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IN THIS ISSUE

Focus of the Month:
Treating Psychosis

Learning Objectives
After reading these articles, you should be able to:
1. Apply techniques of the Open Dialogue approach to patients with psychotic illnesses.
2. Identify how to diagnose and treat first-episode psychosis in individuals.
3. Evaluate the use of ketamine in clinical practice.

Open Dialogue: A Novel Approach to Treating People With Psychotic Disorders

Adrienne T. Gerken, MD, Department of Psychiatry, McLean Hospital, Belmont, MA
Joseph B. Stoklosa, MD, clinical director, Psychotic Disorders Division, McLean Hospital

Dr. Gerken and Dr. Stoklosa have disclosed that they have no relevant financial or other interests in any commercial companies pertaining to this educational activity.

You are an attending on the inpatient unit of your community psychiatric hospital, and the nursing staff informs you of a new admission. Mary is a 26-year-old single woman with schizophrenia; this is her third psychiatric admission. For the past week, Mary has been feeling more

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In Summary

- Open Dialogue is a new approach to treating and communicating with patients suffering from psychotic disorders.
- The key element of Open Dialogue involves sharing all treatment discussions with the patient and the patient's social network.
- A small preliminary study of this approach showed excellent long-term outcomes.

Q&A With the Expert

First-Episode Psychosis
Ann Shinn, MD

Co-medical director, McLean OnTrack
Director of Clinical Research, Schizophrenia and Bipolar Disorder Research Program, McLean Hospital
Assistant Professor of Psychiatry, Harvard Medical School

Dr. Shinn has disclosed that she has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

TCPR: Dr. Shinn, when we see patients with a first episode of psychosis, it can be difficult to know what the diagnosis is and how to proceed with treatment. What's the approach of your program at McLean Hospital?

Dr. Shinn: We start with a good diagnostic assessment. We elicit a patient's history, talk to family members (patient permitting), and review prior medical records. It's important to realize that psychosis can result from many different non-psychiatric conditions—for example, substance use, electrolyte imbalances, thyroid abnormalities, systemic infections, nutritional deficiencies, brain tumors, and seizures, among others. By the time we see them, patients have usually already had a basic medical evaluation in an inpatient hospital or emergency room, and most non-psychiatric medical causes have been ruled out. If an adequate first-episode workup has not been done, we order labs and studies, including a toxicology screen, complete blood count, comprehensive metabolic panel, thyroid stimulating hormone, folic acid, vitamin B12, RPR, ceruloplasmin (to rule out Wilson's disease), and possibly serologies for diseases like Lyme and HIV. We may also order a brain MRI and/or EEG if there is high suspicion of a structural brain lesion or if there are seizures in the clinical history.

TCPR: After organic causes of psychosis have been ruled out, how do you think about the diagnosis?

Dr. Shinn: I think of psychotic disorders as fitting into two broad categories: primary or secondary. Primary psychotic disorders

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suspicious, and she hasn't been eating much due to a belief that she is being poisoned. She says, "I'm scared they're coming to get me because I can hear their inner consciences talking everywhere. My mom made me come, and I don't need to be here because she thinks I'm crazy. I just haven't been feeling good." You go into the nurse's station, confer with the staff and Mary's outpatient psychiatrist, and decide to increase the dosage of Mary's risperidone. The next day on rounds, the nursing staff tells you that Mary declined the risperidone, claiming the pill was the "wrong color," and that she is requesting to be discharged.

Most of us who have done inpatient work on a locked unit will recognize this fairly common scenario. In the vignette, you are practicing according to the standard of care, in which you and your staff each evaluate a patient, have a discussion in a team meeting, come up with a treatment plan, and implement it. You do your best to align with your patient on a plan, and you see confrontation and struggle as a necessary consequence of providing care for people with psychotic illness who have little insight.

