Laura Roberts (00:25):

Hi. I'm Dr. Laura Roberts, Editor-in-Chief for the Books Portfolio of the American Psychiatric Association. And welcome to the APA Books podcast.

(00:45):

So, hey, everybody, welcome to Unbound. And today I'm really delighted to speak with two of my wonderful colleagues, John Barry and Sepideh Bajestan, Dr. "Dr." Bajestan, as I say. And they have worked with the prior editors of the Concise Guide to Neuropsychiatry and Behavioral Neurology to develop a recent third edition of the book. And this is just a wonderful book. You know, APA Publishing doesn't really do Concise Guides anymore, but this one, there is an exception for because it really became the pocketbook for neurology and psychiatry and bona fide neuropsychiatrists to really help them with their clinical work and clinical training. For more than 30 years, the Concise Guide to Neuropsychiatry and Behavioral Neurology has been a critical companion for clinicians caring for patients with issues at the interface of neurology and psychiatry. And this new third edition combines all of the scientific rigor of its predecessor versions, but with a renewed emphasis on kind and empathetic care.

(01:56):

And it's been updated to account for the development of new techniques in brain imaging, improvement in electrophysiological methods to better detect epilepsy, and sleep disorders, and a growing list of blood and spinal fluid biomarkers that really have revolutionized diagnostic capability in the area of Neuropsychiatry. It's a wonderful book for trainees and for experienced practitioners, the full range, and I'm really excited that Sepideh and John took this book on. John is the Fellowship Director of Neuropsychiatry and Behavioral Neurology, the Director of the Neuropsychiatry Clinic, the Co-Director of the Individual Psychiatry Clinic, and is a Professor of Psychiatry and Behavioral Sciences in the Department of Psychiatry and Behavioral Sciences at Stanford. And Sepideh Bajestan, MD, PhD, as I say, Dr. "Dr." Bajestan, is the Chief of the Neuropsychiatry Services, Associate Director of the Neuropsychiatry and Behavioral Neurology Fellowship, Co-Director of the Individual Psychotherapy Clinic, and Clinical Professor in the Department of Psychiatry and Behavioral Sciences at Stanford University School of Medicine.

[NEW_PARAGRAPH]And I have the privilege of working with Sepideh and John. All the time, I've known Sepideh since she was a resident. And John very kindly, and very graciously welcomed me to the Department of Psychiatry 13 years ago. Can you believe it?

John Barry (03:19):

I can't. I don't believe it.

Laura Roberts (03:23):

Yeah, where he's been a professor for many years and a tremendous leader in our institution. So welcome to Unbound and I'm thrilled to talk with you about your book. John, why don't you fill us in on just the topic and the scope of this wonderful guide that you've put together.

John Barry (03:41):

Yeah, I'd be happy to do that. The one thing I want to start off, I'm just saying how much we appreciate all your support. Because all the things that we're doing today would not have happened without you. I want to say that first because I'm going to forget it at the end. I've got it in big letters and everything, I'm going to forget it anyhow, but it doesn't make any difference. But I just want to say that because it's

been really remarkable. This is a book that we thought, and I don't know if you remember Laura, but we talked about this in the APA, and I thought this would be an easy proposition. It wouldn't be very hard to do this at all because it was only 250 pages. So I mean, that's not bad. But it turned out to be a lot more difficult, trying to make things small is a lot harder than trying to make things big. And I never stupidly didn't realize that, but...

(04:28):

So what I'd like to do is just start off by talking a little bit about Neuropsychiatry, is actually, in many ways it's a new yet an old field in some ways, but not too many people know about it. One of our co-authors, Jeffrey Cummings, who's just an extraordinary person, is one of our co-authors. And he gave a good description of Neuropsychiatry, and I thought that I would read it because I don't think I could actually do it any better. But he said it was the clinical discipline devoted to understanding the neurobiologic basis of behavior, optimal assessment, natural history and most efficacious treatments of disorders of a nervous system with behavioral manifestations. And that's the way he described Neuropsychiatry. Neuropsychiatry really seeks to understand the disorders of the CNS responsible for abnormal behavior. And when you look at it, I said initially that it was actually new field, it's not. As if you go back to things like people, like Hippocrates.

