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The Call for Integrated Care: Closer to Reality?

Connie M. Lee, M.D.

In the United States, it has been estimated that two-thirds of adults with a psychiatric disorder receive no treatment (1). Among those who do receive treatment, either in a general medical or mental health setting, half do not actually meet criteria for a psychiatric disorder (1), with treatment often falling below minimal standards of quality (2). Lack of access to mental health care has long been cited as problematic, with important ramifications on individual and population health. In a discussion of current mental health care delivery, one must consider not only the barriers that limit access to or utilization of care but also think critically about the quality of care that is delivered to ensure that limited resources are being used effectively.

Under traditional care delivery, behavioral health has largely been relegated to the periphery. A number of factors contribute to this marginalization. Current payment systems, which arose out of an attempt to contain costs after deinstitutionalization, led to a financing model in which behavioral health benefits are “carved-out” or separately managed or financed outside of the usual provider networks established by medical payers. Separate medical record systems, geographically distinct practice settings, and lack of standardized or routine communication or care coordination between behavioral health specialists and referring medical practitioners all serve to promote fragmentation of care (3).

Though treatment access for mental health has been increasing over time, the rate of increase has largely been in the sector of general medical or primary care services (1). Only a few patients treated in the general medical setting, however, receive minimally adequate care (as defined by evidence-based guidelines) when compared to

Efforts to integrate behavioral health and primary care services have been ongoing for a number of years for good reason.

those treated in mental health sectors (12.7% vs. 48.3% [see reference 2]). Primary care doctors cite shortages of mental health providers, health plan barriers, and inadequate or lack of insurance coverage as important impediments to mental health care access (4). Furthermore, the stigma associated with psychiatric disorders affects patients, their families, health care providers, institutions, and policy makers, ultimately serving to restrict resource allocation, as well as access to and utilization of timely and adequate care (5).

Efforts to integrate behavioral health and primary care services have been ongoing for a number of years for good reason. Neuropsychiatric conditions account for up to a quarter of all disability-adjusted life years worldwide (6). Psychiatric disorders increase the risk for diseases, intentional and unintentional injury, and are independently associated with a substantial increase in all-cause mortality (6). Inadequately treated psychiatric disorders are associated with poor health, higher medical illness and complication rates, increased health care service use, and overall higher health care costs (3).

As the Affordable Care Act continues to take effect, its mandate to expand access to high-quality care while reducing costs is reshaping the landscape of health care delivery. What could not

be achieved under traditional payer models is now a more likely, and financially viable, possibility (3). Hospitals and providers will increasingly receive payment for “value over volume,” and traditional fee-for-service payment will shift toward capitation or bundled payments that will incentivize health care innovations and integration of services. Since there is “no health without mental health,” this most recent health care reform presents a unique opportunity and challenge for psychiatrists to finally realize effective care integration for patients with medical and psychiatric comorbidities.

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On the Same Team: How Combination Programs Can Improve Contact, Consultation, and Patient Care

Jacob A. Bishop, M.D.

Soon after residency training begins, the age-old comments are first heard from the dark corners of the hospital: “The patient doesn’t have a psychiatric problem”; “What will psychiatry do anyway?”; or “The patient will be upset by it.” These attitudes have been documented previously (1) and still persist today, leading to dramatically low numbers of psychiatric consultations offered to patients, with some studies suggesting hospital referral rates as low as 1%–3% (1–2). Yet, integrating psychiatric and medical care has shown substantial benefits for treatment, costs, and patient satisfaction (1–3). Combined residency training programs offer a valuable opportunity to achieve this collaboration.

Stigma-reduction strategies are often used to improve communication and cooperation between supposed dissimilar groups. From a health care perspective, stigma reduction can improve integration of physicians in different fields. Corrigan and Kosyluk (4) reviewed several of these strategies utilizing a social injustice framework. While the subjects differ, the principles can be applicable. Methods of stigma reduction that have shown positive results include “protest” involving actions that chastise those who perpetuate stigma, “education” that provides factual challenges to inaccurate stereotypes, and “contact” between perpetrators and stigmatized individuals. In terms of lasting progress, contact was found to be the superior form of stigma reduction, specifically when it is targeted, continuous, face-to-face contact between similarly credible groups.

Psychiatry clerkships in medical school are one example of contact yield-

As collaborative care is becoming more attainable, it is time to directly address the obstacles that prevent integration.

ing positive effects on attitudes toward psychiatry (5). On a professional level, further integration is needed to facilitate contact between medical and mental health physicians. One strategy to do so is training individual physicians in both medical and mental health specialties, a feat well-accomplished by psychiatry combination programs. Currently, 33 residency programs exist that combine psychiatric training with other specialties of medical training, specifically internal medicine, family medicine, neurology, and pediatrics.

As a resident in a combined pediatric medicine and child/adult psychiatric training program, I have experienced firsthand how collaboration and face-to-face contact between medical and psychiatric providers positively affect patient care. One of my pediatric medicine months was spent with pediatric pulmonologists providing inpatient care to their patients. I was able to work alongside these physicians to provide medical care for patients with diagnoses such as cystic fibrosis, bronchopulmonary dysplasia, and congenital anomalies. As our work experience grew, the attendings’ trust in me continued to develop, and I was able to work with many of the pa-

tients on their mental health and behavioral concerns. Since that time, the pediatric pulmonology team has referred a number of patients to my pediatrics clinic for primary care with a stronger focus on mental health.

It has been estimated that 60% of patients with a psychiatric diagnosis receive no psychiatric treatment (3). This is an unacceptably high number. As collaborative care is becoming more attainable, it is time to directly address the obstacles that prevent integration. Contact between specialties is essential to overcome the stigma preventing collaboration, and combination training is an excellent vehicle to accomplish that goal.

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A Call for Advocacy: How Residents Can Help Decrease Barriers to Psychiatric Care

Luming Li, M.D.

Mental health care is fragmented, with services that are variable in quality and scope throughout the United States. Psychiatrists are often not available, not taking new patients, or do not respond to referral requests. Service users have difficulty accessing care in a timely manner, which results in increased emergency visits (1). Worse yet, many untreated people with mental illness are jailed for misdemeanors or sent to nursing homes at a young age (2). Even though more than 45% of Americans will have a diagnosable mental illness in their lifetime, many community mental health programs lack sustainable funding for core programs (3). In this current system, many patients cannot stay well. Although parity laws require equal reimbursement of psychiatric and medical conditions, more comprehensive mental health reforms are needed to improve access to care.

Earlier this year, a comprehensive mental health reform bill was proposed to Congress. The bill, titled the Helping Families in Mental Health Crisis Act, passed a subcommittee vote in the House of Representatives in November 2015. It awaits the full committee vote before reaching the House floor. The bill calls for a new cabinet position (Assistant Secretary for Mental Health and Substance Use Disorders), grant reform and restructuring, more research funding to the National Institute of Mental Health, and expansion of Medicaid and Medicare coverage of mental health services (4). This bill has gained traction as neutral, bipartisan legislation and is an important step forward.

