THE
MARYLAND PSYCHIATRIST
NOVEMBER 2025 VOLUME: 48 NO: 2

The Role of the APA and MPS During Politically Tumultuous Times

by: Ronald Means, MD

Ronald Means, MD

Over the past year of the Trump presidency, members of MPS have questioned the role of APA and MPS in challenging many of the administrative changes that affect the delivery of behavioral healthcare. Examples of areas of contention are many. There have been clear attacks on scientific knowledge, including misinformation about vaccinations and antidepressants. There have been attempts to undermine the importance and impact of psychiatric services by suggesting reductions of mental health screening or prioritizing lifestyle changes over treatment. There have been actions taken that disproportionately impact psychiatric patients, including campaigns against homelessness and reductions in access to Medicaid.

With these direct and indirect blows to psychiatry and psychiatric patients, members have wondered what the role of APA and MPS is in responding to such insults. Having the opportunity to attend leadership meetings with the APA CEO and communications team, I have come to appreciate the precarious position in which APA falls. First, although it is easy to forget this fact living in Maryland, there are APA members across the world with a variety of political views, and the APA must serve all members. There are often assumptions that all psychiatrists take more liberal stances on matters, but the APA leadership has reminded us that that assumption is inaccurate. Secondly, the APA has already had to respond to protect itself from threats by the administration that could jeopardize federal funding. Reluctantly, refining language related to diversity was an example of these concessions.

In an effort to balance the desires of the membership, protect the financial integrity of the organization and fight against misinformation or policies that will weaken the field of psychiatry or affect psychiatric patients, the APA has taken a stance to advocate strongly about scientific matters. For instance, APA has worked to counter misinformation about the detrimental effects of antidepressants and vaccinations being linked to autism. In contrast, the APA has opted to avoid taking strong stances on social issues that might impact psychiatric patients or psychiatric care but are not directly related to science (e.g. polices related to the unhoused population). With this approach, APA feels that it is striking the balance between being an advocate for scientific fidelity vs. being an activist for social causes.

APA leadership has also made it clear that while the above position is the strategy of the national organization, district branches can chart their own course. The national organization does not want to restrict the ideas and actions of the district branches. I see pros and cons of this strategy, but realize that there is no correct answer on how to address some of the more egregious actions of the current administration that, either directly or indirectly, will impact how and to whom we deliver care.

Submit a Story to The Maryland Psychiatrist

If you are interested in joining the Editorial Advisory Board, or would just like to submit an article for publication in an upcoming issue, please email jhritz@mdpsych.org.

MARYLAND PSYCHIATRIC SOCIETY

A District Branch of the American Psychiatric Association

In This Issue

AI in Healthcare Delivery: Risks and Mitigation

by: Steven Daviss, MD

Steven Daviss, MD

Ed's note: ***Dr. Daviss*** *is a psychiatrist and informatics consultant who recently served as Chief Medical Officer of the Maryland Medicaid Behavioral Health ASO and currently leads* ***Ibis Informatics LLC****, consulting on technology and policy innovations in behavioral health. (Formatting assistance via ChatGPT 5). References are available by contacting him.at drdaviss@gmail.com. Put 'request for references' " in the subject line if contacting him by e-mail.*

Artificial intelligence (AI) is one of the technologies that developed gradually, then explosively, taking 6 decades to emerge from its cocoon. It is now embedded in everyday technologies and workflows, including health care delivery. For psychiatrists, this means that tools capable of writing, analyzing, or predicting are increasingly available to clinicians, staff, patients, and family members. These tools hold real promise, but they also carry substantial risks that physicians must not ignore.

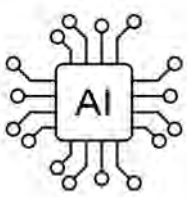
I've seen growing signs over the past couple years that generative AI is already being used in clinical documentation -- often without adequate oversight. A thoughtful and intentional approach is needed to protect patients, practices, and the integrity and quality of care.

Clinical Utility: How AI Can Help

It can enhance efficiency and support care in ways that are particularly relevant to psychiatric practice, when used with awareness of its limitations:

- **Documentation support:** Natural language processing and ambient dictation tools can reduce the time spent charting, but it can "hallucinate" or make up "false facts".
- **Measurement-based care:** Automated collection and interpretation of instruments like the PHQ-9 or GAD-7 can make it easier to track outcomes over

(Continued on next page)



AI in Healthcare Delivery Cont.

time, but one should double-check its math.