(05:31):

He really demystified a disease called the sacred illness, which is really actually epilepsy. And he noted something that was very interesting and that is that it was a reciprocal relationship between melancholia and the sacred disease. And the sacred disease being epilepsy and melancholia obviously being depression. So there seems to be a reciprocal relationship between the two. And it's very interesting because as you look at that, you realize actually, this is the same for almost every neuropsychiatric illness that we treat, and we study. So it's not uncommon at all. In fact, it's much more common than we like to actually think. There were other people who were involved in all this too. One was Kaplan, we won't go into great length. The other is Charcot, who I've always had a great affection for. One of the neurologists at Stanford is a good friend of mine called Charcot, the father of neurology, and I would agree with that.

(06:32):

He's really done remarkable stuff, especially in the field of psychiatry, actually. He developed or he talked about functional neurologic disorder, not in those terminologies, but he called it hystero-epilepsy. And he further clarified this relationship over time. He used to have a session on Friday afternoons where he had a patient that actually lived in [inaudible 00:06:59], and you can diagnostically talk a lot about that. But he would do this manipulational procedure on Fridays, and he would show people how he was able to manifest this functional neurologic process with this manipulation. And people like Freud and Breuer, they never picked that up and they ran off to a different field called psychiatry. And they've really never been the same since until recently. And we'll go through that in just a few minutes because I want to tell you a little bit about how I got interested in this field. And some of it has to do with my coming to Stanford actually and my background in Medicine.

(07:40):

And talking about neurologic illness because I do want to talk about that and complete that before we go further. There's a wild wide variety of psychiatric manifestations in neurologic illness and it has everything that we have in psychiatry. The interesting thing about it is that it's a little different actually. So we have a patient that we saw not too long ago, it had multiple sclerosis and had plaques in the oral frontal cortical region and she looked like she had a bipolar disorder. It was probably secondary to the manifestations of multiple sclerosis. But for all practical purposes it was very similar but different. And

you could say the same thing about many neuropsychiatric illnesses. But the same, they look very phenomenologically very similar to idiopathic disease processes, but they're a little different. And it's one of the reasons why I've gotten really interested in Neuropsychiatry because it's complicated and complex. It's not a Prozac world, it's a world of many different medications and a lot of different causations.

(08:48):

And I find it to be fascinating because of this, but it's one thing that you have to remember. The goal really of the guide is to provide a very simple, very compendium of our present-day knowledge of Neuropsychiatry. And it's meant to complement lengthier textbooks. It's not the end and be-all in and of itself, it's for your back pocket. And that was one of the difficult things that we had to do is to try and include more in the guide, but try and make it still big enough to fit in your back pocket without going over tail or to try and get your pocket actually expanded. And I think we actually did that and the APA, they should get a lot of credit for it. I don't know how the hell they did it to be perfectly honest with you. We gave everything to them and hoped for the best. And Sepideh designed the cover because it was blue before and she looked at it and said, "No, that's not Stanford colors." We have to do it a little differently.

(09:46):

So she made it red, which I think is actually very, very nice change. But to continue, just talking about what we tried to do with the book, we wanted to make it as complete and accurate a reference as possible. When I was a medical resident, one of the things that I did is I actually wrote down and a book very similar to the guide that I had for medicine. And it was an incredibly valuable little tool that I would carry around in my white pocket all the time. I think the guide is very similar to that as well, and that's the way we hope it would actually occur. We'd like to be able to look at every guide that's been published and notice that it's all dog-eared and it's been scarred or whatever. That's the way we want it. We'd like to see it actually used and used frequently and it has been up to this particular point. Again, just of getting back to this issue of the cross-hatch between psychiatry and neurology. Depression, in particular, is a really great example because if you tell all residents who follows this, when you look...

(10:50):

If anybody's ever asked you how frequent is depression in neurologic illness and it's omnipresent and the frequency of it is really significant, it's usually about 20%. Which is usually about one and a half to two times what you see in the general population. You could say that about everything. Illness for example, like brain tumors can present as severe depression, certainly functional neurologic disorder that we talked a little bit about before. Sepideh, who wrote the chapter in the book, let's maybe talk a little bit about it as well, but appears like a seizure disorder and we use hypnosis actually, which maybe we can talk a little bit about if anybody's interested in it, to finally diagnose functional neurologic disorder and actually for treatment. But epilepsy can present as a post-depthal psychosis and have very significant suicidal properties associated with it. And those can be secondary to anti-epileptic drugs as well. So you always have to look at all the complete gestalt of the presentation.

