Fostering Resident Resiliency in the Context of Tragedy

American Association of Directors in Psychiatry Residency Training

Orlando, Florida

March 2015

Speakers

- Robert Boland, M.D., Vice-Chair of Education, Department of Psychiatry, Brigham and Women's Hospital
- Lucy Hutner, M.D., Associate Director of Residency Training, Department of Psychiatry, New York University School of Medicine
- Julie Penzner, M.D., Director of Residency Training in Psychiatry, Weill Cornell Medical College
- Felicia Smith, M.D., Director of Residency Training, Department of Psychiatry, Massachusetts General Hospital/McLean Hospital
- John Young, M.D., Vice Chair for Education and Director of Residency Training, Department of Psychiatry, Hofstra North Shore-LIJ School of Medicine

Outline

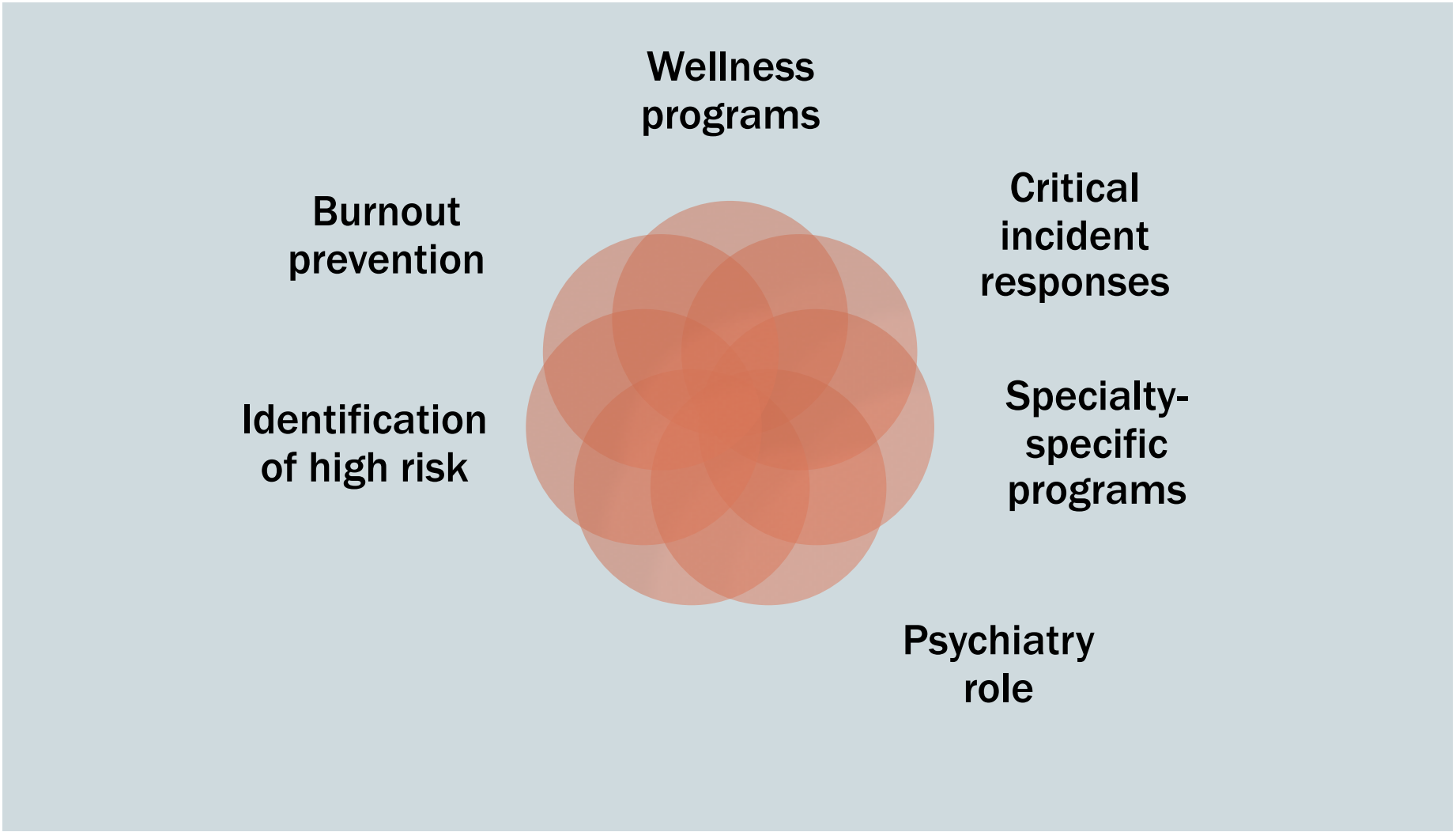
- Background
- Experiences
- Discussion

FALL 2014

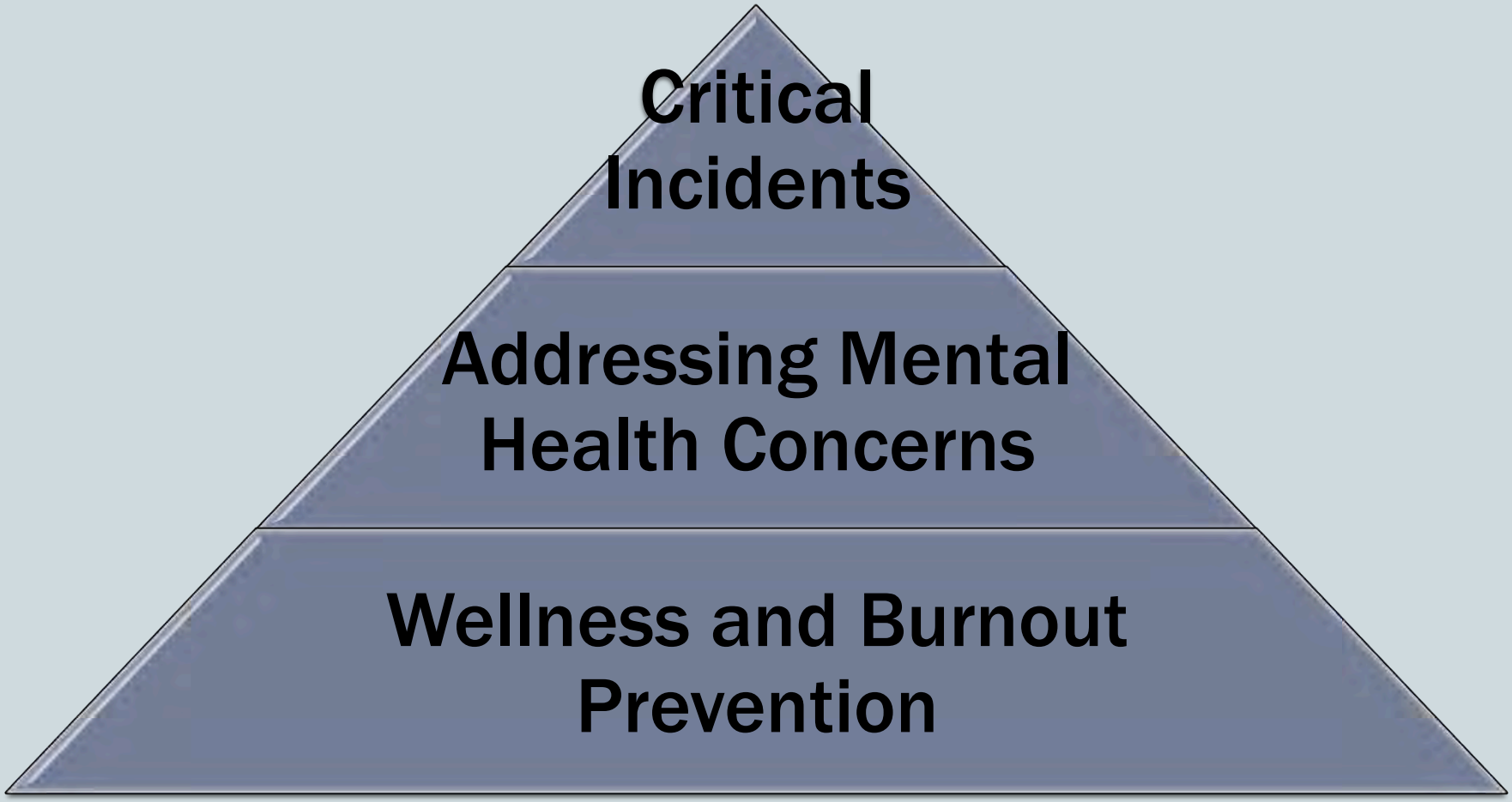
- NYC 2014: two internal medicine trainees died by apparent suicide
- American Foundation for Suicide Prevention: 300 to 400 physicians commit suicide each year
- Physicians have 2x risk of suicide over non-physicians (female > male)
- Recent study: almost 10% of medical students and interns reported thoughts of suicide in the prior two weeks