While this standard of care works for some patients, in many cases it leads to involuntary commitments, court hearings, and traumatic experiences such as seclusion and restraint. Medications help decrease the need for such measures, but meds often do not work quickly enough (or at all), and they may cause unacceptable side effects. Plus, patients may disagree with their providers and family members about the need for medication or even the need for treatment, as providers and patients may not be using the same vocabulary to discuss the issues. We have to do better, and one promising approach that may help is called "Open Dialogue."

Open Dialogue's genesis

In 2001, the Institute of Medicine (IOM) wrote an influential report that identified a "quality chasm" in health care (across all branches of medicine) and called upon providers to focus on patient-centered care. The IOM defined this approach as being "respectful of and responsive to individual patient preferences, needs, and values" (*Institute of Medicine: Crossing the Quality Chasm: A New Health System for the 21st Century.* Washington, DC, 2001. http://www.nap.edu/html/quality_chasm/reportbrief.pdf). Since that report, many health care systems have developed initiatives to increase patient and family participation. Psychiatry has been slower than other specialties to adopt these initiatives, in part because we sometimes see patients with serious mental illness as less able to participate in care discussions. However, one can argue that people in the midst of a psychiatric crisis like psychosis are most in need of transparent, open, and collaborative care.

Open Dialogue, developed in the 1990s in Tornio, Finland, is both a way of communicating (while paying attention to one's vocabulary) and a system of care. All communication about patients occurs in their presence and is based on respectful language that is often derived from the patient's own words. The Open Dialogue vocabulary refers to the patient as "the person at the center of concern," and it drops clinical jargon in favor of creating a common language. (For this article, we will still use the term "patient" as we will often see them in a clinical setting.)

Through Open Dialogue, two or more clinicians will hold "network meetings" to rapidly engage a person in crisis, most often in the patient's home and alongside the patient's support network or family. For continuity, the clinical team remains the same through outpatient and inpatient care, using a flexible approach of meeting as frequently (or infrequently) as needed. Clinicians carefully evaluate patients to create a shared understanding of the psychosis or crisis, and are somewhat less likely to medicate right away than in many other treatment settings. Instead, they deliberately formulate treatment plans, often delaying medications or using lower doses or shorter-term medications when safe to do so (Seikkula J et al, *Psychosis* 2011;3(3):192–204. doi:10.1080/17522439.2011.595819).

Open Dialogue also entails a series of methods for communicating with patients most effectively during treatment meetings. These methods are termed "dialogic practice" and include 12 key elements (Olson M et al, *The Key Elements of Dialogic Practice in Open Dialogue.* Worcester, University of Massachusetts Medical School, 2014. http://tiny.cc/yhdsiy), which we'll explore in more detail below.

Is Open Dialogue effective?

Open Dialogue has been tested in a five-year multicenter study in Finnish Western Lapland. 42 people with nonaffective psychosis like schizophrenia were enrolled. In this area of Finland, Open Dialogue is the standard system of care for public mental health, and all persons with nonaffective psychosis who were being treated using Open Dialogue were eligible to join the study. Outcomes were compared with a retrospective control group of 33 people treated before implementation of Open Dialogue. Compared with the control group, people treated with

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Open Dialogue experienced more rapid improvement in Brief Psychiatric Rating Scale symptoms of psychosis, though five-year total scores were similar between the groups. After five years, 82% of patients had a full remission of psychotic symptoms, 86% of patients returned to employment or education, and only 17% remained on antipsychotics (Seikkula J et al, *Psychother Res* 2006;16:214–228).

Although these results were based on a small number of patients, the study was influential because these outcomes were dramatically better than long-term outcomes reported in other studies in which patients received standard treatment. In such studies, after five years, typically only 40% of psychotic patients had remission of symptoms, over 50% were still on disability, and over 90% were still taking antipsychotics (these studies were reviewed in Seikkula et al, 2006). Groups in a number of other European countries have implemented an Open Dialogue model but have yet to report outcome data (Gordon C et al, *Psychiatr Serv* 2016;67(11):1166–1168).