(11:52):

And I think, and hopefully, the guide will help provide people with a very simple compendium of the important aspects of medicine, neurology, and psychiatry that you need to know. I'm going to stop here and have Sepideh pick up the ball from this point.

Laura Roberts (12:11):

Yeah, well, may I just comment? When I was a intern, there was a lecture by Jeff Cummings that I attended-

John Barry (12:18):

Oh, all right.

Laura Roberts (12:19):

... that really... I mean I think I had always been sensitive, and interested in the neurologic underpinnings of psychiatric conditions, and this overlap areas you're describing. But what he presented were data that showed the prevalence of depression post-stroke. And he emphasized how a caring, empathetic, in fact, you talked about empathy in the intro, a caring empathetic clinician might think, of course someone who had a stroke is depressed. And so, your own empathy would actually disguise how there might be a neurologic origin to that depression because the prevalence of depression depended very much on where the stroke occurred. It didn't depend on the disability. Do you understand what I'm saying? Your concern about the disability might actually lead you to minimize your understanding of the origin of the depression in that case. So anyways, he was just amazing, and I thought really illustrated how careful you have to be in evaluating patients, and how you have to look for your own biases, and how you attribute psychiatric symptoms to a person who's had say, a neurological event. You know what I mean?

Sepideh Bajestan (12:20):

Yeah, exactly.

Laura Roberts (12:20):

Yeah.

Sepideh Bajestan (13:40):

And so, you [inaudible 00:13:40]

John Barry (13:40):

Oh, I'm sorry, Sepideh, can I just jump in just one second? I just wanted to mention that if I had a really good friend in my family who sent us a card. And then, the card says "If I had this, I would be depressed too." And I've always used that in all my lectures because that's not true. And as Laura's talking about that's not the case. And that's not, an important aspect of all this is to realize that this is not something that's a result of a reaction to the disease. It's the disease process itself.

Sepideh Bajestan (14:18):

Exactly.

John Barry (14:18):

And it's really important to remember that. I'm sorry, Sepideh, I just jumped in. I do that a lot of times. I have to be careful.

Laura Roberts (14:19):

Sepideh, go ahead.

Sepideh Bajestan (14:29):

No worries. I just wanted to build on what Laura said as in this treating this very complex Neuropsychiatry disorders and in general in medicine, the more complex the disorder or the disease becomes, it's harder to just get over the biases that can come up. For example, cognitive biases, affective biases can happen more in these complex disorders. And we had actually a symposium at American Neuropsychiatric Association just about misdiagnosis in Neuropsychiatry, given that there are conflicts like this, there are a lot of disabilities, family members involves, lives involves and can end up in affective biases and misdiagnosis by the practitioners. So another hope that they have had for this book was to have a comprehensive guide at bedside that the clinician can just refer to and just use it. We can't just go to our computers and check up-to-date or all the resources that we have. We need something comprehensive at the same time, pocket size at hand. And I wanted to build on what John just said because the field of Neuropsychiatry, if you think about it's quite field. It encompasses a very broad spectrum of topics.

(16:01):

But then we talk about Neuropsychiatry and behavioral neurology as a medical subspecialty as it's defined by UCNS, the United Council for Neurologic Subspecialties, just going to read the phrase, "It's a subspecialty committed to better understanding links between neuroscience and behavior and to the care of individuals with neurological based behavioral disturbances." Those neurologists and psychiatrists could pursue post residency fellowship training for board certification in this medical subspecialty. And this is the beauty of it. This is like one of the very unique situations that neurologists and psychiatrists can go into very similar training. And also, John mentioned the field of neurology and psychiatry, both of these fields were originally combined, but then we had this dualistic approach from late 19th century and each field started having multiple subspecialties, which was a natural progression fueled by the intellectual growth in knowledge and thanks to scientific medical advancements. However, a group of physicians saw a significant overlap between neurology and psychiatry.

(17:27):

And actually in 1988, doctors Fogel and Schiffer, they were both double boarded in neurology and psychiatry. They founded American Neuropsychiatric Association. And as we talked about Dr. Cummings, it's just notable that our previous editions of the editors of the book and the co-editors and the current edition, both Dr. Trimble and Cummings, played very important roles in various stages of association inception. Actually, Dr. Cummings held a distinction of being the ANPA's first president-elect. And my apologies for my horse voice, I'm just still recovering from a bad cold/flu and laryngitis, but I try to carry on with my voice. And as John said, this third edition that we have had, it's intended for clinicians who work in the intersection of neurology and psychiatry.