PROGRAM RESPONSES

- NYT editorial by Yale intern (Sept 2014):
  - Highlighted link between medical training and depression/suicidal thinking in trainees
- Response of training programs:
  - UCSD Suicide Prevention and Depression Awareness Program (2009) aimed at medical students and housestaff
  - Many training programs have not been able to identify and provide treatment for these trainees in a systematic way


Wellness programs
Critical incident responses
Specialty-specific programs
Psychiatry role
Identification of high risk
Burnout prevention

OPTIMIZING MENTAL HEALTH



OUR PROGRAMS

- New York University
- Cornell
- Hofstra North Shore LIJ
- Massachusetts General Hospital/McLean
- Brigham and Women's Hospital

Email, August 26th 2014

Hi Carol and Lucy,

Hope you are both well. I wanted to reach out to you both for a quick question about therapy referrals for some of my medical school classmates. We had Sean's memorial on Saturday, and a lot of my classmates were asking me who they should go to/how they can get into their own treatment to help them manage their feelings around his passing.

A lot of the people who were asking are kind of "skeptical" about seeing someone, so I wanted to try to connect them to someone before they change their minds.

Thanks!

NEW YORK UNIVERSITY

- Wellness initiative in House Staff Leadership Committee
- 1.0 FTE psychiatry faculty member as of July 2015
- Community responses

OUR PROGRAMS

- New York University
- Cornell
- Hofstra North Shore LIJ
- Massachusetts General Hospital/McLean
- Brigham and Women's Hospital