In the United States, through grant funding, Open Dialogue has been implemented in a 12-month feasibility study of 14 young adults (ages 14–35) with psychosis in an outpatient mental health agency in Massachusetts. This initial study has demonstrated qualitatively high satisfaction for participants, families, and providers. Quantitatively, participants exhibited significant positive changes in symptoms and functional outcomes, as measured by the standard symptom rating scales. Most participants (nine out of 14) were working or in school after one year (Gordon et al, 2016).

How Open Dialogue works

At McLean, we have adapted the Open Dialogue approach to our schizophrenia and bipolar disorders inpatient unit (Rosen K and Stoklosa J, *Psychiatr Serv* 2016;67(12):1283–1285), basing our adaptation on Dr. Olson's 12 key elements. Although we have applied the technique to an inpatient unit, it can be used at any level of care and patient interaction, including family meetings, intake interviews, follow-up visits, and phone calls.

Team meeting format

Include two or more clinicians in a team meeting. When you meet with your patient, don't do it solo. It's best to bring two or more clinicians, such as a psychiatrist, therapist, nurse, social worker, community support, or a trainee such as a medical student, all of whom can become collaborators. The first part of the meeting will be an interview you conduct with the patient (and the patient's network), while the second part of the meeting will be a discussion between the clinicians about what was heard. Including more than one clinician decreases the "expert vs patient" or "me vs you" feeling often produced by one-on-one meetings. Differences of opinion between clinicians can help defuse this tension and show the patient that multiple viewpoints might be valid. In the context of our case vignette, Mary would be able to hear different clinicians discussing their concerns and reasons for recommending medication changes, which sets the stage for shared decision-making.

Include social supports. In addition to having clinicians in the meeting, invite others, such as family members, friends, or other important people in the person's life (clergy, teachers, neighbors). These supports may become partners in the treatment planning process, rather than just sources of collateral information. Having supports involved prevents patients from being isolated from the rest of their lives through stigma and secrecy.

Language and phrasing

Use open-ended questions. Start the interview with open-ended questions to allow the patient's story to unfold. Consider asking, "Whose idea was it for you to be admitted to the hospital?" to help establish the patient's level of commitment to being there. Ask, "How would you like to use this meeting?" Ideally, two-thirds of the meeting is based on listening to the patient and the patient's network, and only one-third follows your own checklist of questions. This allows the patient and network to direct the focus of each meeting. For Mary, we can ask, "What might be a good outcome of your hospital stay?" to better align around her goals.

Respond to people with their own words. Try to use your patient's exact words when asking questions or making comments, rather than paraphrasing or translating into psychiatric symptoms, because creating a common language is a main goal of dialogic practice. For Mary, who said, "I'm scared they're coming to get me because I can hear their inner consciences talking everywhere," you might respond, "Other people's consciences—what were they saying?" (You can ask this rather than a paraphrased question such as, "What were those voices saying?"—recall that Mary never mentioned "voices.")

Emphasize the present moment. Consider using what is observed and shared in the room rather than outside collateral information. For Mary, you might say, "You said it was your mom's idea to come, and you haven't been feeling good," rather than, "Your mom left me a message saying you were acting strangely"—the message isn't part of what Mary has shared with you.

Timing and flow

Elicit multiple viewpoints (regardless of whether multiple people are present). Invite everyone to speak so that you give a voice to all present, rather than allowing the most talkative person to take over. It's not necessary to establish consensus as each person speaks, but rather notice that each person has a unique viewpoint. For those people not present but important to the patient's support network, consider asking how they might respond if they were present. In Mary's case, you might say, "I know your mom isn't here, and you said it was her idea to come. What would she see as a good outcome to your hospitalization?" This invites more perspectives into the discussion.