(18:31):

And this still, this field remains unfamiliar to many psychiatrists and sometimes even neurologists and many mental health clinicians. There's a still confusion among clinicians who often mistakes Neuropsychiatry for neuropsychology. As we talk, Neuropsychiatry is a medical sub-specialty practiced by physicians and neuropsychology involves application of cognitive and psychological tests by neuropsychologists to assess cognitive function, behavior, and personality traits. And we use the results of this test for our treatment decisions. And I can just have this time as gateway for more questions and John and I are happy to delve into our personal journeys, how we became interested in this field of Neuropsychiatry to treat even more complicated patients. So we'll be happy to discuss that.

Laura Roberts (19:32):

That's great. And I always found it very interesting that there are a few departments that have combined psychiatry, neurology. Tulane, it was a rare example where for many, many years it was a combined department, but these disciplines really did develop and then became administratively almost calcified as separate... They're certainly separate disciplines in medicine and administratively they've become different. And yet when we encounter our patients, I think it's good to be able to pull from both disciplines to truly understand them. And so I think this is one of the big contributions of your book.

John Barry (20:15):

I was just going to say that. Well, I can tell you a little bit about my odyssey as far as getting into Neuropsychiatry, but one of the things I just wanted to mention is that Stanford has a very unusual maybe situation. I am very comfortable in the neurology service as much as I am in the psychiatry service. That was not the way it was when I first came here. One of the things that really got me interested in Neuropsychiatry is that in 1992, I came here in like 86, and I met this person by the name of Martha Morrell, who I adore, she's one of the epileptologists. And she continued to feed patients to me, and I got more and more interested actually in neurology and psychiatry together. I'd done a variety of different things. There was a country doctor up in Maine and ER doctor, an infectious disease specialist and a variety of different things.

(21:08):

But this combination of neurology and psychiatry I found incredibly fascinating. And the interesting thing about it, many interesting thing about it, but it has every neurologic, some specialty, again, as I mentioned before, has very similar idiopathic psychiatric illnesses and that can go for everything. I spent a lot of time looking at epilepsy patients. But you can see epilepsy patients with schizophrenia, we call it in the epilepsy world, schizophrenia-like disorder of epilepsy. And that's probably just that way because everybody likes to have their own specialty. So this way the epileptics just have their own specialty, but it looks for all intents and purposes like schizophrenia. So there's that aspect to it in addition to anxiety, depression, whatever. And you see it again in every neurological illness, if you go to things like Parkinson's disease for example, you're in the same, everything has a little bit of difference. For example, with Parkinson's disease, and the association of dopaminergic issues causing deficiency, causing the disease process, but also, the replenishing causing difficulty as well. So it becomes incredibly complicated.

(22:30):

The same sort of things that you see in Huntington's career, for example, in stroke as we were talking about just a few minutes ago. And in addition to that, one of the things that has to be really paid attention to too in neuropsychiatric illness is the amount of suicide that's associated with it. That this is not just a depression with a small D, this is depression with a big D. and it can be really important. Again, it stresses that whole issue of the necessity really to pay attention to the psychiatric aspects of these disease processes because they're very important and they're very difficult to control sometimes. But first thing is you have to recognize them. So developing sensitivity to this process between the two I think is really important. But again, one of the things that I found really fascinating is the presentation of illness and neuropsychiatric illness can be very different in some capacities and needs to be paid attention to. But I'll turn it over to SepideH now. She can tell us about her odyssey as far as getting here as well.

Sepideh Bajestan (23:33):

So I would say during my psychiatric residency here at the Stanford University, I was fascinated in every facet of the field from psychotherapy and complex psychopharm, interventional psychiatry. Simultaneously, as a molecular neuropsychiatrist, I was marveling at the biological underpinning of psychiatric disorders. As you say, Laura, it has always been quite fascinating to learn that part. And also, on top of everything, the integral of psychiatry with various fields of medicine also intrigued me. And despite my residency director's advice, Chris Herbert's advice at the time to choose a niche, especially that I wanted to go on an academic path, my wide-waging ranging interests persisted. So I contemplated doing a Consultation-Liaison Fellowship, [inaudible 00:24:32] a fellowship. It felt too broad for my interest. I thought about doing a Sleep Fellowship. It seemed again too narrow for my diverse interest and I considered doing either Consult Liaison or Sleep Fellowship, but they didn't feel to have the widest scope of the spectrum, at least my own interest. And at that time, John Barry was my psychotherapy advisor at the time.