Residents are important stakeholders in local and national policymaking

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for several reasons. First, residents are in the frontlines for many inpatient and outpatient services and can contribute useful dialogue about specific patient needs. Second, residents can use insightful clinical vignettes to discuss psychiatric conditions publicly and can educate others about the realities of mental illness and substance use disorders. Finally, residents can be empowered to voice the negative effects of budgetary cuts and ask for additional funding for poorly resourced services.

Residents can help by proactively learning about national reform efforts and participating in advocacy efforts. Most trainees already participate in micro-level advocacy through direct care of patients. This includes consulting social work or making direct referrals to patient assistance programs by calling drug companies for medication subsidies. Advocacy should also include macro-level efforts to support mental health reform. In fact, the Accreditation Council for Graduate Medical Education requires psychiatry residents to develop skills in advocacy, which is a subsection of systems-based practice (5).

Residents can participate in the political process through writing op-eds, emailing congressmen, and going to open public hearings to talk about resource shortage. These opportunities occur throughout the year. Residents can ad-

vocate by reading and forming viewpoints about bills, such as the Helping Families in Mental Health Crisis Act, and can write to state and national legislators about the importance of comprehensive mental health reform. Residents can also consider participating in local residency-related grassroots events. Through advocacy efforts, residents can help achieve meaningful, national mental health reform that improves resources and funding for one of society's most discriminated population.

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The Burden of Mental Illness Beyond Clinical Symptoms: Impact of Stigma on the Onset and Course of Schizophrenia Spectrum Disorders

Gil Dov Hoftman, M.D., Ph.D.

In 2013, 18.5% or 43.8 million American adults suffered from mental illness (1). In the National Survey on Drug Use and Health/Substance Abuse and Mental Health Services Administration (NS-DUH-SAMHSA) survey, about one out of every five people aged 18–25 years old—during the years that young adults form critical professional, social, and romantic relationships and transition toward independence—reported mental illness symptoms.

A 2007 survey of roughly 200,000 adults across 35 states focused on attitudes toward mental illness and showed that 57% of people believed that others were caring and sympathetic toward people with mental illness (2). Only 25% of individuals afflicted with an illness themselves believed the above to be true, highlighting the lack of support they feel. Adverse attitudes toward individuals with serious mental illnesses could underlie stigmatization of those individuals.

Prototypical serious mental illnesses affect roughly 10 million U.S. adults and include schizophrenia spectrum disorders, which are characterized by clinical symptoms of hallucinations, delusions, affective dysregulation, and cognitive dysfunction. Current medications that treat delusions and hallucinations often have severe side effects that result in slowed thoughts, slowed or abnormal movements, and significant weight gain. These medications are largely ineffective in treating the affective and cognitive symptoms, leaving individuals still debilitated.

In addition to clinical symptoms, people with schizophrenia spectrum disorders are often targets of negative

attitudes and social labels that lead to stigma (3). The stigma associated with schizophrenia can precipitate initial episodes of psychosis, trigger relapses, and promote a more severe course (4). The present review discusses the concept of stigma, its impact on schizophrenia onset and course, and strategies for health care professionals to eradicate stigma.

WHAT IS STIGMA?

In Ancient Greece, stigma was a brand that was cut or burnt into the body to advertise a person's permanent physical or psychological blemish. In modern Western culture, stigma has evolved to indicate some disgraceful attribute such that others see the stigmatized person as an acceptable target for discrimination. Stigma has become a justification for labeling others as inferior and threatening (5).

The concept of stigma has multiple components that include 1) labeling of socially important differences (e.g., hearing voices or having delusions), 2) linking labeled people with negative stereotypes (e.g., people with schizophrenia are violent and unpredictable), 3) categorizing labeled people to facilitate social exclusion (e.g., “psychotic,” “schizophrenic”), and 4) status loss for and discrimination toward labeled people (e.g., employment and health care inequalities, incarceration, homelessness, retaliatory violence) (6).

Stigma can be divided into at least three different subtypes (see Table 1). Internalized stigma develops when stigmatized individuals internalize negative stereotypes and view themselves

as flawed relative to others, leading to emotions of embarrassment, shame, fear, and alienation (6). Interpersonal stigma results in the social rejection and isolation of a stigmatized person due to emotions of anger, anxiety, pity, or fear elicited in those who are not stigmatized (6). Finally, institutional stigma occurs when institutional practices result in the discrimination of stigmatized groups (6).

IMPACT OF STIGMA ON ONSET AND COURSE OF SCHIZOPHRENIA SPECTRUM DISORDERS

Stigma contributes to the onset and negative clinical course in schizophrenia disorders in multiple ways. Individuals experiencing subclinical psychotic symptoms tend to internalize negative stereotypes about those with mental illness, an example of internalized stigma. One study examined whether the perception of discrimination was associated with symptom onset and found that perceived discrimination predicted incident delusional ideation in a dose-response fashion (7). Internalized stigma also contributes to social isolation in individuals with schizophrenia, which has long been known to increase the risk for poor health outcomes (8). Other consequences of internalized stigma include delayed treatment seeking, perceiving the need for treatment as weak, and decreased treatment adherence (9).

Interpersonal stigma effects on schizophrenia are described by stress-vulnerability models, which postulate that social stressors contribute to the clinical onset of schizophrenia (3, 10). Subtle changes in the behavior of those

TABLE 1. Stigma Types, Definitions, Examples, and Eradication Strategies

Stigma Type	Definition	Examples	Eradication Strategy
Internalized	Negative stereotypes and views of permanent flaws accepted by labeled individuals	Negative self-labeling; low self-esteem; devalued identity; negative self-image	Engaging in a collaborative and empathic relationship focused on patient empowerment
Interpersonal	Labeled individuals socially categorized facilitating discrimination	Social rejection and isolation; bullying or labeling at home, school and/or work	Encouraging regular, informal social contact between labeled and unlabeled individuals
Institutional	Labeled individuals excluded by institutional policies and practices	Decreased opportunities for education, jobs, housing, and health care	Enlisting advocates for policies that protect people with mental illnesses and increase research funding

experiencing subclinical psychosis may give rise to negative social interactions and discrimination, which increases the risk for delusional ideation. For example, the observed risk for schizophrenia in minority groups increases with the level of discrimination endured (11). Another study showed that individuals who were either at high or ultra-high risk that transitioned to schizophrenia reported higher stigma-related harm and that higher perception of harm due to stigma at baseline predicted the transition to schizophrenia (12). Studies also demonstrate that interpersonal stigma can exacerbate schizophrenia symptoms and increase vulnerability to relapse due to increased stress and delayed treatment seeking (4).

Institutional stigma increases negative outcomes in schizophrenia as well. Mental illnesses including schizophrenia receive the least amount of funding per disability-adjusted life-years despite having one of the largest disease burdens worldwide (13). Treatment facilities for schizophrenia tend to be located in isolated, disadvantaged, or otherwise limited-access areas (6). In addition, having a history of mental illness leads

to resource-reducing discrimination in employment, wages, mortgages, housing, and education (14).