Use a relational focus in the dialogue. Consider framing the patient's symptoms in terms of relationships, rather than relying on diagnostic labels, which risks oversimplifying problems and causing patients to feel at odds with clinicians. Let's say Mary's mother is in the meeting. Rather than saying, "Mary is paranoid and isn't taking the medication she needs for her schizophrenia," you might say,

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include schizophrenia, schizoaffective disorder, and schizophreniform disorder. In primary psychotic disorders, psychotic symptoms are the principal problem and are more or less present throughout the course of illness. By contrast, psychosis can be secondary, occurring in the context of other conditions. In addition to organic causes, which I already mentioned, a number of psychiatric conditions can present with psychosis. Mood disorders like bipolar disorder or major depressive disorder, also known as "affective psychoses," are among the most common of these. In affective psychosis, psychotic symptoms are present only when a person is manic or depressed. There are no psychotic symptoms inter-episode, ie, in the periods between mood episodes.

TCPR: But then there's that gray zone of "schizoaffective disorder."

Dr. Shinn: Right. There can be significant overlap in symptoms. Evidence suggests that these disorders are not biologically discrete, but rather lie on a continuum. A patient with schizoaffective disorder will have episodes of psychosis with depression and/or mania, but will be more like a patient with schizophrenia in that the psychotic symptoms are persistent, continuing even after the symptoms of depression or mania have resolved.

TCPR: Given that schizophrenia, schizoaffective disorder, and psychotic mood disorders share so many symptoms, how can you distinguish among them?

Dr. Shinn: Schizoaffective disorder and psychotic bipolar disorder can be particularly hard to distinguish when someone presents acutely with both prominent mood and psychotic symptoms. In such instances, we rely on information about the person's longitudinal course. When there is little past psychiatric history to guide us, as is typically the case with new-onset psychosis, we have to follow the patient's course over time to be more certain about the diagnosis.

"By providing intensive treatment soon after a first episode, we are trying to change the patient's trajectory so that the patient can return to school, work, and relationships rather than down a road toward disability. ... If you treat early, you may slow or prevent progression."

Ann Shinn, MD

TCPR: That makes sense. Can you give us a specific example?

Dr. Shinn: Yes. We saw a young man who experienced his first psychotic episode at the start of his senior year in college. He was easily distracted, heard voices, and had ideas of reference, such as thinking that his professor was lecturing specifically about him. His roommates, teachers, and coaches became concerned, and the patient was forced to leave school. He went to live at his parents' house, where he could not sleep, had racing thoughts, and ended up smashing some cars with a baseball bat thinking that Martians were invading Earth and that he had to lead a revolution against them. He was hospitalized at a community psychiatric hospital, and diagnosed with unspecified psychosis (formerly termed "psychosis not otherwise specified"). After hospitalization, he became severely depressed; he was prescribed antidepressants at his local clinic, but did not improve. That is when he was referred to our program. After seeing the patient and going through his medical records, we diagnosed him with bipolar disorder with psychotic features and started him on lithium, and he's done quite well.

TCPR: Under what circumstances might this patient have been diagnosed with schizoaffective disorder?

Dr. Shinn: If there were periods when manic and depressive symptoms were absent, but he continued to have psychotic symptoms.

TCPR: You recently reported on a series of patients who have come to your clinic with first-episode psychosis. It would be interesting for us to get a sense of the diagnostic breakdown of these patients.

Dr. Shinn: Yes, we reported on the patients we treated during the first 2.5 years of our program's existence. Among the 89 patients who presented to our clinic with first-episode psychosis, 33% had a primary psychotic disorder, 44% had affective psychosis, and 21% had psychosis NOS at the time of referral.

TCPR: So you followed these patients for a while. Did you find that the original diagnosis was accurate, or did you get more information over time that prompted you to change the diagnosis?

Dr. Shinn: We found that diagnostic change is common in early psychosis. Half the patients had their diagnosis change. For example, among patients we initially diagnosed with schizophrenia, 55% kept that diagnosis, 11% changed to the NOS category, and 22% changed to schizoaffective disorder.