ACGME

ACGME Meeting

- To discuss role of ACGME in this issue

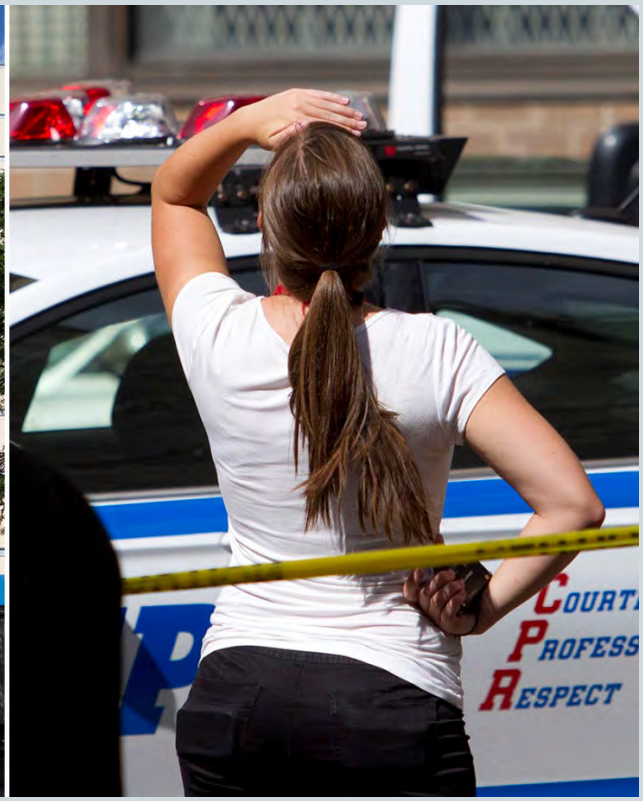
ACGME Planning Committee

- To plan for meeting in fall 2015

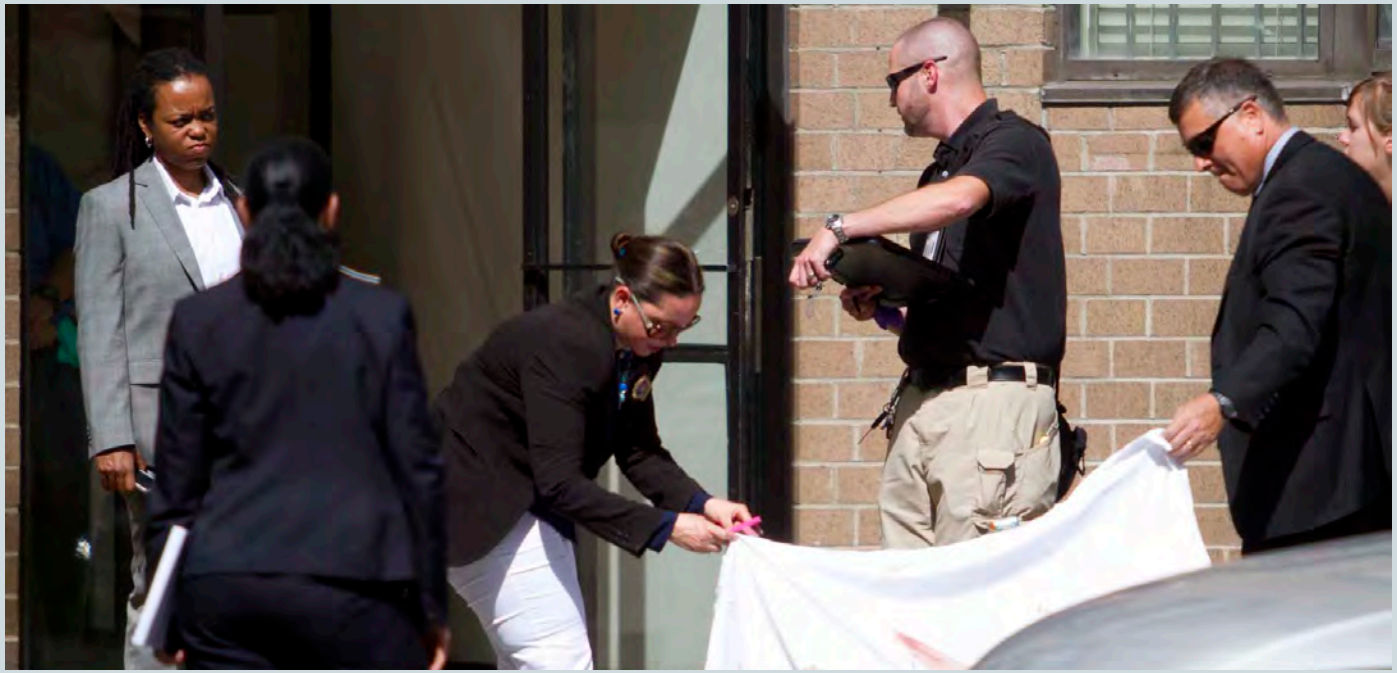
ACGME-funded meeting

- Plan for recommendations from ACGME
- Approach may be different per specialty
- Does psychiatry have a special role to play?

August 18th, 2014



August 18th, 2014



August 22nd, 2014

Framing the Issue

- What is the scope of our current programs to support resident resiliency?
- Are these efforts enough?
- National perspective?

- Coping in the face of peer tragedy
- How are these similar or different to other adverse events?

Literature

- Literature on physician trainee reactions to peer events

Individual programs

ACGME

Discussion

- Action steps

References

Clarify the diagnosis

- Identified diagnoses and pattern
  - Likelihood of exacerbation, morbidity
  - Triggering factors: hormonal changes, prior pregnancies, stressors
  - Protective factors: social support, coping skills
  - Effect of sleep (or lack thereof)
  - Treatment effects: medication and/or psychotherapy
- Associated diagnoses
  - Anxiety disorders
  - Psychotic disorders
  - Substance dependence
  - History of sexual assault/trauma
  - Body image concerns/eating disorders