This combination of internalized, interpersonal, and institutional stigma has a synergistically corrosive effect on mental and physical health that extends far beyond clinical symptoms. Stigmatized individuals often deplete adaptive coping mechanisms while managing a devalued identity and then engage in maladaptive emotional regulation strategies such as rumination and other maladaptive coping behaviors such as smoking and drinking, increasing their risk for other adverse health outcomes (15). Also, the stigmatized fear that publicizing the illness will decrease job opportunities and social status, cause shame, and lead to involuntary hospitalization results in delayed treatment seeking and worse clinical outcomes.

ERADICATING STIGMA

It is crucial to recognize and break down the barriers to reducing stigma. These barriers are manifold (for details, see reference 16), but it is important to note that some stem from the biased at-

titudes and practices of mental health professionals. Members of the care team, including physicians, psychologists, and care managers, can denigrate individuals with mental illness and hold low expectations for improvement (16). Mental health workers may develop negative attitudes toward the patients they treat because of repeated exposure to derogatory and inaccurate media images of mental illness and of helping professionals (17). Even physicians affected by mental illness suffer from interpersonal stigma due to a deeply rooted view in the medical profession that disclosing mental health issues admits constitutional weakness and invalidates their ability and reputation as physicians (18).

Hinshaw and Stier (16) suggest multiple pathways for overcoming negative attitudes and practices by mental health professionals, including improved training in evidence-based interventions, engaging in a collaborative and empathic relationship focused on patient empowerment, and the provision of psychological support for mental health professionals in response to the daily stresses resulting from working in the mental health field.

A significant barrier to eradicating interpersonal stigma is a paucity of social contact with stigmatized individuals, leading to a lack of empathy (16). Unfortunately, contact with stereotyped representations of people with mental illness—for example, interacting with a homeless individual with profound thought disorganization on the street—appears to reinforce the negative beliefs that the entire group consists of deviant, dangerous individuals (16). In contrast, when majority group members contact stigmatized individuals in

KEY POINTS/CLINICAL PEARLS

- Severe mental illnesses require access to high-quality and affordable care that is evidence-based, respectful, and empathic.
- People with severe mental illnesses like schizophrenia spectrum disorders are often targets of negative attitudes and social labels that lead to stigma.
- Stigma associated with schizophrenia can precipitate initial episodes of psychosis, trigger relapses, and promote a more severe course.
- Mental health professionals can perpetuate stigma in people with mental illness, unless care is taken to provide a collaborative and empathic relationship focused on patient empowerment.

conditions of relatively equal power and status, the interaction is far more likely to generate positive attitudes and chip away at stigma. Regular, informal contact is most likely to eradicate negative perceptions of stigmatized individuals (16). Shared goals and cooperative work toward common ends between people with and without mental illness promote an environment where attitudes are more likely to be positive and contact is likely to continue.

CONCLUSIONS

Stigma is a form of social injustice that contributes to the onset of psychosis in schizophrenia spectrum disorders, delays treatment attainment, promotes social isolation, stress, and maladaptive coping behaviors, and places individuals with schizophrenia at higher risk for a more severe illness course. Reduction and eradication of mental illness stigma will require concerted efforts at the individual (affected person and family unit), interpersonal (schools, workplaces, clinics, hospitals, mental health professionals), and institutional levels (media, advocacy groups, policy changes, new legislation). Mental illnesses are debilitating disorders that require access to high-quality and affordable care that is evidence-based, respectful, and empathic. Effectively integrating these factors can decrease symptom burden while at the same time reducing discrimination, enhancing accurate empathy, and promoting helpful social contact.

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Management of Depression in Parkinson's Disease

Anna Frenklach, M.D.

Although traditionally considered a purely motor disorder, Parkinson's disease is increasingly recognized as a complex disease process with diverse neuropsychiatric complications in addition to its motor symptomatology. The range of neuropsychiatric complications associated with Parkinson's disease is broad and includes depression, anxiety, apathy, psychosis, cognitive impairment, impulse control disorders, and sleep disturbances. These neuropsychiatric complications become increasingly prevalent over the course of the disease and are often associated with poorer quality of life, increased disability, worse outcomes, and greater caregiver burden (1). As mental health providers commonly encounter depression in the Parkinson's disease population, it is important to be familiar with available, validated treatment options for this illness.

A trial of citalopram was begun in an elderly man with a history of Parkinson's disease with depression and suicidal ideation.

A 68-year-old man with a 4-year history of Parkinson's disease stable on levodopa and no previous psychiatric history was brought by his wife to the emergency department for worsening depression and suicidal ideation. Screening laboratory tests and chest x-ray were unremarkable. Per neurology consultation, the patient was at his baseline with respect to motor symptoms with no new neurological deficits. A head CT had recently been obtained, and repeat imaging was not indicated. He was subsequently admitted to the psychiatry service for management of his depressive symptoms. On admission, he was started on citalopram, which was slowly titrated to a maximum daily dose of 20 mg without any worsening of motor symptoms. Over the next

2 weeks, he reported improved mood without any further suicidal ideation. He was discharged home with outpatient psychiatry follow-up.

PARKINSON'S DISEASE AND DEPRESSION

Parkinson's disease is a chronic, progressive neurodegenerative disorder clinically diagnosed by a combination of cardinal motor signs: bradykinesia, resting tremor, rigidity, and postural instability. The pathological hallmarks of Parkinson's disease include the loss of dopaminergic neurons within the substantia nigra and the presence of Lewy bodies, intracytoplasmic inclusions comprised mainly of alpha-synuclein (2). While the estimated prevalence for Parkinson's disease has varied widely, a recent meta-analysis reported the worldwide prevalence to be approximately 0.3% in the general population, suggesting that there are 7.5 million people living with the disorder worldwide (3). The incidence has been found to rapidly increase in populations over 60 years of age, with a mean age at diagnosis of 65 years (2). A male predominance has also been observed in many but not all epidemiologic studies, suggesting that men may have a higher risk for developing the disease than women (3).

Among the neuropsychiatric complications of Parkinson's disease, depression is one of the most common and is associated with increased disability and reduced quality of life. Depending on diagnostic criteria used, the estimated prevalence of depression in Parkinson's disease has varied widely across studies, from 2.7% to more than 90%, with an average prevalence of about 35% (4). Factors that have been found to be consistently correlated with depression in Parkinson's disease include early-onset,

advanced progression of the disease, "atypical" parkinsonism, female gender, and a personal or family history of depression, as well as psychiatric comorbidities, including anxiety, apathy, psychosis, cognitive impairment, and insomnia (1). While the underlying mechanism remains unclear, depression in Parkinson's disease is thought to result from a complex interaction of psychological, social, and neurobiological factors. For some patients, depressive symptoms may actually represent a prodromal syndrome presenting before motor symptoms become apparent (5). Although depression is common in the disease and increasingly recognized as adversely affecting disability and quality of life, depression in Parkinson's disease remains under-recognized and undertreated in clinical practice (4).