- **Decision support:** AI tools can suggest differential diagnoses, highlight potential drug interactions, or flag significant changes in symptom patterns, but confirm its accuracy.
- **Population health management:** Predictive algorithms can identify individuals at elevated risk of relapse, crisis, or hospitalization, allowing for earlier interventions, but use it only as a first-pass tool--and use your clinical judgment.
- **Administrative efficiency:** AI can assist with drafting prior authorization requests, in utilization management, and in care coordination, but ensure errors are corrected before submission.

Many of these features are already built into electronic health record systems, payer portals, and patient engagement platforms. But their usefulness depends entirely on responsibly integrating them into clinical practice.

Recognizing the Risks

Like any powerful technology, AI can be misused. Last year at the BHASO, we saw increasing amounts of clinical documentation bearing the hallmarks of AI generation: verbose, overly polished and creative text; inaccurate or inconsistent patient details; generic language that lacks individualized nuance; and age or gender errors. These mistakes can have real clinical, legal, and ethical implications.

Major categories of risk include:

- **False or misleading information** entered into the medical record, becoming permanent legal and clinical artifacts if not corrected.
- **Privacy and security vulnerabilities**, particularly when using AI tools, such as ChatGPT, Claude, or Gemini, that lack HIPAA protections.
- **Lapses in clinical judgment**.
- **Lack of transparency** about when and how AI was used.
- **Ethical and legal exposure**, including potential liability under the False Claims Act if inaccurate documentation leads to improper billing.
- **Bias and inequity** introduced or amplified by algorithms trained on non-representative populations.

Mitigating Risk: Practical Steps for Physicians and Practice Groups

Psychiatrists and their organizations can reduce liability and enhance the safe use of AI by taking a deliberate, policy-driven approach.

1. **Develop a written policy** on AI use in your practice. Set clear expectations about when and how it may be used in documentation, decision support, data analysis, or patient communication.
2. **Educate and train your staff**.
3. **Vet any AI technology** for compliance with privacy and security requirements. At a minimum, request a Business Associates Agreement to ensure compliance with HIPAA requirements. Avoid companies that refuse to provide this.
4. **Review the Terms of Use** for any AI tools. Many explicitly prohibit use in medical services or carry other restrictions that can create liability.
5. **Test and validate output** carefully before incorporating it into patient records or payer communications.
6. **Monitor and audit** documentation issued by your practice. Unsanctioned staff shortcuts can create major legal exposure.
7. **Regularly seek updated guidance** from professional societies, malpractice carriers, and federal and state agencies. The APA, and the AMA and others are actively developing ethical frameworks and best practices.

Looking Ahead: Psychiatric Leadership in AI

Psychiatrists are uniquely positioned to lead on ethical, thoughtful integration of AI in clinical settings. We already navigate complex questions of privacy, consent, communication, and judgment. Emerging developments such as ambient documentation, conversational agents, and predictive modeling will continue to shape clinical workflows. Meanwhile, regulators such as the FDA, HHS, and CMS, are beginning to clarify oversight frameworks. Clinicians must be educated and involved to help shape these policies--not simply react to them.

AI is not going away. It will likely become as ubiquitous in psychiatric practice as the EHR is today. The real question is whether we use it blindly or wisely. When applied responsibly, it can support better access, more efficient workflows, and more data-informed clinical care. But when used without guardrails, it can amplify errors, increase liability, and harm patients.

Psychiatrists must stay informed, lead policy discussions, and build safeguards into their practices. Thoughtful adoption and attention to detail is critical to reduce risk while improving quality and efficiency.

Fortune Favors the Bold

State of the Department of Psychiatry at University of Maryland

By Shyam H Bhatt, M.D., MPH

Shyam H Bhatt, MD, MPH

As the need for high-quality psychiatric care continues to rise, the availability of resources for society's most vulnerable populations remains strained. In the face of growing challenges, the University of Maryland's Department of Psychiatry continues to expand its reach and strengthen its support for the greater Baltimore community. During a State of the Department address on September 18th, Chair Jill RachBeisel, MD outlined its progress over Fiscal Year (FY) 2025 and its vision for FY2026.