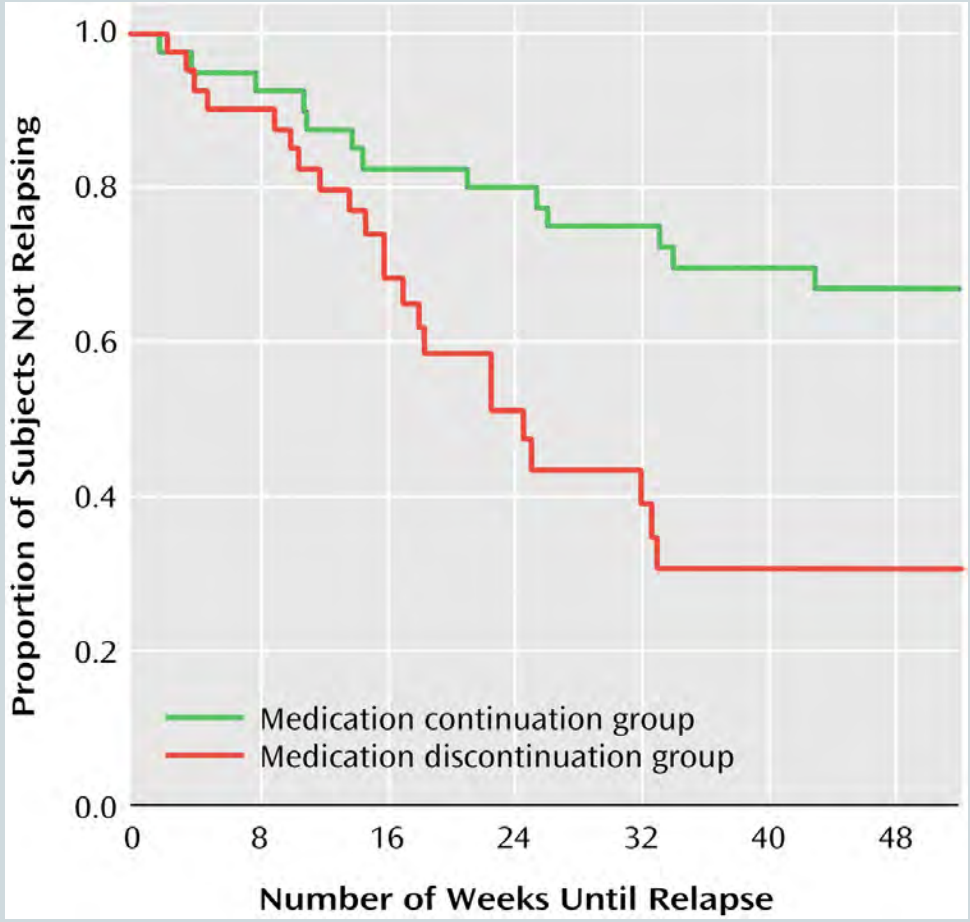
Clarify the diagnosis

- Medical history:
  - Obstetric-gynecological
  - Endocrine
  - Nutrition
- Family history:
  - Bipolar or other mood disorder
  - Psychosis
  - Suicide attempts or other harm
  - Postpartum episodes
- Social history:
  - Coping style, insight
  - Attitudes about parenting
  - Experiences of early family life
  - Attachments

Framework for decision-making

- Clarify diagnosis
- Weigh options
- Evaluate evidence
- Discuss risk reduction strategies
- Determine patient's preferences
- Communicate and educate

Relapse of mood episodes



Prospective observational cohort
N = 89
History of bipolar disorder
Outcomes: risk of recurrence
rate of discontinuation

Viguera et al 2007

Weighing the options

Potential risks of untreated illness

- Relapse of mood episode
- Prematurity
- Low birth weight
- Lower Apgar
- Small for gestational age
- Neurodevelopment/autism
- Long term outcomes for individual, dyad and family

Potential risks of SSRI exposure

- Miscarriage
- Teratogenesis
- PPHN
- Prematurity
- Low birth weight
- Lower Apgar
- Small for gestational age
- Neonatal adaptation syndrome
- Neurodevelopment/autism
- Long term outcomes

Guidelines

- Consensus guidelines exist for the management of mood disorders in pregnancy (Yonkers 2004):

- Bipolar disorder:
  - Reduce behavioral risk factors for poor outcome (e.g. SA)
  - Provide psychoeducation
  - Prescribe folic acid
  - Make dose adjustments
  - Monitor levels of medications as needed
  - Recognize and address risks of malformations
  - Fetal assessments
  - Later pregnancy and delivery
  - Postpartum

However:

Clinical Case Conference

From the Women's Life Center, Department of Psychiatry, UCLA–Geffen School of Medicine

Bipolar Disorder and Pregnancy: Maintaining Psychiatric Stability in the Real World of Obstetric and Psychiatric Complications

Vivien K. Burt, M.D., Ph.D.

Caryn Bernstein, M.D.

Wendy S. Rosenstein, M.D.

Lori L. Altshuler, M.D.