EVALUATION OF DEPRESSION IN PARKINSON'S DISEASE

Recognizing depressive symptoms in Parkinson's disease can be challenging because the psychomotor slowing and blunted affect commonly seen in depression can resemble the bradykinesia and masked facial expression of Parkinson's disease. Additionally, somatic features of depression such as decreased appetite, low energy, and sleep disturbances are commonly seen in patients with Parkinson's disease who do not have depression. Furthermore, depression must be differentiated from apathy, which commonly occurs in Parkinson's disease, is characterized by diminished motivation, and has significant overlap with depressive symptoms. A potentially useful discriminating feature is mood, which is negative in depression and neutral in apathy (6). It is important to remember that the differential diagnosis for depression is broad and in-

cludes other psychiatric disorders such as bipolar disorder, cognitive disorders, neoplastic processes affecting the central nervous system, metabolic and endocrine abnormalities, infections, hypoxemia, sleep disorders, medication side effects, and substance use, as well as hypoactive delirium caused by a variety of underlying illnesses.

The initial assessment of patients with Parkinson's disease presenting with depressive symptoms should involve a comprehensive medical and psychiatric history, review of current medications, collateral information, and physical examination. Screening laboratory tests should include blood cell counts, complete metabolic panel, thyroid-stimulating hormone, and vitamin B12. Depending on the degree of clinical suspicion for other etiologies, such as substance use, sexually transmitted infections, and/or delirium, it may be necessary to check blood alcohol level, blood/urine toxicology, screens for HIV and syphilis, arterial blood gas, and chest x-ray. Head imaging, neurology consultation, and neuropsychological testing should also be considered as clinically indicated (see Table 1).

Once other etiologies have been considered and appropriately ruled out, a diagnosis of depression can be made clinically based on symptomatology. According to a 2008 study by Starkstein et al. (7), DSM-IV diagnostic criteria for major depressive disorder and dysthymic disorder have been validated for use in patients with Parkinson's disease, while the categories of minor and subsyndromal depression likely need further validation for use in this patient population.

MANAGEMENT OF DEPRESSION IN PARKINSON'S DISEASE

Pharmacologic Management

At this time, there is no clear consensus regarding the use of antidepressants for the treatment of depression in patients with Parkinson's disease. There is some evidence to suggest that selective serotonin reuptake inhibitors (SSRIs), serotonin norepinephrine reuptake inhibitors (SNRIs), monoamine oxidase type B inhibitors (MAOBIs), and tricyclic an-

TABLE 1. Management of Depression in Parkinson's Disease

Evaluation
<ul style="list-style-type: none"> • Comprehensive medical and psychiatric history. • Review of current medications. • Physical examination. • Collateral information. • Laboratory testing to rule out medical etiologies. • Head imaging, neurology consultation, and neuropsychological testing as clinically indicated.
Diagnosis
<ul style="list-style-type: none"> • DSM-IV diagnostic criteria for major depression and dysthymic disorder have been validated for use in this patient population (7).
Pharmacologic treatment
<ul style="list-style-type: none"> • No clear consensus regarding antidepressants for the treatment of depression in Parkinson's disease exists at this time. • There is some evidence to support the use of selective serotonin reuptake inhibitors (SSRIs), serotonin norepinephrine reuptake inhibitors (SNRIs), monoamine oxidase type B inhibitors (MAOBIs), tricyclic antidepressants, and dopamine agonists (9–13). • SSRIs remain the most commonly prescribed antidepressants given their more favorable side-effect profile; however, the strength of evidence for the efficacy of antidepressants in treating depression in Parkinson's disease is controversial (1, 4, 8). • MAOBIs and tricyclic antidepressants may be used cautiously for patients who have not responded to treatment with SSRIs and/or SNRIs (12, 15).
Non-pharmacologic treatment
<ul style="list-style-type: none"> • There is insufficient evidence to support the efficacy of either ECT or transcranial magnetic stimulation; however, these treatments may be considered in severe, refractory cases that have failed pharmacotherapy (16). • Psychotherapy, particularly cognitive-behavioral therapy, is increasingly being studied with promising results (10).

tidpressants may be effective pharmacologic agents for treating depression in Parkinson's disease. However, the strength of evidence for the efficacy of antidepressants in treating depression in this patient population is controversial. According to a meta-analysis comparing the use of SSRIs and placebo for the treatment of depression in Parkinson's disease, there was insufficient evidence to reject the hypothesis of no difference in efficacy between SSRIs and placebo (8).

The antidepressants with the most evidence for treating depression in Parkinson's disease include citalopram, sertraline, paroxetine, fluoxetine, venlafaxine, amitriptyline, nortriptyline, and desipramine (9–11) (see Table 2). In addition to the role of MAOBIs in treating motor symptoms of Parkinson's disease, a recent randomized double-blind, placebo-controlled multicenter trial (ADAGIO study) showed that rasagiline in combi-

nation with antidepressant therapy was well tolerated and associated with reducing worsening of depression in patients with Parkinson's disease (12). There is also some evidence to support the use of dopamine agonists, pramipexole and ropinirole, for the treatment of depression in the disease (9, 10, 13). Despite limited evidence and the lack of formalized treatment guidelines, SSRIs remain the most commonly prescribed antidepressants for the treatment of depression in Parkinson's disease given their more favorable side-effect profile (4).

While SSRIs are generally well tolerated, there is concern that SSRIs may aggravate motor symptoms in patients with Parkinson's disease. However, clinical experience and open-label studies have suggested relatively good tolerability of SSRIs with low incidence of worsening motor symptoms in this patient population (1, 4). Additionally, as MAOBIs are commonly prescribed