TCPR: So let's say we've diagnosed a patient with some type of psychosis. Why is early intervention thought to be so important?

Dr. Shinn: By providing intensive treatment soon after a first episode, we are trying to change the patient's trajectory so that the patient can return to school, work, and relationships rather than down a road toward disability. Like medical conditions such as cancer and heart disease, psychosis progresses through stages of severity, and if you treat early, you may slow or prevent progression.

TCPR: That's interesting. What are the stages of psychotic illness?

Dr. Shinn: Patrick McGorry, Michael Berk, and others developed the concept of psychiatric staging. According to their models, stage 0 is actually no illness: The individual has no symptoms and is simply at risk, possibly because there is a family history of psychosis in a first-degree relative. Stage 1 corresponds to the prodromal period, when an individual may experience nonspecific or subthreshold symptoms, along with some decline in academic, work, or social functioning. This is where you might see attenuated positive symptoms (APS) or brief limited intermittent psychotic symptoms (BLIPS), which are recurring episodes of frank psychotic symptoms that spontaneously go away and last no more than a week. Stage 2 is full-blown psychosis, ie, the first episode.

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Stage 3 consists of incomplete remission from the first episode or recurrence. Stage 4 is severe, persistent, or unremitting illness. Patients usually present to our program in stage 2 or early stage 3, and we say we provide early intervention to these patients. But in actuality, the first psychotic episode, when a person has converted to full-blown psychosis, is already considered a relatively late stage.

TCPR: How would we ascertain that a patient is in a very early stage of the prodrome, even before the patient has any APS or BLIPS?

Dr. Shinn: There are symptoms more subtle than APS and BLIPS, called basic symptoms, that are among the first symptoms to appear in the schizophrenia prodrome. Unlike APS and BLIPS, which are just milder or briefer psychotic symptoms, basic symptoms are qualitatively different from hallucinations, delusions, and other full-blown psychotic symptoms.

TCPR: So if basic symptoms are not frank psychotic symptoms, how do you recognize them?

Dr. Shinn: Basic symptoms are subtle, subjective disturbances of experience, especially self-experience. Psychiatrists usually associate disorders of self with borderline personality disorder. While in borderline personality disorder, the self-disturbance tends to be in the third-person perspective or narrative sense of self, basic symptoms reflect disturbances of first-person perspective, involving more fundamental and immediate experiences like experiencing oneself as continuous in time and immersed in one's body and the world. Thus, a person might wonder about self-evident things like why our hands have five fingers or why the grass is green. The person may experience derealization and depersonalization—these are terms that psychiatrists typically associate only with trauma spectrum disorders like PTSD, but they are very common in early psychosis. A person may perceive a subtle change in the environment, like an atmospheric shift, and experience the world as surreal or illusory.

TCPR: These sound like very subtle, even esoteric experiences. How do you ask patients about them?

Dr. Shinn: You're right, they are subtle. Unlike frank psychotic symptoms, they are rarely observable and usually only accessible by self-report. The only way to assess if they are present is to ask patients about them. The difficulty is that patients may not always have the words to describe what they are experiencing. A person might just report feeling perplexed or anxious or say, "Something is wrong; I don't have the words for it." Josef Parnas and his colleagues developed a semi-structured interview called the Examination of Anomalous Self-Experiences (EASE) (Parnas J et al, *Psychopathology* 2005;38(5):259–267). An interview tool like the EASE can help clinicians explore some of these very subtle experiences with patients. I provide some screening questions that your readers might find helpful (Editorial note: see accompanying table). But mere recognition by a patient is not enough. The key is to use open-ended questions and engage in a dialogue that allows patients to describe their experiences using, as much as possible, their own words.

