



Left: Psychiatrists Joe Bienvenu and Michael Clark with medicine resident Colin Massey and physician assistant Victoria Gargon in the Johns Hopkins Hospital medical intensive care unit. Right: Pediatric psychiatrist Marco Grados helps explain how the stress of long hospital stays interferes with the course of medical illnesses.

Integrating Psychiatry and Medicine

The consulting psychiatrists at Johns Hopkins seem to be everywhere. They move through the 1,000-bed hospital interacting with patients who are recovering from surgery, learning to live with chronic illnesses or pain, or dealing with new diagnoses. And, they are increasingly spending time with patients who are not doing well despite the best medical care.

“Mental health and behavioral issues are one of the largest drivers of complications, longer lengths of stay and poor outcomes,” says psychiatrist **Michael Clark**, who is also vice chair for clinical affairs. “Rather than having the patients come to us, we visit them to evaluate these issues and provide treatment options.”

The goal is to integrate psychiatry with medicine, allowing a seamless delivery for patients whose clinical outcomes are affected by either pre-existing psychiatric or behavioral illnesses or psychiatric issues that develop as a result of their medical diseases.

Visiting pediatric patients in their rooms can be especially important, says pediatric psychiatrist

Marco Grados. “Psychiatric illnesses still have a stigma,” he says. “Parents who might not take their children to a psychiatrist may consent to us seeing their children in the pediatric building.”

By visiting with the children and their parents, the pediatric psychiatrists can explain how the stress of long hospital stays interferes with the course of medical illnesses. Grados says that once parents understand this, they are more likely to accept assistance.

Close working relationships between psychiatry and medicine can also lead to changes in treatments. After observing the disturbing effects of heavy sedation on children in critical care settings, psychiatrists are helping the pediatric intensive care unit medical staff change highly sedating medications to other options, such as low-dose neuroleptics when indicated to lessen the confusion and anxiety children experience when they are brought out of sedation.

In some medical situations, it can be difficult to determine whether a disease or a medication is causing a psychiatric issue.

Psychiatrist **Joe Bienvenu** recalls a case in which a 50-year-old with a history of bipolar disorder and viral hepatitis was transferred to Johns Hopkins because of a second bout with confusion and fever and the development of hyperreflexia and myoclonus. A detailed review of his medical history and his physical signs suggested a diagnosis of serotonin syndrome, and the symptoms resolved quickly with administration of the serotonin blocker cyproheptadine.

Still, not all cases are complex. “Our most common differential diagnosis,” Bienvenu says, “is deciding whether a patient’s sad mood is due to acute brain dysfunction (delirium), whether it is a reaction to demoralizing circumstances, or whether there is a depressive illness.”

Once these possibilities are evaluated, the psychiatrist can recommend an appropriate course of treatment. For many patients, says Bienvenu, nailing this down makes all the difference in their recoveries. ■

The Eugene Meyer III Professorship in Psychiatry and Medicine



Glenn Treisman, director of the AIDS Psychiatry Service, has been named the Eugene Meyer III Professor.

Psychiatrist Eugene Meyer III (no relation to Adolf Meyer) held dual appointments in medicine and psychiatry at Johns Hopkins for nearly four decades. He was an early leader in the Psychiatric Liaison Service, among the first of its kind to provide psychiatric consultations for medical and surgical patients. An endowed professorship was created in his honor at the time of his death in 1982.

(continued on back page)

1989

The Johns Hopkins AIDS Psychiatry Service was formed in 1989.

From Grassroots to EPIC Psychosis Treatment

Presenting to Johns Hopkins during his first psychotic episode, the 16-year-old was 100 percent sure that what he needed was not medical care, but an exorcism. During his time in the hospital, he came to agree that he was psychiatrically ill and began to take medication. Once he left the hospital, however, he soon stopped returning for appointments. Therapist **Krista Baker** and a case manager went to his community to find him, and they learned that he was once again calling churches for an exorcism.

“That event was so compelling, I couldn’t stop thinking about it,” says Baker. “So I researched existing models of care for adolescents with new onset psychotic episodes. There was very little out there.”

In 2008, the Early Psychosis Intervention Clinic (EPIC) was born. Today, the program is at the forefront of a national movement to provide early, coordinated care for patients with new-onset psychosis and schizophrenia that includes individual and family therapy, medication management and case management services. The EPIC team includes adult psychiatrist **Russell Margolis**, child psychiatrist **Carolyn Howell** as well as therapists and case managers. A three- to five-day-per-week on-site rehabilitation program helps patients reach such goals as returning to school, developing social skills, strengthening interpersonal relationships and maintaining employment.