TABLE 2. Pharmacologic Agents for Treating Depression in Parkinson's Disease

Medication Class	Dose Range (mg/day)	Side Effects for Medication Class	Contraindications for Medication Class
Selective serotonin reuptake inhibitors	Fluoxetine: 10–60 mg/day Citalopram: 10–40 mg/day <i>(10–20 mg/day in poor CYP2C19 metabolizers and patients older than 60 years old.)</i> Sertraline 25–200 mg/day Paroxetine 10–50 mg/day	Common: Gastrointestinal side effects ^a , sexual dysfunction, insomnia Rare/serious: Induction of mania, activation of suicidal ideation	Caution with other serotonergic agents due to risk of serotonin syndrome
Serotonin norepinephrine reuptake inhibitors	Venlafaxine: 37.5–225 mg/day Duloxetine: 20–120 mg/day	Common: Gastrointestinal side effects ^a , sexual dysfunction, insomnia, dose-dependent increased blood pressure Rare/serious: Induction of mania, activation of suicidal ideation	Caution with other serotonergic agents due to risk of serotonin syndrome
Monoamine oxidase type B inhibitors	Rasagiline: 1–2 mg/day <i>(hepatic dosing: 0.5 mg/day for mild impairment; avoid use in moderate-severe impairment)</i>	Common: Nausea, headache, orthostatic hypotension, dyskinesia Rare/serious: Hypertensive crisis, impulse control disorders, paranoia, hallucinations, confusion, sudden sleep episodes, increased risk of melanoma	Caution with other serotonergic agents due to risk of serotonin syndrome Caution with rapid dose reduction or discontinuation due to risk of neuroleptic malignant syndrome-like reactions Contraindicated with concomitant use of other MAOIs (including selective MAOIs), meperidine, methadone, propoxyphene, or tramadol within 14 days of rasagiline or concomitant use with cyclobenzaprine, dextromethorphan, or St. John's wort
Tricyclic antidepressants	Amitriptyline: 25–300 mg/day Desipramine: 25–200 mg/day Nortriptyline: 25–150 mg/day	Common: Anticholinergic side effects ^b , weight gain, dizziness, orthostatic hypotension, sexual dysfunction Rare/serious: QTc prolongation, cardiac arrhythmias, sudden death, induction of mania	Caution with other serotonergic agents due to risk of serotonin syndrome Contraindicated in the acute recovery phase following a myocardial infarction, in patients with a history of QTc prolongation or cardiac arrhythmia, or uncompensated heart failure
Other	Mirtazapine: 7.5–45 mg/day	Common: Sedation, increased appetite, weight gain, elevated cholesterol Rare/serious: Induction of mania, activation of suicidal ideation	Caution with other serotonergic agents due to risk of serotonin syndrome
	Bupropion: 100–450 mg/day	Common: Nausea, weight loss, anxiety, agitation, insomnia Rare/serious: Seizure, induction of mania, activation of suicidal ideation	Contraindicated in patients with a history of seizures, anorexia, bulimia, or undergoing abrupt discontinuation of ethanol or sedatives
Dopamine agonists	Pramipexole: 1–3 mg/day	Common: Nausea, dyskinesia Rare/serious: Impulse control disorders, paranoia, hallucinations, confusion	Caution if renal impairment

^a Gastrointestinal side effects include decreased appetite, nausea, diarrhea, constipation, and dry mouth.

^b Anticholinergic side effects include sedation, dry mouth, constipation, urinary retention, and blurred vision.

for the treatment of motor symptoms in Parkinson's disease, there is concern for precipitating serotonin syndrome when MAOIs are used in combination with SSRIs and/or other antidepressants. Although several studies have found this adverse event to be infrequent, cases of severe, sometimes fatal, serotonin syndrome have been associated with

concurrent MAOBI and antidepressant treatment, suggesting that caution be used when prescribing combination therapy in this patient population (STACCATO study) (14).

When beginning pharmacotherapy for depression in a patient with Parkinson's disease, the choice of antidepressant should be based on an assessment

of potential benefits versus potential side effects for the individual patient. In general, it is reasonable to start with an SSRI given the decreased risk of adverse events for SSRIs compared to other antidepressants. While the anticholinergic side effects of tricyclic antidepressants may be particularly troublesome in this patient population, a tricyclic antidepressant

KEY POINTS/CLINICAL PEARLS

- Among the neuropsychiatric complications of Parkinson's disease, depression is one of the most common and is associated with increased disability and reduced quality of life.
- The initial evaluation of patients with Parkinson's disease presenting with depressive symptoms should include a comprehensive medical and psychiatric history, review of current medications, collateral information, physical examination, and laboratory testing to rule out medical etiologies.
- There is no clear consensus regarding choice of antidepressants for the treatment of depression in Parkinson's disease at this time. Selective serotonin reuptake inhibitors (SSRIs) are commonly prescribed due to their more favorable side-effect profile. Serotonin norepinephrine reuptake inhibitors (SNRIs) may also be considered. Monoamine oxidase type B inhibitors and tricyclic antidepressants may be used cautiously in patients who have not responded to treatment with SSRIs and/or SNRIs.
- ECT or repetitive transcranial magnetic stimulation may be considered in severe, refractory cases that have failed pharmacotherapy. Psychotherapy, particularly cognitive-behavioral therapy, is increasingly being studied with promising results.

pressant may be an appropriate option for patients who have not responded to treatment with SSRIs and/or SNRIs (15).

Non-Pharmacologic Management

Non-pharmacologic interventions, including ECT and repetitive transcranial magnetic stimulation (rTMS), are being explored for the treatment of depression in Parkinson's disease. Thus far, there is insufficient evidence to support the efficacy of either ECT or rTMS for depression in this patient population; however, ECT and/or rTMS may be considered in severe, refractory depression that has failed pharmacotherapy (16). Finally, psychotherapy is increasingly being studied with promising results. According to a recent meta-analysis, cognitive-behavioral therapy appears to be a safe and efficacious treatment for depression in patients with Parkinson's disease; however, further studies are needed to establish the magnitude of this treatment effect (10).

CONCLUSIONS

Although traditionally considered a purely motor disorder, Parkinson's disease is increasingly recognized as a complex disease process with a wide array of neuropsychiatric complications. Depres-

sion is one of the most common neuropsychiatric complications of Parkinson's disease; however, the current evidence guiding the treatment of depression in the disease is limited. Given the potential negative impact on motor disability and quality of life, it is important that clinicians consider and treat depression in patients with Parkinson's disease. Further research is required to assess the efficacy and safety of both pharmacologic and non-pharmacologic treatments in order to better inform our management of depression in this disease.

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Finding Ishmael: Using a Patient's Connection With Story to Foster Insight and Progression in Treatment

Ashleigh Colin, M.B.B.Ch., M.A.

The Drama's done. Why then here does any one step forth?

—Because one did survive the wreck.
(Ishmael, *Moby-Dick*)

Story has the power to move man. Perhaps this is because stories reflect universal human experience, providing a mirror of analogy between the universal and the individual. When a patient struggles to talk about emotionally laden experience, identification with a fictional character can be used to increase diagnostic clarity (1) and develop a personal narrative in the service of healing. Rather than directly confronting a patient, story can be used as a tool for reflection, bypassing defensiveness, allowing distancing, and the development of insight, as demonstrated in this case report (1, 2).

CASE

"Mike" was the older of two brothers. He took responsibility for protecting his brother as they moved from foster home to foster home. As teenagers, the brothers were reunited with their mother, who was a heavy drug user. Both brothers began to use heroin. At age 17, Mike's brother was diagnosed with AIDS. A few months later, he died alone in a hospital room; Mike did not go to see him. Nearly 2 years after his brother's death, Mike was taken to a hospital for a non-resolving abdominal mass and diagnosed with HIV. He took no food, was sick, and on the verge of death. When I started seeing him, he was living in a residential home struggling to stay clean. He had asked to start treatment for help.

He described an ever-present urge to return to his mother's home, knowing

that this may lead to relapse and worsening health. He reported it as something out of his control, saying "I don't want to die, but I can't help it." He struggled to go into more detail about this, using most of his time to complain about the residence and how they policed him. For the first few months, he would sit slouched in his chair playing on his cellphone. He would often report that he had nothing to say and leave early.

One day, after about 8 months, he came into the session talking about the movie *Moby Dick*. "What did you think of it?"; I asked. "Ahab wasted his life over a stupid whale. For what? What did he spend his whole life running after a stupid [expletive] whale for?" Mike repeated the question a number of times.