This article describes complex, real-life issues faced by a woman with bipolar I disorder who wished to bear a healthy child while remaining psychiatrically well. The therapeutic issues include balancing treatment decisions that affect fetal and maternal risks. The authors address the importance of carefully considering the patient's history of response to medications when evaluating risks to maternal and fetal health. They discuss the role of the psychiatrist as a part of the treatment team faced with unpredictable but not unexpected complexities, such as miscarriage, abnormal or questionable prenatal screening tests, gestational diabetes, and the emergence of fetal decelerations, preterm labor, and psychiatric decompensation. The article presents and evaluates treatment decisions made in the setting of multiple obstetric and psychiatric complications that do not clearly fit published algorithms. The importance of incorporating family and social supports as an integral part of the treatment plan is emphasized.

(Am J Psychiatry 2010; 167:892–897)

FDA Pregnancy Categories

- A: Controlled studies show no risk
- B: No evidence of risk to humans
- C: Risk cannot be ruled out
- D: Positive evidence of risk
- X: Contraindicated in pregnancy

- Most antidepressants: category C
- Many mood stabilizers (valproate, lithium): category D

- Limitations of FDA categories

Where does the data come from?

- No randomized, controlled studies
- Data derives from:
  - Animal studies
  - Adverse event reporting
  - Case reports
  - Case control (association ≠ causation)
  - Retrospective cohort: claims databases, registries
  - Prospective cohort: most reliable, but hard to obtain

Data registry (2011)

Where does the data come from?

- Interpretation of findings
  - How was data collected?
  - How was medication exposure quantified?
  - Did the study attempt to control for confounding variables?
- Translation into meaningful clinical recommendations
  - Combination of exposure plus untreated residual illness
  - Behaviors associated with psychiatric illness (prenatal care, SA)
  - Stress/anxiety may influence outcomes

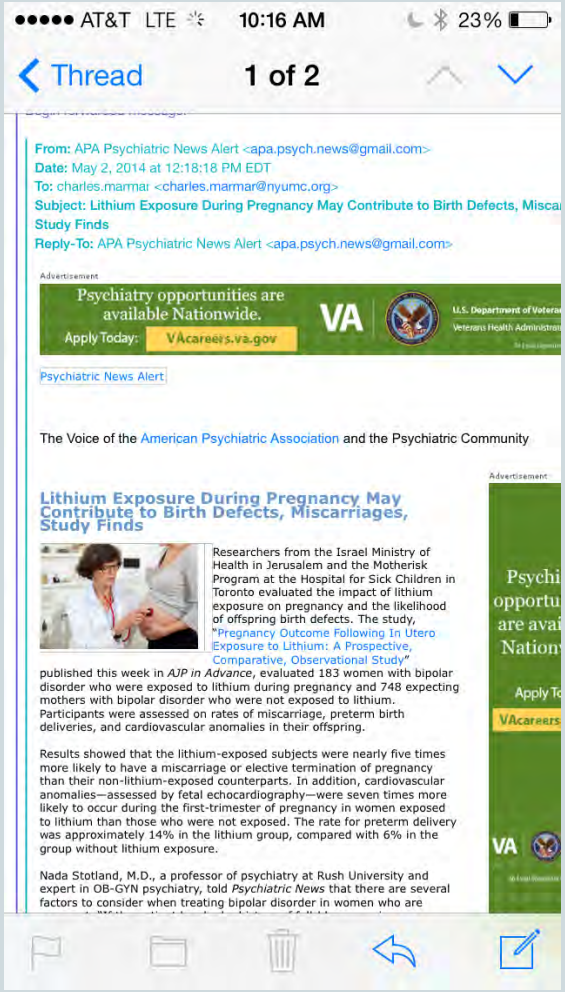
Clinical significance

- Small differences: clinically meaningful?
  - Meta-analysis of SSRIs and obstetric outcomes (Ross 2013)
  - LBW difference was 74 g
  - Shorter gestation: 3 days
  - Lower Apgar scores: 0.5 points
- Absolute vs relative risk
  - Lithium: Ebstein anomaly (tricuspid valve)
  - Relative risk: 100-fold increase in exposed population
  - Absolute risk: 0.05-0.1%
- Confounding by indication
  - Autism data

Risk of autism in offspring with exposure to SSRIs in pregnancy

- Rai (Sweden, BMJ 2013):
  - Cohort study of 50,000 live births in Swedish registry
  - "For instance, antidepressant use may be a marker of the severest forms of depression during pregnancy…It was therefore impossible to ascertain whether the antidepressant use was a marker for active depression in pregnancy"
  - Possible confounding by indication
- Hviid (Denmark, NEJM 2013):
  - Cohort study of over 600,000 live births in Danish registry
  - Risk association with SSRI use in pregnancy may be related to the indications for its use rather than a causal effect"

