase suicidality in that condition (based on published data). I knew that lithium reduces such suicidality, but he never was given it.

In short, I can provide a strong scientific rationale for why his diagnosis and medications were wrong, but one would have to go outside the DSM box. The exclusion of mixed depression from DSM has never been based on a strong scientific rationale. The insistence of “major depression” as being legitimate when it includes mixed states with other conditions has never been proven scientifically. These are just decisions made by DSM committees by fiat. The problem is not just that they may be wrong, but that if they are wrong, they can be deadly, as in the case of my friend.

We follow the rules, but we don’t ask enough how well proven those rules are.

A skeptical reader might say that any treatment can fail, and this could just be one of those cases, and that many other people improve. The Gallup poll says otherwise: It tells us that these failures aren’t exceptional. Remember, we get an A only from 1% of the public.

(continued on page 3)