“Adolescents who get early treatment for their schizophrenia have a better prognosis and are more likely to stay on a nearly normal life track,” says Margolis. “Although the evidence is somewhat controversial, there is some suggesting that earlier treatment may also diminish ultimate damage to the brain.”

The program, which strives to prevent a chronic cycle of instability, downward spirals and acute episodes, seems to be working. As a result of the team’s efforts, many of the patients do not require repeated hospitalizations and report an improved overall quality of life. Adolescents stay with the program until early adulthood, when the team helps transition them to an adult-oriented level of care.

“More than 45 percent of our patients are either in school or working,” says clinic supervisor Krista Baker, who was and is a major force behind the clinic, “and the no-show rate is less than 5 percent, which is almost unheard of.”

As one of only a few such programs in the country, EPIC draws patients from well beyond the Baltimore area, and the team provides consultation services internationally, which can be an invaluable service for clinicians and patients with little or no access to comprehensive schizophrenia programs, especially ones that target early psychosis intervention.

For information call: 410-550-0137



From left, Carolyn Howell, Krista Baker and Russell Margolis



Jason Brandt provides neuropsychological assessments for physicians.

Assessing Impairment in Physicians

Two years ago, the directors of a large group medical practice approached Johns Hopkins psychologist **Jason Brandt** about providing neuropsychological assessments, not for their patients, but for their staff physicians. The practice management was primarily interested in detecting problems in cognitive functioning, such as memory, speed of processing and decision-making, that could put patients at risk, and they wanted to provide a mental health benefit for the physicians.

“The practice directors are very forward-thinking,” says Brandt, a professor of psychiatry and neurology and director of the Division of Medical Psychology. “They reasoned that they invest a great deal in recruiting their doctors and providing them with the resources they need to practice at a very high level. They want their physicians to be happy and successful, and this means attending to their cognitive and emotional well-being. In addition, if someone is having difficulty that puts patient welfare in jeopardy, it’s best to detect that before a problem emerges. This was their concern, especially with their more senior clinicians.”

In response to this request, Brandt developed the Physician Neuropsychological Wellness Program. Each physician met with a psychologist for an hourlong session, which included a comprehensive history and a discussion of a range of topics, including family life, career decisions, and stress and stress management. The physician then took two to three hours of neuropsychological tests focusing on concentration, working memory, executive cognition and psychomotor performance, and completed the mood, personality and symptom inventories. The results were conveyed in a detailed letter that included recommendations for intervention, if appropriate, and future follow-up.

“The beauty of the program as it is set up,” Brandt says, “is that the results of these baseline neuropsychological evaluations go only to the individual physicians, not to the practice management. However, if the practice directors have a significant concern about a specific doctor, they can also order ‘for cause’ evaluations, the results of which they receive.”

Even though many of the physicians were wary at first, says Brandt, most say they have enjoyed the experience. For many, it was the first time they ever discussed their life choices, joys, disappointments and frustrations with anyone,

much less a mental health professional.

One of the challenges in constructing the protocol was to select cognitive tests that would be appropriate for very high-functioning individuals. “Most neuropsychological tests are intended to detect frank cognitive deficits, and many lack sensitivity on the high end,” says Brandt. “Since most doctors are bright, they can have subtle, but not insignificant problems that are not easily detected by most tests.”

Another assessment challenge, Brandt says, is determining neuropsychological benchmarks for use for competence to practice. This is especially problematic when evaluating older physicians. Should a 75-year-old physician be compared to other 75-year-olds, as is typically done in psychology, or to 35-year-olds who are at the top of their game? A 90-year-old doctor may be functioning at the 80th percentile of other 90-year-olds, but should he or she take out your gallbladder?

By comparing physician cognitive evaluations over time, Brandt hopes to identify markers of physician impairment, particularly in the prodromal period when interventions can be beneficial. The ultimate goal, Brandt says, is to help doctors have long and productive careers and fulfilling personal lives while simultaneously ensuring that patients are not exposed to unnecessary risks by distressed physicians. ■

For information: 410-955-3268

When Memory May Be Fading

To help people gain insight into the risk of developing late-life cognitive impairment for themselves or a loved one, Johns Hopkins memory disorders expert Jason Brandt has launched version 2.0 of a free online questionnaire he developed that takes only about 10 minutes to complete. Called the Dementia Risk Assessment, the updated and improved survey is not meant to replace in-person evaluation by a qualified physician or other dementia specialist, but to help guide health care decision making. The survey is available through the Johns Hopkins-affiliated Copper Ridge Institute, an education and research organization devoted to Alzheimer’s disease and related conditions, which Brandt directs. To check out the survey, go to <http://alzcast.org/memorysurvey/>.