Examples of Anomalous Self-Experiences: Basic Symptoms in Early-Stage Psychosis

Symptom	Screening question
Reduced sense of "mineness"	"Have you ever had thoughts that don't feel like your own?"
Derealization	"Does the world ever feel strange, unreal, or otherwise changed (as though you are in a movie)?"
Depersonalization	"Have you ever felt you were observing yourself from outside yourself?"
Loss of common sense/perplexity	"Do you spend a lot of time wondering about or confused by everyday things?"
Experiencing the body as strange or different	"Has your body or its parts ever felt strange, alien, lifeless, or not a part of you?"
Feeling existentially vulnerable	"Have you ever felt dangerously exposed, too open or transparent, or somehow at the mercy of the world, even though there was no specific reason to feel this way?"
Dramatic or fundamental shifts in worldview	"Have you developed new interests in any existential, metaphysical, religious, philosophical, or psychological ideas?"

Adapted from Parnas J et al, *Psychopathology* 2005;38(5):259–267

TCPR: How do we know if patients with these experiences will develop a psychotic disorder?

Dr. Shinn: It's hard to know, in part because adolescence, which is usually when prodromal symptoms occur, is normally a period of a lot of change. Not everyone with basic symptoms will necessarily transition to full-blown psychosis. According to one study of 160 prodromal patients, basic symptoms predicted transition to schizophrenia with a probability of 70% over almost 10 years of follow-up (Klosterkotter J et al, *ArchGen Psychiatry* 2001;58(2):158–164).

TCPR: Is there evidence that intervening at the early stages can decrease the likelihood of developing a full-blown psychotic disorder?

Dr. Shinn: The results are mixed and depend on the intervention. CBT (eg, Ising HK et al, *Psychol Med* 2015;45(7):1435–1436) and intensive psychosocial treatment involving things like family education, home visits, social skills training, and help with substance abuse (Nordentoft I et al, *Schizophren Res* 2006;83(1):29–40) seem to reduce or at least delay conversion to full-blown psychosis. Supplementation with omega-3 fatty acids (Amminger GP et al, *Arch Gen Psychiatry* 2010;67920:146–154) has also been shown to help. On the other hand, there is little evidence for treating at-risk individuals with antipsychotics. At least two randomized controlled trials of atypical antipsychotics in preventing psychosis have been negative (see Preti A and Cella M, *Schizophren Res* 2010;123(1):30–36 for review).

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Anecdotes From the Field: Prescribing Ketamine

Michael Posternak, MD, psychiatrist in private practice, Boston, MA
Dr. Posternak has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

This article is intended to be an anecdotal discussion of the author's experience prescribing ketamine; for more comprehensive coverage, see *TCPR,* May 2016.

What is ketamine?
Ketamine, known by the street name "special K," is an N-methyl-D-aspartate (NMDA) receptor antagonist that was first introduced in the 1960s as an anesthetic alternative to the drug phencyclidine (PCP) and approved by the U.S. Food and Drug Administration (FDA) in 1970 as a prescription injectable anesthetic. It's a Schedule III controlled substance because of its potential for misuse for its dissociative properties.

When did you start prescribing ketamine?
I started prescribing ketamine two years ago. I generally tend to be conservative in trying newer treatments—especially ones not yet approved—but I was very impressed with both the safety and efficacy of ketamine (Lapidus KA et al, *Biol Psychiatry* 2014;76(12):970–976). When a patient of mine with refractory depression who had struggled with suicidal thoughts on a daily basis was looking for other treatments, we agreed to try ketamine. His suicidal thoughts remitted almost immediately and have not returned since. (For more information on ketamine and suicidal ideation, see Murrough JW et al, *Psychol Med* 2015;45(16):3571–3580.)

How do you prescribe it?
I prescribe intranasal ketamine, 50 mg–100 mg per mL, two puffs to each nostril. I instruct patients to take it in the morning, and will quickly titrate the dosage up until either it works or until they develop side effects. The most common side effect is a transient sense of derealization, dissociation, or dizziness that usually lasts 10–20 minutes. Some patients prefer to take it at night so that they are in bed by the time these side effects occur. Ketamine seems to work just as well when dosed at night. Because it is unclear whether tolerance may develop, I generally recommend to my patients to take one day off a week, and will also try to titrate the dosage back to 3 times a week within the first few months. One of my patients takes it on an as-needed basis for depression, similar to how PRN benzodiazepines are often used for anxiety.