(24:59):

And I happened to talk to John about my dilemma of what to do for future, and he proposed the idea of creating the Neuropsychiatry Fellowship together. And this idea caught me off guard, especially considering my active involvement at the American Psychiatric Association, the APA. I was in every single meeting even before getting into residency, and I have never ever heard of such a speciality. I've never heard of Neuropsychiatry as a fellowship. It was quite intriguing and interesting to me and felt like the perfect fit. So rather than letting go of my various interests, I could blend my background in Neuropsychiatry with psychiatry and into neurology. So instead of narrowing down, I combined and blended and merged my interests, especially for neurology because it's the core of our mind's residence in the nervous system. So it's the mind's house. It felt very, very fascinating. And really interestingly, many of our faculty in Neuropsychiatry sections.

(26:16):

And our Neuropsychiatry fellows, our trainees, share similar stories that they find discovering Neuropsychiatry and Behavioral Neurology as the ideal field for them to explore the interface between medicine and psychiatry. So was for me also in not a very direct way to get to North Psychiatry, but it worked at the end. I didn't have to let go of my interest. It became more of an interdisciplinary approach and blending the interest. And pretty much like our book at the beginning it felt okay, that's quite exciting and interesting, let's get it started. And when we started the fellowship, I pretty much created my own dream fellowship with John's support and help. But it took so much work. So you guys, you are both pioneers in the field, you know how much work it takes to build something. So it felt with the book that we wrote, it was a repetition of our story with the fellowship, very exciting at the beginning, a lot of hard work and sweat. But at the end, all the hard work and sweating and blood, it's worth all the effort at the end of this story.

Laura Roberts (27:36):

That's great. So I want to pivot just a little bit because you've done such extraordinary work. Can you bring it down to earth to two or three ideas or principles that you would like to share with practicing psychiatrists who might be listening to this podcast, which is through APA and all that? How do they recognize when they need to bring in someone with Neuropsychiatry expertise? What are two or three pointers or signals where they would think, "Oh, this is a job for somebody like Sepideh or John to help me understand this patient better?"

Sepideh Bajestan (28:21):

I've written and I've done presentation on misdiagnosis in psychiatry and neurology, something that both John and I teach our fellows given our disorders are quite complex is whenever you see a patient play devil's advocate, if this were not to be depression or if this were not to be anxiety, what else could it be? We don't want to play doctor of all fields, but we are still physicians. So have a comprehensive differential diagnosis that like one, two, three, four, and this is the part that doesn't seem fit. It's what I usually see as the most important patterns of this disorder that I think might be the main diagnosis. And that's the part that a psychiatrist can say, "Okay, there's something else might be going on. I need to consult with somebody else." That would be a part to prevent misdiagnosis that they advocate for all the time.

(29:30):

And if the patients have comorbid or some parallel neurological disorders that they feel that is interfering with the psychiatric treatment or presentation, that would be a good time to consult us as well. For example, in Parkinson's, we have had patients with Parkinson's and anxiety. And working around the medication for anxiety and Parkinson's is quite important to treat the anxiety. It may be just on-off anxiety because of Parkinson's medications that are bearing off. Because the disease is progressing and the poor patient is waking up, is feeling anxious. So that requires working with the neurologist and that's the part that we can do and can comment on what might be going on.

Laura Roberts (30:21):

Great. John, did you have some thoughts on this?

John Barry (30:24):

Yeah, as always, Sepideh, you say everything's so perfectly well, so I don't have to do anything, but I'm going to do it anyway. I think that the point is really well taken. Sepideh and I are one of these national conferences and somebody asked this whole group, "Listen, what would you tell somebody in Neuropsychiatry just starting, what would be the important personality characteristic?" And somebody pointed to me immediately and I said, "Curiosity." And I think curiosity, if it looks unusual, if it doesn't fit, think that it's organic and it's something that you need to work up. Give you an example, patient who develops a first onset of depression at the age of 65 or 70. MRI, you have to have to figure out that there's something wrong. Somebody with an FDD, for example, personality change, looks okay, not demented, but really change in personality and behavior. Then you're thinking about something with a Frontotemporal dementia or somebody with a new-onset psychosis.