Bariatric Surgery and Eating Disorders

Medical professionals who treat eating disorders are seeing a new type of patient.

In the last year alone, 8 percent of patients admitted to the Johns Hopkins Eating Disorders Program had a history of bariatric surgery, says the program's director, psychiatrist **Angela Guarda**. Some patients developed an eating disorder after surgery. Others had a pre-existing eating disorder that worsened after gastric bypass.

Anorexia nervosa, bulimia and binge eating disorder are serious conditions that interfere with both physical and psychological health and quality of life. Some patients restrict themselves to eating only a handful of low-calorie foods; others intermittently binge eat high-calorie density foods and may vomit or abuse laxatives to compensate for bingeing. Binge eating is associated with a sense of loss of control over eating.

"Screening bariatric surgery patients for eating disorders before surgery and careful follow-up are required components of the multidisciplinary approach to bariatric surgery at Johns Hopkins," Guarda says. "It is important to identify and promptly treat these conditions."

bariatric surgery patients are most at risk of actually developing eating disorders.

"Bariatric surgery remains the most effective treatment we have for severe obesity," says Johns Hopkins psychologist Janelle Coughlin. "Most patients experience improvements in medical comorbidities and quality of life and do not develop eating disorders." In a minority, however, eating disorders can complicate the effectiveness of the surgery, and as bariatric surgery becomes more widespread, recognizing and treating eating disorders in the bariatric surgery population is important to optimizing surgical outcomes.

Once an eating disorder is diagnosed, the treatment of post-bariatric patients



Angela Guarda and Allisyn Pletch discuss protocols for post-bariatric patients with eating disorders.

30 The Hopkins Eating Disorders Program is nationally recognized, with over 30 years of experience.

And therein lie some of the challenges, as eating disorder behaviors are often secretive and accompanied by a sense of guilt or embarrassment. Following bariatric surgery, Guarda explains, occasional vomiting can occur in up to 40 percent of patients due to plugging of the stomach pouch by certain foods, such as dry meats and bread. In some patients, however, vomiting due to plugging may evolve over time into vomiting as a means of weight control and develop into bulimia or anorexia nervosa. Additional behaviors that may develop in the service of weight loss include chewing and spitting out food, picking and nibbling at food, and laxative or diuretic misuse. These are all warning signs of a possible eating disorder.

"We know that suboptimal weight loss and weight regain are not uncommon in patients who have undergone bariatric surgery," says Guarda. Preliminary research suggests that experiencing a feeling of loss of control over eating may predict weight regain or inadequate weight loss after surgery. However, it's far from clear yet which post-

requires dietary interventions that differ from those used for other patients with eating disorders. "You can't treat them the same way," says Guarda, "because their anatomy has been changed. Surgery drastically reduces the size of the stomach, so patients cannot eat regular size meals, especially in the first few years after surgery. For those who have lost excessive weight and now have anorexia nervosa, this means we cannot prescribe the same weight gain diet we would recommend for a patient with anorexia nervosa and normal anatomy."

Taking into consideration the different needs of this population, the Johns Hopkins Eating Disorders Program has adapted its protocol so that post-bariatric patients with eating disorders receive six small meals with increased percentages of protein but fewer calories, rather than eating three high-calorie meals per day, says **Allisyn Pletch**, a clinical nurse specialist in the Eating Disorders Center. They also need to drink fluids between rather than with meals to prevent liquid

from filling their pouch and making eating more difficult.

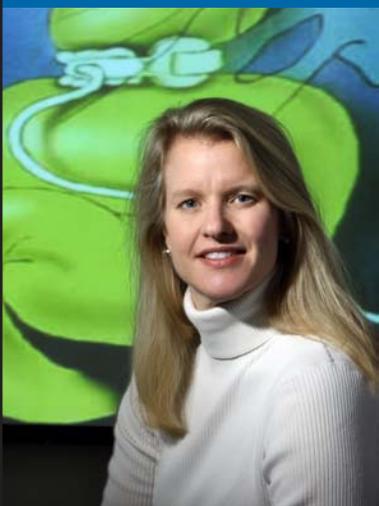
Most important is helping patients change behaviors that have become automatic or rewarding.