DISCUSSION

Such a strong reaction to Ahab, from a usually nonchalant Mike, took me by surprise. It was the first intense emotion he had displayed. Kirmayer (1) describes the importance of paying attention to "the metaphorization of distress," stressing its value in the creation of meaning both for the therapist and the patient.

Mike often used metaphor and symbol to describe his struggles. For instance, after an operation, he came in lifting his shirt literally bearing his scars for me to see. His intense association to the character of Ahab in *Moby Dick* was another symbolic communication. Shechtman (2) believes that the process of identification with a character allows for a reconnection with feeling and experience. Symbolic associations can thus aid a therapist in uncovering, and then understanding, emotionally

charged experiences that cannot yet be put into words (1, 2).

MOBY DICK

The story.

Moby Dick was written by Herman Melville in 1851 and has been dubbed a "world classic" novel (3). The story is written in the first person by Ishmael, a sailor on a whaling ship. It tells the story of the ship's captain, Ahab, who puts his ship and men in peril as he pursues a vendetta against a white whale, *Moby Dick*, which cost Ahab his leg. In the end, only one character survives Ahab's quest—that is Ishmael.

AHAB AND HIS OBSESSION

The discovery of meaning in analogy.

Many aspects of the *Moby Dick* story mimicked Mike's struggle to separate from his destructive impulses, reflected in the figure of Ahab relentlessly pursuing his whale and his doomed fate. Ahab says of analogy, "O Nature, and O soul of man! How far beyond all utterance are your linked analogies!" (4). Ahab here is noting that what one sees on the outside, in "nature," reflects what one is experiencing on the inside, in the "soul of man." Mike's resonance with Ahab was reflecting an inner experience. Kirmayer (1) argues that metaphors hold diagnostic value via their origin in a patient's "unself-conscious self-representation."

When a patient is struggling to say what the inner experience might be, like Mike, one method of discovery is to research archetypal symbolism. Archetypes are the repeated underlying patterns seen in the themes and images of a

KEY POINTS/CLINICAL PEARLS

- When a patient struggles to reflect upon emotionally laden experiences, identification with a fictional character can be used to foster insight without triggering defensiveness.
- When stuck in thoughtless repetition, finding the intersection between the archetypal meaning and the individual response to symbolism in literature can help build reflective understanding and shift perspective.
- A patient's affinity with a story or character can increase diagnostic and therapeutic clarity.
- Using story can help build a patient's self-narrative, creating cohesion out of disparate parts.

story. Jung (5) believes that archetypes, as represented in mythology, folklore, fairy tales, and images, represent aspects of the deeper levels of man's psyche, containing within them universal psychological significance.

In *Moby Dick*, The white whale is laden with archetypal symbolism. According to Edinger (6), the whale is described at one point as being, "Cellini's Cast Perseus," likening the whale to Medusa, with the ability to petrify and stultify life. Ahab, according to Edinger, is "petrified into a single obsession" with an inability to let go of his aim.

Mike's addiction gripped him and "petrified" him into an inability to reflect upon and question his urge to return to his mother. He could resonate with the idea of being propelled thoughtlessly forward on a destructive path, like Ahab was. His emotional reaction to Ahab "wasting" his life away offered an opening, a way to shift this petrification.

Authors (1, 3, 5, 7, 8) stress that the reflective nature of art, literature, and drama provides a mirror in which a greater world of being can be reflected and mediated upon. By evoking emotion and felt experience, the symbolic nature of story can elicit a shift in patients who are stuck within a rigid pattern of thought or behavior (1).

ISHMAEL AND HIS SURVIVAL

The clarification of conflict.

A metaphor or story describing a certain problem holds its own suggestions for resolution (1, 7). In *Moby Dick* there

lies massive destruction—yes. But there also lies hope in the survival of Ishmael.

Edinger (6) wrote that Ahab met with his destruction because he lacked an ability to reflect upon his actions and to attend to others' responses. He did not gain insight into his unconscious intentions as mirrored in the reaction of others. Gomez (3) concurs that Ahab could not reflect upon what he was doing and put his life and those of his crew in peril, but Ishmael, on the other hand, reflected on the events of his life. This was through his interaction and friendship with his crewmates and through the writing of his book.

In the above case, Mike had asked to start treatment. He had an inner Ishmael, an inner desire to reflect and so survive, instead of thoughtlessly returning to his old life. By using his attraction to the story, which opened up a way to maneuver beyond initial defensiveness, his access to this reflective capacity could be found and strengthened. Mike's willingness to seek treatment and then to explore his connection to Ahab and *Moby Dick*, fostered his ability to connect with his urges on a deeper level, and he began to put his experiences into words.

By the 16th month of treatment, Mike described a fear that if he did not return to his mother, she would abandon him to die alone, as he had once abandoned his brother. He did not want to die of the complications of AIDS, but he also did not want to die alone and abandoned. It was this fear of dying alone that had "petrified" him. He became able to talk about and connect emotionally with this fear. Ishmael survived clinging onto a

coffin, symbolically accepting loss. Mike had to process and accept the loss of his relationship, albeit a toxic one, with his mother. He had to metaphorically stop chasing his whale and risk feeling disconnected and alone.

The use of *Moby Dick* as an indirect analogy to Mike's plight revealed itself to be less threatening than direct confrontation. Mike's resonance with the story provided an opportunity to explore his destructive as well as constructive desires, which allowed the treatment to progress from a position of stagnation to one of movement and exploration. The type of therapy shifted from supportive in nature to insight-driven with a focus on his ambivalent desires (symbolically his Ahab and his Ishmael), and the ability to create a narrative about them.

Goldwyn (9) argues that one way in which psychotherapy works is through the co-creation of a more resonant narrative through the development of insight. Such a narrative can provide meaning, purpose, and connection, uniting disparate themes and contradictions (1, 9), such as Mike's desire to stay healthy and live, which seemed to contradict the ever-present urge to return to his mother and consequent relapse.

Mike first told his story in therapy. A few years later, he told his story in a newspaper article in order to help others in similar situations. He still struggles but has stayed at the resistance and remained sober. Like with Ishmael, a painful experience when reflected upon through the mirror of art had redeeming value.

Dr. Colin is a second-year child and adolescent psychiatry fellow in the Department of Psychiatry, Yale University, New Haven, Conn.

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Writing a Scholarly Article

The American Journal of Psychiatry-Residents' Journal Workshop

Residents, fellows, and students are invited to attend the 2016 American Journal of Psychiatry Residents' Journal Workshop, to take place at the American Psychiatric Association Annual Meeting in Atlanta.

- Write your first scholarly article in the session. (If you are interested in volunteering as an author for the session, please e-mail rajiv.radhakrishnan@yale.edu.)
- Bring your thoughts and ideas about the *Residents' Journal*
- Hear a brief presentation about the Journal's new developments
- Meet with *Residents' Journal* editors and editorial staff
- Meet the *American Journal of Psychiatry* Editor-in-Chief Robert Freedman, M.D.