FY2025 marked a period of substantial growth and achievement. The department welcomed 14 new full-time faculty members, 5 part-time hires, and 5 newly promoted full professors. Drs. David Mancini and Andrew Vandervaart were named Assistant Program Directors for the residency program, further strengthening the educational mission. These advances were supported by strong financial performance, improved documentation practices and notable growth in the Psychiatry Associate Faculty practice, Psychiatric Emergency Services, and the Advanced Depression Treatment (ADepT) Clinic's TMS program. Impressively, FY2025 saw the department's highest revenue collections since before the pandemic- an encouraging sign of recovery from COVID-19.

Academically, the department continued to distinguish itself as a leader in research and innovation. Faculty members produced 218 peer-reviewed articles, 177 presentations, 102 posters, and one book. All active grants were fully-funded, reflecting both the rigor and strategic alignment of the department's research initiatives.

Looking ahead to FY2026, Dr. RachBeisel emphasized a spirit of courage and forward momentum: "Fortune favors the bold, not the cautious." The roadmap for the year centers on 5 guiding strategies: creating a positive narrative, cultivating confidence, taking small steps, finding connection, and staying calm. Key initiatives include expanding access to specialty care through programs such as the ADepT Program for severe treatment resistant depression, women's perinatal reproductive mental health services and enhanced child psychiatric testing. The department also plans to deepen collaborations with the Shock Trauma Center and local county jails to ensure comprehensive, community-focused care. To further enhance visibility and outreach, a new partnership with the marketing agency Accent Interactive was announced.

While 2025 has presented challenges, the Department of Psychiatry remains unwavering in its mission. Having served Baltimore since 1823, its commitment to the city and state of Maryland and its residents runs deep. With bold leadership, sustained growth, and an unrelenting dedication to compassionate, evidence-based, person-centered, and trauma-informed care, the University of Maryland stands as a beacon of psychiatric excellence and hope for the future.

2025 MPS Paper/Poster Contest

The MPS established annual "best paper" awards to recognize outstanding scholarship by young psychiatrists in Maryland. Previous winners are listed here. The Academic Psychiatry Committee is currently soliciting nominations for the 2025 Paper of the Year Award in three categories:

Best Paper by an Early Career Psychiatrist Member
Best Paper by a Resident-Fellow Member
Best Paper by a Medical Student Member

A winner in each category will receive a **$200** cash prize as well as a complimentary ticket to the MPS annual dinner in April 2026. Dinner ticket funding courtesy of the Maryland Foundation for Psychiatry.

Scholarly work of all kinds (e.g., scientific reports, reviews, case reports) will be considered. If you would like to nominate a paper and author, including your own, please email the paper to either of the co-chairs below by **January 31**. Please include a brief explanation of why you believe the work is worthy of special recognition.

The MPS Poster Competition for our Resident-Fellow Members will be held again this year, with all entries displayed at our annual meeting in April 2026! The winner will receive a **$200** cash prize as well as a complimentary ticket to the meeting. Two finalists will also be selected and will receive **$100** each in addition to complimentary tickets. Dinner ticket funding courtesy of the Maryland Foundation for Psychiatry.

Winners in past years are listed here. Please click here for complete details about the process and requirements. **The deadline to enter is January 31.** Electronic copies of posters are due **February 10**.

Matthew Peters, M.D. mpeter42@jhmi.edu
Traci Speed, M.D., Ph.D. speed@jhmi.edu
Academic Psychiatry Committee Co-Chairs

Cheers from the Chair

by: Jimmy Potash, M.D.
Previously Printed in *Cheers from the Chair June 6, 2025*

Jimmy Potash, MD

History doesn't repeat itself, but it often rhymes.
—Attributed to Mark Twain

Mark Twain, America's master humorist and magnificent novelist, has been on my mind, as I am reading Ron Chernow's new biography of him. Twain clearly suffered with depression in his life and had frequent mood swings, including enormous enthusiasms, which sometimes involved spending sums he could ill afford despite his substantial assets, resulting in eventual bankruptcy. He came to prominence in a period he would give name to with his novel--*The Gilded Age: A Tale of Today*. That era produced enormous wealth, and among its titans was Henry Phipps, co-owner of Carnegie Steel. Phipps's interest in psychiatry has been attributed to a memoir of mental illness popular at the time, *A Mind That Found Itself*. But Phipps had already been thinking about psychiatric philanthropy for several years, possibly because of his old friendship with Harry Kendall Thaw, who in 1906 had murdered a famous architect during a performance in New York's Madison Square Garden Theatre, motivated by delusional jealousy (per Dr. Dean MacKinnon in his pending book on the history of our department). Thaw had engaged in wild and reckless excesses for years prior to this violent act, which was followed by the "Trial of the Century," a procedure that resulted in a verdict of "not guilty by reason of insanity."