Most important, however, is helping patients change behaviors that have become automatic or rewarding.

"With eating disorders, restricting, bingeing and vomiting become behaviors that are increasingly driven and difficult to interrupt," says Guarda. "Treatment must focus on behavior change. Otherwise, bariatric surgery can be less effective over time." ■

For information: 410-955-3863

POSTOPERATIVE OUTCOMES



The WATCH Screening Tool

Janelle Coughlin and colleagues have developed a quick assessment tool* to help clinicians assess whether post-bariatric surgery patients may be at risk for suboptimal outcome and maladaptive eating behaviors. Called the WATCH, this five-item screening questionnaire can be used by a wide range of health professionals, including general practitioners, medical specialists, nurse practitioners and nutritionists, to help identify who may be at risk for an eating disorder following bariatric surgery.

*Coughlin JW, Guarda AS, Clark JM, Furtado MM, Steele KE, Hienberg LJ: A Screening Tool to Assess and Manage Behavioral Risk in the Postoperative Bariatric Surgery Patient: The WATCH. J Clin Psychol Med Settings 2013;20:456-463.

Janelle Coughlin, co-developer of WATCH

Mark Your Calendar

2015 Eating Disorders Conference
Bridging the Gap: Applying Research to Treatment

May 11, 2015

Johns Hopkins School of Medicine, Turner Auditorium
720 Rutland Ave.
Baltimore, MD 21205

http://bit.ly/JH_Eating_Disorders_Conference



The Eugene Meyer III Professorship in Psychiatry and Medicine *(continued from front page)*

In keeping with Meyer's legacy, **Glenn Treisman** was recently named as the latest Eugene Meyer III Professor in Psychiatry and Medicine. Treisman also holds dual appointments in psychiatry and internal medicine. As director of the AIDS Psychiatry Service, he studies the psychiatric disorders that both increase risk for infection with HIV and are caused by HIV, and how they contribute to the ongoing epidemic. He makes his home in the HIV/AIDS clinic, where patients receive medical and psychiatric care.

"By working in the clinic, we can interact with the patients when they come in for care and we can consult with the medical team," says Treisman, who also authored *The Psychiatry of AIDS* textbook. "Psychiatric consults are especially important for patients with AIDS because they often have concurrent substance abuse problems,

affective disorders and poor coping skills, which make them less likely to stick with their medical regimens."

If depression is treated, then patients more often take their medications and avoid risky behaviors.

Patients with HIV/AIDS are four to six times more likely to have depression than the general population. AIDS also tends to exacerbate existing psychiatric disorders, and in turn, psychiatric disorders tend to increase the likelihood of risky behaviors.

As the Eugene Meyer III Professor, Treisman says he will continue to promote integration of psychiatric care with medical illness and to champion psychiatry as an integral discipline of medicine. ■

Hopkins **BrainWise**

This newsletter is published for the Department of Psychiatry and Behavioral Sciences by Johns Hopkins Medicine Marketing and Communications. 901 South Bond Street, Suite 550 Baltimore, MD 21231

Some of the research in this newsletter has corporate ties. For full disclosure information, call the Office of Policy Coordination at 410-223-1608.

To make a gift, contact:
Jessica Preiss Lunken,
Director of Development
Johns Hopkins Department of Psychiatry and Behavioral Sciences Fund for Johns Hopkins Medicine
550 North Broadway, Suite 914
Baltimore, MD 21205

If you no longer wish to receive this newsletter, please email mayd@jhmi.edu

Department of Psychiatry and Behavioral Sciences

J. Raymond DePaulo Jr., M.D.
Director

Marketing and Communications

Dalal Haldeman, Ph.D., M.B.A.
Senior Vice President, Marketing and Communications

Karen Harrop, Writer
Mary Ann Ayd, Managing Editor

MSK Partners, Designer
Keith Weller, Photography

©2014 The Johns Hopkins University and The Johns Hopkins Health System Corporation



Non-Profit Org.
U.S. Postage
PAID
Permit No. 5415
Baltimore, MD

Check our departmental website for more news:

www.hopkinsmedicine.org/psychiatry

Hopkins **BrainWise** WINTER 2015

THE NEWSLETTER OF THE JOHNS HOPKINS DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL SCIENCES



Integrating Psychiatry and Medicine

PAGE 1



Assessing Impairment in Physicians

PAGE 2



Bariatric Surgery and Eating Disorders

PAGE 3