Unknowns in data



Email on my iPhone:

To: Judy Greene, Lucy Hutner
From: Charlie Marmar

Topic: Lithium exposure during pregnancy may contribute to birth defects and miscarriage

Date: May 2, 2014

Framework for decision-making

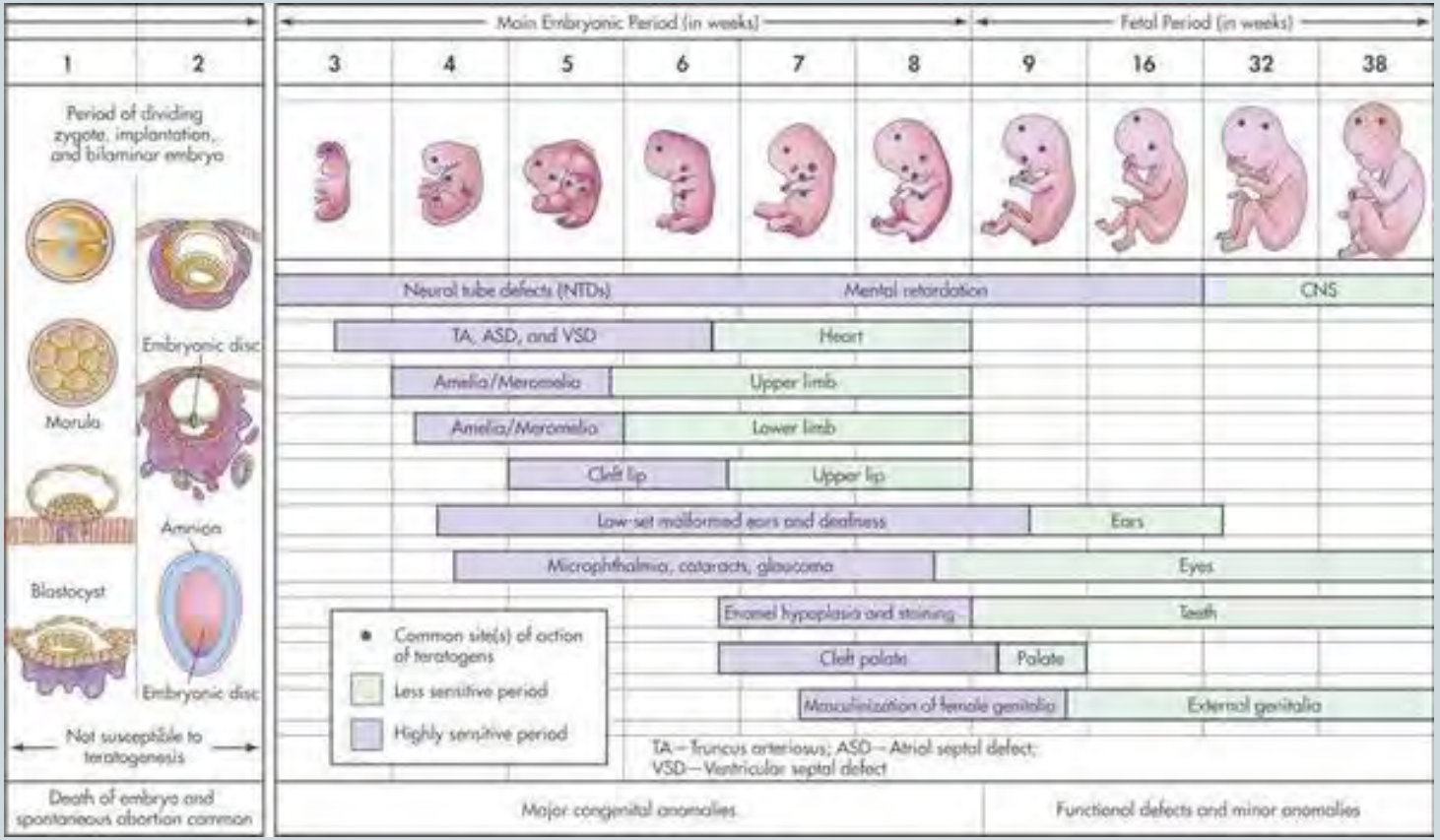
- Clarify diagnosis
- Weigh options
- Evaluate evidence
- Discuss risk reduction strategies
- Determine patient's preferences
- Communicate and educate