In June of 1908, Henry Phipps famously donated $750,000 to build a psychiatric clinic at Hopkins, and pledged additional annual funds over ten years to support it. For his own family, Phipps created the Bessemer Trust, named after the first inexpensive industrial process for the mass production of steel, to manage their assets. All these years later, Bessemer is a thriving concern, and George Phipps is the chair of its board. His predecessor, Baltimorean Stuart Janney, took pride in continuing the family legacy of support for our renowned department, founded by his great-grandfather. And George Phipps, of the San Francisco Bay area, has followed in his cousin's footsteps. He told us "Johns Hopkins has such an amazing reputation, and it has been gratifying to learn about the history and contributions of the Department of Psychiatry."

On a June day this week, 117 years later, history repeated itself, as an agreement between George Phipps and the Bessemer board, and Johns Hopkins was finalized. It grants our department $750,000 over five years, and the School of Medicine another $250,000. I am immensely grateful for George's generosity and Bessemer's beneficence. So much so that I've composed an ode for the occasion (with help from AI, the steel of our generation).

Henry Phipps, with quiet dread,
Watched reason crack where beauty bled.
But Phipps, not one to sit and brood,
Chose hope, where once was solitude.
A clinic rose with mending light,
To study shadow, dream, and fright.
And from that root, a legacy
Was born, in care and empathy.
Years turned like Twain's old river bends,
But still the past comes back as friend.
George Phipps, with wisdom, grace, and care,
Will build on what has flowered there.
From madness, grief, and steel once poured,
Come healing hands and hearts restored.

Join the MPS Listserv

MPS members are encouraged to join the listserv to easily share information with colleagues. An email message sent to the listserv goes to all members who have joined. Posts can be questions, information, thought-provoking articles and more. To join the listserv, please go to: http://groups.google.com/group/mpslist or email mps@mdpsych.org. The listserv is open to members only so you will have to wait for membership approval and will be notified by email. If you have any trouble, please call or text the MPS office at 410-625-0232.

On Clinical Humility

By Douglas W. Heinrichs, M.D.

Douglas W. Heinrichs, MD

In a recent discussion on the MPS e-mail list, I opined that official statements from the APA should avoid the appearance of arrogance and demonstrate appropriate humility. I suggested that this may involve more than correcting our message, but would require us to actually look at the extent to which we embody the virtue of clinical humility. I would like to elaborate on the need for us to do that, both as a profession and as individual clinicians, and suggest some of the forces working against us.

I think we all enter the field aware of how much we do not know about what makes human beings tick. For many of us, that is part of our fascination with the field. But psychiatry, like the rest of medicine, is rightly expected to provide useful expertise in helping patients. We spend our years of training struggling to learn our specialty in order to become experts. Patients then come to us for the expertise we have to offer in helping them. For many medical specialties, it is fairly easy to characterize that expertise. A cardiologist knows a great deal about the physiology of the cardiovascular system. The range of interventions and their mechanisms are fairly well understood, and the outcomes fairly predictable. There certainly are cases that vary from the predictable. But these are clearly exceptions.

What about the psychiatrist? We know little about how the human nervous system works to generate human personality and behavior. Furthermore, while it is relatively straightforward to say when the human heart is functioning normally, the range of human personalities and ways to live a good life vary immensely. We struggle even to define the demarcation line between variations of normal and psychopathology. Consider, for instance, the ongoing debate about major depression and grief.

Furthermore, a human is the product of the interaction between an organ with over 100 trillion synapses and a complex environment. Each person's brain has been uniquely transformed by a life history up to that point, as well as by a unique genetic makeup. We should not be surprised at the vast array of problems we are called upon to help people solve, and the tremendous variability of responses to the treatments we offer. When we study most of our interventions, the variability among individual responses swamps group differences between active and control treatments. Furthermore, a wide range of unexpected and paradoxical effects can happen for any given patient. For any of our treatment interventions, we usually know only a *proximal* effect on the nervous system, e.g. inhibiting serotonin reuptake by an SSRI. How this effect reverberates through the highly individualized nervous system of a specific patient to produce an effect is largely shrouded in ignorance.