How well has it worked?
So far I've prescribed ketamine to about 20 patients, most with either refractory depression or bipolar depression. A handful did not tolerate it and stopped it within the first few days, either because they derived no benefit or because they found the sense of derealization intolerable. For those who responded, it almost always worked right away—either the very first day, or immediately after titrating the dosage up. Several patients reported a significant decrease in suicidality, while several others experienced a complete remission from their depression. The benefits have persisted in almost all cases (from 6 months to 2 years to date). Depending on how one defines effectiveness, I would say that about half have responded, which is a pretty high percentage for such a refractory population. There are reports suggesting that it may also be effective for PTSD symptoms (Feder A, *JAMA Psychiatry* 2014;71(6):681–688), though I have yet to prescribe it for this purpose.

Any other risks or concerns?
Ketamine is an abusable substance, so it is crucial to be aware of signs of abuse or dependence (Schak KM et al, *Am J Psychiatry* 2016;173(3):215–218. doi:10.1176/appi.ajp.2015.15081082). I get a baseline EKG and follow-up EKG if patients stay on the drug and monitor vital signs, but I have not had any problems to date. All of my patients were taking other psychiatric medications as well, and so far there have been no issues with drug interaction. In theory, lithium may decrease the effectiveness of ketamine, while scopolamine may augment it—though I have not had any luck with this strategy so far. Intranasal ketamine is only available at compounding pharmacies, which may not be accessible in certain parts of the country. It costs about $50–$100 per month.

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TCPR: And what sort of interventions do you recommend for first-episode patients, such as those you see in your clinic?
Dr. Shinn: First, while medications are usually necessary, use "gentle" pharmacology, meaning the lowest effective dose to minimize risk of side effects. Remember that most first-episode patients are drug-naïve. You want to engage a person in treatment and not have the person's first experience with meds be negative. We know from the CATIE trial that about 75% of patients over an 18-month period stop medications, either because of side effects or because the medications were not very effective. Second, medications are important, but not sufficient—a more integrated approach is key. A recent paper in *AJP* (Kane JM et al, *Am J Psychiatry* 2016;173(5):535–536) showed that an integrated team-based approach is more effective than treatment as usual. This includes individual therapy, family psychoeducation, and employment and education support—in addition to medication. Traditional treatment approaches focus on symptomatic recovery, using antipsychotics to target positive symptoms. But to really help patients with psychosis get back on track with their lives, we need to do more to help people develop good coping skills and social skills, and help them navigate school, work, and relationships.
TCPR: Thank you, Dr. Shinn.

CME Post-Test

To earn CME or CE credit, you must read the articles and log on to www.TheCarlatReport.com to take the post-test. You must answer 75% of the questions correctly to earn credit. You will be given two attempts to pass the test. Tests must be taken by January 31, 2018. As a subscriber to *TCPR*, you already have a username and password to log onto www.TheCarlatReport.com. To obtain your username and password, please email info@thecarlatreport.com or call 978-499-0583.

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For those seeking ABPN Self-Assessment (MOC) credit, a pre- and post-test must be taken online at http://thecarlatcmeinstitute.com/self-assessment/

Below are the questions for this month's CME/CE post-test. This page is intended as a study guide. Please complete the test online at www.TheCarlatReport.com. Note: Learning Objectives are listed on page 1.