Risk reduction strategies

- Non-medication options
  - Psychotherapy: cognitive-behavioral, interpersonal psychotherapy, psychodynamic psychotherapy all have evidence of benefit
  - Lifestyle modification: stress modification, relaxation techniques

- Minimize exposure
  - Avoid polypharmacy
  - Utilize the lowest *effective* dose
  - Reassess at regular intervals throughout perinatal period
  - Make a longitudinal plan

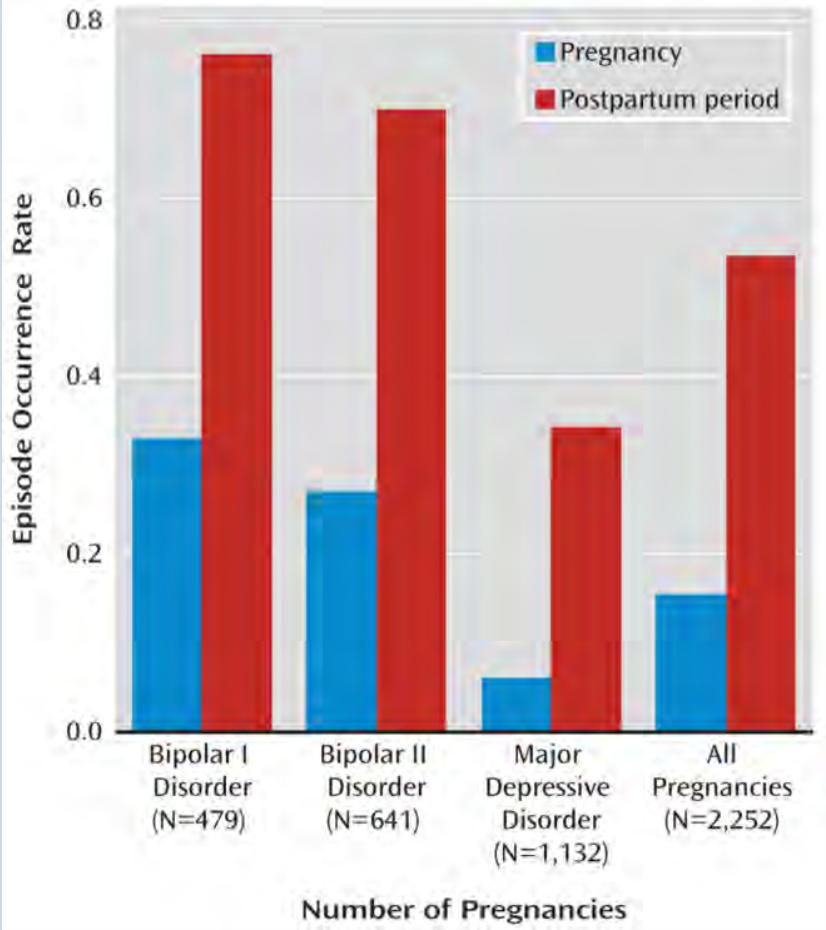
Longitudinal planning



Longitudinal planning

- Preconception: fertility
- First trimester: miscarriage, teratogenesis
- Second trimester: CNS development, PPHN (20 weeks)
- Third trimester: preparation for delivery
- Lactation
- Postpartum

Postpartum period



Naturalistic study
Over 2000 patients
with mood disorders

Viguera et al 2011

Framework for decision-making

- Clarify diagnosis
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- Determine patient's preferences
- Communicate and educate

Patient preferences

- Deeply personal decision, N = 1
- Preferences of partner and family
- Relational ethics (maternal/fetal well-being is intertwined)
- Capacity

Framework for decision-making

- Clarify diagnosis
- Weigh options
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- Communicate and educate

Planning for postpartum period

- Planning for sleep
- Infant feeding
- Supports
- Re-initiation of medication
- Partner education
- Review warning signs of mood episodes

Consultation as Educational Intervention

- Moment of opportunity
- Motivation for positive change
- Becoming a parent
- Proactive model of maintaining well-being

Arrival of infant

Temperament

Development

Attachment

“Good enough”

Becoming a family