It is easy to be insecure as to whether we truly possess expertise at all.

At a time when our expertise was generally accepted, this could remain a quiet, nagging doubt. But we live in a time when expertise of all kinds is being challenged, sometimes in outlandish ways. This can readily lead to a defensiveness in our responses that can simply appear as arrogance. We are inclined to respond to categorical challenges with equally unnuanced defenses of what we do. Is it enough to say that antidepressants are overwhelmingly safe with little risk of inducing violence? As far as it goes, that is true. But can they in some situations induce violence? They certainly can.

Consider just two scenarios. An individual with an undiagnosed bipolar propensity is given an antidepressant, and becomes manic, highly aggressive and homicidal. Or someone is given an antidepressant for high levels of anxiety, who also has strong homicidal impulses that are kept in check by anxiety of the consequences. He takes the antidepressant, his anxiety decreases, and he becomes homicidal.

One of the unintended consequences of the application of evidence-based medicine (EBM) in psychiatry has been to encourage arrogance. I do not doubt that EBM, as a strategy for accessing the literature, has much to offer. However, when it is put forth as a *method* for deciding about the individual patient, it becomes problematic. Essentially, we are instructed to turn "How do I best treat Ms. Jones?" into "What is the optimal treatment for a group of patients who share certain attributes with Ms. Jones, usually a diagnosis?" We then are to go to the literature and compare treatments, picking the one with the best statistical outcome and best evidence, despite the tremendous variability among respondents. The assumption is that at this point there is a best answer to the question of how to optimally treat Ms. Jones. Our job then is to get Ms. Jones on board with this intervention. We are supposed to acknowledge that she may have certain values and preferences, but we are left on our own to figure out how to incorporate these. But in truth,

(Continued on next page)

On Clinical Humility Cont.

neither we nor the patient know the best treatment for Ms. Jones in advance. We must work through a therapeutic experiment together.

So, do we really have relatively little in the way of expertise? I do not think so. But we should carefully reconsider what constitutes our expertise. We cannot claim to know how the brain works in the same way that the cardiologist can claim to know how the heart works. Nor can we predict an individual's response to a treatment intervention with the same accuracy as the cardiologist. Our real expertise is in managing the therapeutic process. We know how to assess our patient as an individual, including an appreciation of the reasons for seeking treatment. We can draw on our knowledge base to suggest interventions that we believe have a reasonable chance of being helpful. We can work with the patient and monitor the ongoing experiment that constitutes the clinical encounter. We know how to help the patient characterize what is good and not so good in their responses. We can detect negative effects from our interventions and can take prompt corrective action. We know how to use failed or inadequate responses to guide the selection of the next alternatives. And we know how to keep our patients safe through the process.

All of this constitutes a valuable expertise. But we tend to treat it as background, rather than the core of what we know, because very little effort has been put into making this clinical reasoning process explicit. Trainees tend to learn it by modeling their teachers and supervisors, rather than understanding it explicitly. I believe such a methodology exists and that it can be articulated. It then can be used to teach trainees, as well as to establish an epistemological justification for what we do and what we know. In my recent book (*How Psychiatrists Make Decisions: The Science of Clinical Reasoning*, 2025, Oxford University Press) I attempt to do precisely this.

So, what sort of response should we make to the wild challenges to our expertise and to the safety of what we do?

I think we should say something like the following: "We have the knowledge to say statistically and at the group level what is the overall ratio of the benefits and harms of the treatments we offer. We acknowledge that there is tremendous variation between individuals in their responses to any of our treatments. We can guide individuals through the process of finding an effective treatment for each of them. We usually succeed in making their situation better. We can do this in a way that maximizes an individual's chance to have a desirable outcome, while minimizing the risks and dangers of this process."

This is an honest statement of our expertise that embodies appropriate clinical humility. And it is one of which we can be proud.

In Memoriam: Paul McClelland, M.D.

By Bruce Hershfield, MD

Paul McClelland, MD

Paul McClelland, MD, a former MPS President and Lifetime of Service awardee, died at age 76 on May 31st.