Tuesday, May 17th, 2016 • 1:30 PM–3:00 PM

Georgia World Congress Center - Building B - Level 3, Room B310



AJP Residents' Journal Featured in May 2016 American Journal of Psychiatry!

The May 2016 issue of the *American Journal of Psychiatry* will feature an Education in Psychiatry article titled: "The American Journal of Psychiatry Residents' Journal: Training the Next Generation of Academic Psychiatrists"

Authored by past and present Editors of the *Residents' Journal* and AJP Editor Robert Freedman, M.D., this article discusses how the AJP-RJ has transformed over the past decade into a national model for a trainee-led and operated academic journal.

Want to learn more about the *AJP Residents' Journal*? Attend the RJ workshop at the APA Annual Meeting:

"Writing a Scholarly Article"

Tuesday, May 17th • 1:30 PM–3:00 PM

Georgia World Congress Center Building B - Level 3, Room B310

Look for These Events at the Annual Meeting in Atlanta!

(May 14th–18th, 2016)

Visit the Resident Resource Center in the Georgia World Congress Center.

Saturday, May 14th

Medical Student-Resident Competition

Poster Sessions

10:00 AM – 12:00 PM

Interactive Session-Residency Education

1:30 PM – 3:00 PM

Diversity Experiences in Residency Training

American Association for Social Psychiatry

3:30 PM – 5:00 PM

Sunday, May 15th

“Closed”: Resident Tales from the Front Line—and What We Can Learn—When a Psychiatric Emergency Department Shuts Its Doors, APA Child and Adolescent Psychiatry Fellowship

12:30 PM – 2:00 PM

A Resident’s Guide to Borderline Personality Disorder: From the Experts (Part 1 of 2)

12:30 PM – 2:00 PM

American Association of Directors of Psychiatric Residency Training Presidential Symposium

1:00 PM – 4:00 PM

A Resident’s Guide to Borderline Personality Disorder: From the Experts (Part 2 of 2)

2:30 PM – 4:00 PM

Resident Well-Being: Strategies to Prevent Burnout

2:30 PM – 4:00 PM

Monday, May 16th

Neuromodulation Primer for Residents: An Introduction to ECT, TMS, and DBS

9:00 AM – 10:30 AM

Residents Teaching About Racism: A Novel Educational Approach to Combating Racial Discrimination in Mental Health Care, APA Council on Medical Education and Lifelong Learning

9:00 AM – 10:30 AM

Managing Violence Risk and Interview Safety: A Primer for Residents

3:30 PM – 5:00 PM

Tuesday, May 17th

Patient Suicide in Residency Training: The Ripple Effect

9:00 AM – 12:00 PM

Developing and Running a Successful Research Track for Psychiatry Residents

11:00 AM – 12:30 PM

**Writing a Scholarly Article: The American Journal of Psychiatry Residents’ Journal Workshop*

1:30 PM – 3:00 PM

Georgia World Congress Center, Room B310, Building B, Level 3

Burnout in Resident Physicians: What Can We Do?

3:30 PM – 5:00 PM

MindGames

5:15 PM – 6:15 PM

Wednesday, May 18th

Exploration of Medical Students’ Choice of Psychiatry as a Career

9:00 AM – 10:30 AM

Call for Applications to Join the 2016 Editorial Board

The *American Journal of Psychiatry—Residents' Journal* is now accepting applications to join the 2016-2017 Editorial Board for the following positions:

SENIOR DEPUTY EDITOR POSITION 2016

Job Description/Responsibilities

- Frequent correspondence with AJP-Residents' Journal Editorial Board and AJP professional editorial staff.
- Frequent correspondence with authors.
- Peer review manuscripts on a weekly basis.
- Make decisions regarding manuscript acceptance.
- Work with AJP editorial staff to prepare accepted manuscripts for publication to ensure clarity, conciseness, and conformity with AJP style guidelines.
- Collaborate with others as necessary to develop innovative ideas.
- Coordinate selection of book review authors and distribution of books with AJP professional editorial staff.
- Collaborate with the Editor-in-Chief in selecting the 2017 Senior Deputy Editor, Deputy Editor, and Associate Editors.
- Attend and present at the APA Annual Meeting.
- Commitment averages 10–15 hours per week.

Requirements

- Must be an APA resident-fellow member.
- Must be a PGY-3 in July 2016, or a PGY-4 in July 2016 with plans to enter an ACGME fellowship in July 2017.
- Must be in a U.S. residency program.

Selected candidate will be considered for a 2-year position, including advancement to Editor-in-Chief.

DEPUTY EDITOR POSITION 2016

Job Description/Responsibilities

- Frequent correspondence with Residents' Journal Editorial Board and AJP professional editorial staff.
- Frequent correspondence with authors.
- Peer review manuscripts on a weekly basis.
- Make decisions regarding manuscript acceptance.
- Work with AJP editorial staff to prepare accepted manuscripts for publication to

ensure clarity, conciseness, and conformity with AJP style guidelines.

- Collaborate with others as necessary to develop innovative ideas.
- Prepare a monthly Residents' Resources section for the Journal that highlights upcoming national opportunities for medical students and trainees.
- Collaborate with the Editor-in-Chief in selecting the 2017 Senior Deputy Editor, and Associate Editors.
- Attend and present at the APA Annual Meeting.
- Commitment averages 10 hours per week.

Requirements

- Must be an APA resident-fellow member.
- Must be a PGY-2, PGY-3, or PGY-4 resident in July 2016, or a fellow in an ACGME fellowship in July 2016.
- Must be in a U.S. residency program or fellowship.

This is a 1-year position only, with no automatic advancement to the Senior Deputy Editor position in 2017. If the selected candidate is interested in serving as Senior Deputy Editor in 2017, he or she would need to formally apply for the position at that time.

ASSOCIATE EDITOR POSITIONS 2016 (two positions available)

Job Description/Responsibilities

- Peer review manuscripts on a weekly basis.
- Make decisions regarding manuscript acceptance.
- Manage the Test Your Knowledge questions on Facebook and work closely with authors in developing Board-style review questions for the Test Your Knowledge section.
- Keep our Twitter and Facebook accounts active and up to date
- Collaborate with the Senior Deputy Editor, Deputy Editor, and Editor-in-Chief to develop innovative ideas for the Journal.
- Attend and present at the APA Annual Meeting.
- Commitment averages 5 hours per week.

Requirements

- Must be an APA resident-fellow member

- Must be a PGY-2, PGY-3, or PGY-4 resident in July 2016, or a fellow in an ACGME fellowship in July 2016
- Must be in a U.S. residency program or fellowship

This is a 1-year position only, with no automatic advancement to the Deputy Editor or Senior Deputy Editor position in 2017. If the selected candidate is interested in serving as Deputy Editor or Senior Deputy Editor in 2017, he or she would need to formally apply for the position at that time.