1. A key component of the Open Dialogue approach to treatment is: (LO #1)
   - [ ] a. Discussing potential side effects of medications with the patient
   - [ ] b. Holding all assessment and treatment discussions in the presence of the patient
   - [ ] c. Prescribing low doses of antipsychotics
   - [ ] d. Never using the term "patient" in team meetings

2. In Dr. Shinn's early intervention program, she found that: (LO #2)
   - [ ] a. 75% of patients initially diagnosed with schizophrenia kept that diagnosis
   - [ ] b. Half of all patients diagnosed with schizophrenia were reclassified as schizoaffective
   - [ ] c. The majority of patients were eventually given the diagnosis of unspecified psychosis
   - [ ] d. Half of all psychotic patients eventually had their initial diagnosis changed

3. Ketamine can be an effective treatment for patients with symptoms of depression. (LO #3)
   - [ ] a. True [ ] b. False

4. The main empirical study of Open Dialogue was: (LO #1)
   - [ ] a. Randomization of 2,000 patients in the NIMH CATIE trial
   - [ ] b. A double-blind randomized controlled trial in Sweden
   - [ ] c. An open-label trial of 152 patients compared with a retrospective control group
   - [ ] d. An open-label trial of 42 patients compared with a retrospective control group

5. In the concept of psychiatric staging for psychotic disorder, first-episode psychosis is stage 1. (LO #2)
   - [ ] a. True [ ] b. False

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"Mary says she's been scared lately, and though she finds the medicine helpful, she feels stressed being frequently asked at home whether she took her medicine—then, because she gets so stressed, she ends up stopping it." This sort of explanation allows everyone to be a part of the solution, creates more common understanding, and avoids unhelpful blame.

Response to psychosis

Discuss your thoughts about patients by having "reflecting talks" with other clinicians. After you have interviewed your patient and the patient's network, it is time to discuss your assessment with other clinicians in the meeting. To pivot into this mode, start by asking, "Do you mind if I share a few words with my colleagues now?" You can physically turn toward your colleagues and have a dialogue in front of the patient's network. Pay special attention to your language, use the patient's words while avoiding jargon, and employ exploratory, tentative phrasing like "I wonder" or "I'm curious about." Openly share your treatment ideas and their rationale with your patient. For example, you might say to a colleague, "I was struck by Mary's fears and all the inner consciences she described. I wonder if we might help the fear with a different dose of her risperidone medication—I'd recommend we add another milligram." Your colleague could respond, "I also really resonated with her fear; in fact, I felt tense as I listened. It seems like a risperidone adjustment might be helpful." This creates a space for clinicians to listen to themselves and their inner dialogues, as well as for the patient and network to listen without pressure to respond to a treatment plan. Afterward, you can turn back to the network and say, "Does anyone have any reflections on what you heard? What did you agree or disagree with?"

Be transparent. Discuss treatment options openly. This is where the "open" part of Open Dialogue comes in: Clinicians co-create treatment plans, including hospitalization and medications, transparently through shared decision-making in a team meeting.

Tolerate uncertainty. Consider an approach where everyone has a valid perspective, rather than some being more right than others. In this style, the clinician creates safety by making sure all perspectives are heard before formulating treatment recommendations. This allows

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Treating People With Psychotic Disorders

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the full story to be told, which in itself may be healing and lead to crisis resolution.

Conclusion: Why does Open Dialogue work?

In our experience, many clinicians are intrigued by the Open Dialogue approach, but are curious how a change in communication style could actually improve treatment outcomes as dramatically as some research suggests. Here are some hypotheses:

1. Transparency eliminates the patient's fear of what clinicians are really thinking, leading to a more genuine connection. Connection and alliance are key ingredients to good outcomes.
2. By including the support network, open meetings enhance connection and communication between patients and families. This decreases loneliness and isolation—factors that lead to poorer outcomes.
3. Creating a common language helps patients understand their problems and communicate with their clinicians and network. Enhanced communication may lead to higher-quality information, bolstering our treatment decisions.

TCPR VERDICT:

The Open Dialogue approach is a nice way to prevent patients from being alienated from caregivers. While the evidence that it improves outcomes is preliminary, it might be worth implementing some of these techniques, since the downsides (if they exist) are likely minimal.