Originally from a small town in New York, where he was valedictorian and captain of both the basketball and baseball teams, he earned a degree at Syracuse, did graduate work at Johns Hopkins in physics, and taught at Western High School before going to medical school at the University of Maryland, where he completed a psychiatric residency. He served as Chair of Psychiatry at GBMC and St. Agnes Hospital and was Chief of Psychiatry at the University of Maryland Shock Trauma Center. .He was Medical Director of the Physicians' Health Program and he chaired the MPS ethics committee for many years.

Dr. Joanna Brandt said of him, "I first met Paul during residency at University of Maryland, where he was a valued teacher and mentor, training a generation of young psychiatrists in consultation-liaison. Later, Paul and I worked together for many years on the MPS Ethics Committee. Paul was always able to guide the committee in complex deliberations with reasoned and balanced judgement. I learned so much from Paul and will greatly miss his keen intellect and his warmth, compassion, and gentle demeanor.

Jeffrey Janofsky, MD commented, "I first met Paul when we served together on the Executive Committee. Later, I had the pleasure of working with him on the Ethics Committee. He was a soft-spoken and deeply thoughtful person. His insights were highly respected and he often played a key role in resolving complex issues with remarkable poise and clarity."

Dr. Scott Spier said on the MPS e-mail list that working with him was "like coming home to a good spot. What a lovely and wise man."

Paul was an excellent psychiatrist and a kind and thoughtful man. I asked him for advice and trusted him completely. I'm glad I knew him—he made me and everyone else who worked with him better.

Sports Psychiatry

By: Michael Young, MD

Michael Young, MD

I enjoyed talking about sports psychiatry at the joint Southern Psychiatric Association and Mississippi Psychiatric Association conference in Biloxi this summer. While sports psychiatry is in many ways akin to general psychiatric practice, there is a special focus on optimizing functioning and minimizing barriers to peak performance (i.e. medication side effects).

Specific Stressors

In working with athletes, and especially student-athletes, it is always important to remember their unique combination of stress that comes along with balancing sports, academics, social life, and family responsibilities--and the high risk of burnout that can be associated. When treating them, it is important to keep in mind "adjustment disorder with depression" secondary to specific stressors such as transitions to a higher level of play and the fear of failure in a highly competitive environment. Stopping participation in elite sports is another period of psychological vulnerability, as certain developmental milestones may have been delayed. Serious injuries, such as fractures, can be very significant stressors and lead to questions such as, "will I play again?", "will I play at the same level?", and "will I get reinjured?" Psychological factors can have a significant impact on recovery. Furthermore, financial pressures and performance pressures--with the reality of harassment, abuse, and cyberbullying commonly directed through social media-- can add additional stress.

Anxiety Disorders

When evaluating athletes with anxiety, patterns of symptom onset, duration, and severity must be assessed to differentiate competition performance anxiety from other types. "Adjustment disorder with anxiety" is relatively common. Injured athletes tend to report more severe anxiety symptoms and SSRI's are often the medications of choice for them. Caution with beta blockers is needed, as athletes often have low blood pressure and heart rate.

Mood Disorders

While the prevalence of depressive symptoms is thought to be similar among athletes and the general population, they may be less likely to seek help, due to stigma. Women may be significantly more likely to report depressive symptoms. Different sports are associated with different depression risk; depressive symptoms may be more common in individual-sport athletes (compared to those who play on teams). Over-training, sometimes referred to as "non-functional overreaching", should always be considered as a factor. Symptoms of over-training can include low energy (calories burned>caloric intake), depressed mood, fatigue, insomnia, and appetite changes. Lamotrigine is often considered a good choice for bipolar disorder. Lithium, while frequently clinically effective, needs to be used with caution due to risk of toxicity when hydration varies. Weight gain and metabolic side effects can be especially problematic for athletes.

ADHD

This may be more common in elite athletes, as some may be drawn to participate because of the positive reinforcing effects of physical activity. Post-concussive syndrome is an important differential diagnosis consideration when evaluating an athlete for ADHD. Both can include deficits in memory, attention, and concentration. ADHD may prolong the recovery from sport-related concussion. Insomnia should also be considered in the differential diagnosis for ADHD, with the additional awareness that there is an increased obstructive sleep apnea risk in larger athletes. A Therapeutic Use Exemption may be needed for an athlete to be allowed to use stimulants.