(31:31):

What about something like limbic encephalitis? Have you looked at all these kinds of potential possibilities? So if it looks... You have to be one of these things where you look at something and say, "That's strange, that's funny. It just makes me feel unusual. I just don't quite get it." That's when you jump in and say, "This is a neurologic process that needs to be rolled out or medical process that needs to be rolled out." So I would think, and just what you just said, Sepideh, I would totally agree with that. If it looks unusual, if it looks different, if it looks like something that you haven't seen before, then you have the first thing that you have to do is not put them in the inpatient unit and treat them for a psychiatric illness. You need to look for the cause because there's something that's causing that particular illness. So you can treat the depression, or the psychosis, or the anxiety, whatever. But why is it there? Where did it come from?

(32:25):

And if it's unusual, different presentation, different time of presentation for most psychiatric illnesses, make sure that you look a neurologic illness. And if it still doesn't seem to be there and something that you can see, always redo your evaluation in a certain period of time, a month or so. Everything looks normal, can't figure it out, still unusual. Make sure something hasn't just reared its ugly head like a limbic encephalitis for example. So I think that's the important thing is curiosity. Always wonder why, why in the hell is that there? That's the one thing I think that would be most important. I think that's what you said, Sepideh. I totally agree with that. I think that's right.

Sepideh Bajestan (33:09):

Daniel Kahneman has a beautiful book called Thinking, Fast and Slow. So I think sometimes us as psychiatrists get too much use to thinking fast. And it's a discipline to have ourselves always think about differential diagnosis. If it wasn't, what is the usual thing, what else could it be? And slow it down in a disciplined manner, not to miss anything. Both John and I have encountered some misdiagnosis cases that could feel very different at the beginning. And as John says, if we keep our curiosity on and have the differential diagnosis listed, that will reduce the misdiagnosis and the biases just to slow down the thinking process and have a disciplined way of thinking about complex disorders and even simple ones.

Laura Roberts (34:24):

Yeah, I just couldn't agree with you more. I mean, I think we are all so grateful for the evolution of the DSM. I mean it brought reliability and diagnosis across the world to the care of people with psychiatric and mental disorders. But it does have a problem, an intrinsic problem, which is that it really does not, it's phenomenological, it's descriptive and it does not really seek to define in most cases. The origin of a particular syndrome, psychiatric syndrome, that people are set of symptoms that people are experiencing. And it seems to me that Neuropsychiatry is different fundamentally in that you are always looking for the cause. And I am not sure in General Psychiatry that we're always holding ourselves to that standard. We're holding ourselves to an accurate description, an accurate capturing of the experience of the patient and the deficits or the unfolding of the experience and deficits of the patient, if the abilities and disabilities there. But I'm not sure that we're holding ourselves to the rigor of always for potential cause, it seems like a Neuropsychiatry you do hold yourselves to that, that standard. That's the point.

John Barry (35:45):

Yeah. One would certainly hope. So I think also, and I know we all do this as physicians, you think about the mistakes, things that you didn't do, something that happened in the past. And I have a cavalcade of them unfortunately, that I think about every once in a while. It's not very pleasant, but I do. And almost all of them were unusual circumstances where somebody was hurried, somebody had a trip to go on or whatever, but it was an unusual thing. They ordinarily would've done it, but they didn't. The person who got septic because of the stone, the urinal stone, that they didn't go down and look at the X-ray, they looked at it quickly, they didn't pay any attention to it. So I think those are right, you really need to pay attention to it. And I'd do one thing I think in our particular field that's crucially important.

Sepideh Bajestan (36:35):

Slowing down, as Sepideh says, being really careful.

Sepideh Bajestan (36:41):

Exactly. That's what we try to teach our fellows and keep ourselves to that standard also. That every phenomenon that we see, any interaction that we see that seems different from normal, just to slow down. It's not hard, just write down a list of differential diagnosis. A patient say this, but this sounds like weird for this patient, what's going on? Just write down four things, three things that would create the clarity of the mind to go forward and not to miss anything. [inaudible 00:37:17]

John Barry (37:17):

And I would say also, just to jump in there again, just to add onto it, and I just said this, is to make sure that if you don't find anything, don't stop. So if you don't find it that first time, and it may not be there until a month, weeks afterwards. So stop, reevaluate everything and make sure that you didn't miss something along the road. And again, mistakes that have been made of had a patient that I saw that had an MRI done. Well, they didn't look at it. The patient was transferred some place and somebody thought that they had looked at the X-ray, but they didn't, whatever. And it took them several months before they realized she had a brain tumor. So I mean, in all those situations, we just look at it, don't decide that you looked at it once and it's not there. You always have to make sure that you keep your curiosity up.