MEDIA EDITOR POSITION 2016 (one position available)

Job Description/Responsibilities

- Manage our Twitter and Facebook accounts
- Oversee podcasts
- We are open to many suggestions within reason
- Collaborate with the associate editors to decide on content
- Collaborate with Senior Deputy Editor, Deputy Editor, and Editor-in-Chief to develop innovative ideas for the Journal.
- Attend and present at the APA Annual Meeting.
- Commitment averages 5 hours per week.

Requirements

- Must be an APA resident-fellow member
- Must be a PGY-2, PGY-3, or PGY-4 resident in July 2016, or a fellow in an ACGME fellowship in July 2016
- Must be in a U.S. residency program or fellowship

This is a 1-year position only, with no automatic advancement to the Deputy Editor or Senior Deputy Editor position in 2017. If the selected candidate is interested in serving as Deputy Editor or Senior Deputy Editor in 2017, he or she would need to formally apply for the position at that time.

For all positions, applicants should e-mail a CV and personal statement of up to 750 words describing their a bit about who they, their reasons for applying, as well as any ideas for journal development to Katherine.Pier@mssm.edu. The deadline for applications is 4/15/2016.

Residents' Resources

Here we highlight upcoming national opportunities for medical students and trainees to be recognized for their hard work, dedication, and scholarship.

**To contribute to the Residents' Resources feature, contact Hun Millard, M.D., M.A., Deputy Editor (hun.millard@yale.edu).*

DEADLINES

Fellowship/Award and Deadline	Organization	Brief Description	Eligibility	Contact	Website
American College of Neuro-psychopharmacology Travel Award Deadline: April 30, 2016	ACNP	This travel award offers an opportunity to attend a scientific program in clinical and basic research on brain-behavior-drug interactions and interact with internationally distinguished researchers and scientists. In addition to travel funds, benefits include an ACNP mentor, opportunity to present a poster, and invitation to attend additional ACNP annual meetings.	Medical students and psychiatric resident. Applicants may be no more than 5 years post training.	Erin Colladay: ecolladay@acnp.org; or Sarah Timm, stimm@acnp.org	http://www.acnp.org/annual-meeting/travelawards.aspx
The Robinson-Cunningham Award Deadline: May 2, 2016	AACAP	Award is given for the best manuscript written by a child and adolescent psychiatrist during residency training; \$1,000 honorarium.	The paper must involve children, adolescents, or their families and be published in a professional, peer-reviewed journal within 3-5 years of graduation from a residency training program.	Department of Research, Training and Education at 202-587-9663 or training@aacap.org.	http://www.aacap.org/AA-CAP/Awards/Resident_and_ECP_Awards/Robinson_Cunningham_Award.aspx
Outstanding Resident Award Program (ORAP) Deadline: May 6, 2016	NIMH	This award recognizes residents with outstanding research and academic potential who are currently at the PGY-2 level. Award includes framed certificate, invitation to visit the NIH campus for a 2-day award program, and opportunity to present a poster about their own research.	Resident currently in PGY-2 level.	Joyce Chung, M.D. at 301 443 8466 or chungj@mail.nih.gov	http://www.nimh.nih.gov/labs-at-nimh/scientific-director/office-of-fellowship-and-training/outstanding-resident-award-program/index.shtml
Webb Fellowship Program Deadline: July 1, 2016	APM	This fellowship is designed to support residents and fellows in psychosomatic medicine at an early stage in their career. One-year appointments in which each fellow will have a designated mentor and present a paper at the Annual Meeting. Financial support will be provided for each fellow's organizational membership for one year and for Annual Meeting registration fees.	PGY-3 psychiatry resident or psychosomatic fellow.	http://www.apm.org/awards/webb-fship.shtml	http://www.apm.org/awards/webb-fship.shtml
Trainee Travel Award Deadline: July 1, 2016	APM	To encourage psychosomatic fellows, residents, and medical students to join APM, attend the Annual Meeting. A limited number of monetary awards are given to help offset the cost of attending the Annual Meeting (APM Council determines the dollar amount and number of awards.)	Medical Student, residents, and fellows.	http://www.apm.org/awards/trainee-travel.shtml	http://www.apm.org/awards/trainee-travel.shtml

Author Information for *The Residents' Journal* Submissions

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Deputy Editor

Hun Millard, M.D., M.A.
(Yale)

The Residents' Journal accepts manuscripts authored by medical students, resident physicians, and fellows; manuscripts authored by members of faculty cannot be accepted.

To submit a manuscript, please visit <http://mc.manuscriptcentral.com/appi-ajp>, and select a manuscript type for *AJP Residents' Journal*.

- 1. Commentary:** Generally includes descriptions of recent events, opinion pieces, or narratives. Limited to 500 words and five references.
- 2. History of Psychiatry:** Provides a historical perspective on a topic relevant to psychiatry. Limited to 500 words and five references.
- 3. Treatment in Psychiatry:** This article type begins with a brief, common clinical vignette and involves a description of the evaluation and management of a clinical scenario that house officers frequently encounter. This article type should also include 2-4 multiple choice

questions based on the article's content. Limited to 1,500 words, 15 references, and one figure. This article type should also include a table of Key Points/Clinical Pearls with 3-4 teaching points.

- 4. Clinical Case Conference:** A presentation and discussion of an unusual clinical event. Limited to 1,250 words, 10 references, and one figure. This article type should also include a table of Key Points/Clinical Pearls with 3-4 teaching points.
- 5. Original Research:** Reports of novel observations and research. Limited to 1,250 words, 10 references, and two figures. This article type should also include a table of Key Points/Clinical Pearls with 3-4 teaching points.
- 6. Review Article:** A clinically relevant review focused on educating the resident physician. Limited to 1,500 words, 20 references, and one figure. This

article type should also include a table of Key Points/Clinical Pearls with 3-4 teaching points.

- 7. Drug Review:** A review of a pharmacological agent that highlights mechanism of action, efficacy, side-effects and drug-interactions. Limited to 1,500 words, 20 references, and one figure. This article type should also include a table of Key Points/Clinical Pearls with 3-4 teaching points.
- 8. Letters to the Editor:** Limited to 250 words (including 3 references) and three authors. Comments on articles published in *The Residents' Journal* will be considered for publication if received within 1 month of publication of the original article.
- 9. Book Review:** Limited to 500 words and 3 references.

Abstracts: Articles should not include an abstract.

Upcoming Themes

Please note that we will consider articles outside of the theme.

Social Media and Psychiatry

If you have a submission related to this theme, contact the Section Editor
Spencer Hansen, M.D.
(shansen3@tulane.edu)

Psychiatry in the General Hospital

If you have a submission related to this theme, contact the Section Editor
Kamalika Roy, M.D.
(Kroy@med.wayne.edu)

Suicide Risk and Prevention

If you have a submission related to this theme, contact the Section Editor
Katherine Pier, M.D.
(Katherine.Pier@mssm.edu)

*If you are interested in serving as a **Guest Section Editor** for the *Residents' Journal*, please send your CV, and include your ideas for topics, to Rajiv Radhakrishnan, M.B.B.S., M.D., Editor-in-Chief (rajiv.radhakrishnan@yale.edu).