Sepideh Bajestan (38:10):

And just to build on keeping the curiosity on, something that I'm hoping as we go and for our trainees, we get used to in medical field, in psychiatry, being able to say, "I don't know," without shame, "I don't know yet. It doesn't fit the disorders that I know." Let's be more curious. We don't have to come up with the final answer in the very first intake appointment. Just getting used to, "I don't know, let's just pause, slow down, make some consultations, see what's going on." That's very crucial. And then, lowering the bar for some mistakes. We all make mistakes and not to hold it as something shameful and preaching perfectionism in our field that doesn't help anybody, not the patients, not the clinicians.

Laura Roberts (39:11):

It sounds like you would like clinicians to be more empathetic toward themselves, not just more empathetic toward patients. Tell me about that emphasis on empathy in the care of patients that you wanted to really highlight in this book.

Sepideh Bajestan (39:28):

Of course, of course. So empathy, as you said, Laura, is both towards the patient and ourselves. So I was fortunate to work in the WellConnect team. I was on call every Monday for a few years for any emergencies in mental health that could come from the whole medical community, faculty, residents, fellows, and our physicians. They're doing an amazing job every single day. But we know that the rate of burnout is quite high. And if somebody is tired or for some reason have, as we say in our psychiatric lingo, has counter-transference towards a patient or a situation, that increases the effective bias or misdiagnosis. So it's a combination of being mindful of our own reactions and what's going on with the patient and having the opportunity and luxury of slowing down when things doesn't seem right. So in this book, we have used a lot of tables, a lot of algorithms, a lot of pictures that a clinician who has these questions at the bedside is a complex disorder can quickly look at and can come up with differential diagnosis like one, two, three, four, doesn't look like five, six, seven, eight, and be able to find a clear path going forward.

(41:09):

So it's a relationship that the physician would have with the patient, the family member, the dynamic in the room and with themselves, herself, or himself, or themselves, that would create a comprehensive care for the patient. Both John and I have been trained extensively in psychodynamic psychotherapy as well. So it brings us into the bedside. So we try to shed light in the dynamic that's going on here. So our psychiatric disorders create a lot of disabilities and changes the family dynamic. And then, what's going on right now in the realm between the patient, the caregiver, and us, and how can be helpful not just for only treating the patient and the symptoms, but also, the dynamic pivoting a little bit can help significantly, maybe even more than prescribing your medication. Just we pivot a little bit the dynamic and that's what the patient and the family needs.

Laura Roberts (42:18):

Well, I'm so appreciated talking with you. Any last thoughts for our audience? Just want to thank you for this wonderful book and...

Sepideh Bajestan (42:25):

Of course, thank you for the opportunity. We are very grateful that this opportunity came our way with your generous offer, Laura, as the Editor-in-Chief of APA. And I personally would like to thank our authors of the book. This was an international effort. Many authors from different parts of North America, many of them are members of the APA, many of them are wonderful graduates from our own fellowship, other fellowships. But I look at the book, it feels like a reunion at American North Psychiatric Association. It's fun to look at the name. So thank you for providing the opportunity.

John Barry (43:14):

And I would totally agree on everything that you said. But I want to finish up with a little story if we can. You talked about empathy, and I always tell the story when I was a resident at King's County Hospital. We used to make rounds with a Germanic surgeon who was everybody's hellion, he was awful. Everybody thought he was just terrible. But whenever we made rounds, and I'll never forget this, he said two things, "You never sit on a patient's bed. You never walk in, sit in their bed, talk to them, and don't forget to sit down and hold their hand because that's what makes them better. It's not your medications or whatever. It's the human interaction between you and the patient." And I think of that in reference to things like we're talking about using Zoom and all this stuff now, you need to be able to sit down and actually talk to the patient. That's what makes them better, not anything else. And anyway, all the things that you said, Sepideh, but I would totally agree with.

(44:14):

And also, I have an incredible pleasure and joy working with you because-

Sepideh Bajestan (44:20):

Thank you. Same here.

John Barry (44:22):

... it just really a complete joy. So I just want to make sure that everybody realizes that, so thank you. And thanks Laura, I appreciate it.

Speaker 4 (44:31):

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Speaker 5 (44:59):

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