Acute Stress Disorder/PTSD

Severe musculoskeletal injuries, such as fractures or other injuries requiring surgery, are associated with increased PTSD symptoms, which can contribute to inconsistent athletic performance and somatic complaints. Additionally, fear of re-injury can increase the risk of subsequent injuries due to avoidance and inhibited effort. PTSD symptoms may follow concussions and those with pre-existing exposure to trauma may be more vulnerable. Harassment can also trigger symptoms of past abuse. PTSD can frequently be associated with co-occurring substance use disorders or eating disorders. CBT, cognitive processing therapy (CPT), and prolonged exposure (PE) can be useful interventions.

Substance Use Disorders

Alcohol, cannabis, nicotine, and caffeine are frequently used. During initial and follow- up evaluations, it is important to evaluate for ergogenic (performance enhancing) substance use. Caution is needed with dietary supplements. Self-report surveys and day-of-competition drug screening likely under-report substance misuse. The

(Continued on next page)

prevalence of substance misuse among athletes has been shown to vary by sport, as well as in-season versus out-of-season. Substance misuse appears to be higher in team sports compared to individual ones.

Eating Disorders
These occur at a significantly higher prevalence, compared to non-athletes. Elite female athletes have frequently reported body-shaming from coaches. Dissatisfaction with body image has been shown as the strongest predictor of eating disorders in athletes. Sports where appearance is important (i.e. gymnastics, figure skating) and sports that are divided into weight classes (i.e. wrestling, weightlifting, horse racing) present a particular risk.

Medication management
It is particularly important to account for potential negative impacts on performance such as sedation, decreased reaction time, weight changes, and GI symptoms. The clinician must consider both the *therapeutic* performance-enhancing effects--when the medications treat symptoms and do not enhance performance themselves--and *non-therapeutic* performance enhancing effects--when medications enhance performance beyond just treating the symptoms. Specific side effects can occur, given that athletes often exercise at a much higher intensity level. For example, stimulants can increase heart rate and blood pressure, placing athletes at additional risk of heat stroke. It is important to evaluate all athletes for "stimulant stacking", like when caffeine and nicotine and sports drinks are added to the adderall that is prescribed.

Psychotherapy considerations
Psychoeducation and psychotherapy are often the treatments of choice. Given their demanding schedules, the therapist may need to offer flexibility with timing of sessions, while still maintaining appropriate boundaries. Personal characteristics such as discipline and the ability to cooperate can make athletes especially good candidates for psychotherapy. Acceptance Commitment Therapy (ACT) and time-limited psychodynamic psychotherapy can often effectively address personality and behavioral issues. Performance training techniques, including breathing exercises, positive visualization, mindfulness, and meditation, can also be of great benefit.

Conclusion
The field of sports psychiatry has been gaining momentum over the past several years, with new pathways for extra training and certification being developed and a new curriculum being implemented within some training programs. Psychiatrists need to be aware of the sports-specific stressors that can negatively impact mental health in this population.

Interview: Douglas Heinrichs, MD

Sparks, MD September 19, 2025

By Bruce Hershfield, MD

Q: "Please tell us about your career."

Dr. H.: ""I started working at the Maryland Psychiatric Research Center, doing research in schizophrenia with Will Carpenter for about a decade. I was increasingly struck by how much what was being done in the research world was limited in its relevance to clinical care. Since I really enjoyed treating patients, I went into private practice in the mid-'80s. During that time I have been very much involved with the interface of Philosophy and Psychiatry. My undergraduate education was in philosophy and psychology and I later got involved with the Association for the Advancement of Philosophy and Psychiatry. It struck me how our field is fraught with conceptually confused concepts, but we do use them. You're always doing philosophy—it's just whether you're doing it tacitly or explicitly. If you're doing it tacitly, you're likely to be wrong a good portion of the time and it's likely to have practical consequences.

That's what got me interested in this. The particular project that led to my book—*How Psychiatrists Make Decisions—the Science of Clinical Reasoning*-- is something I've been working on since about 2015. What has struck me in my career—that spans the period from the dominance of psychoanalysis to the rise of biological psychiatry and all the changes that that entails-- has been the devaluing of clinical judgment of the individual patient. That is very illustrated by the way that Evidence-based Medicine is presented to us. What the clinician is essentially supposed to do is know the literature, and take the patients and put them into certain categories. For example, I decide my patient has Major Depression, then I am supposed to say, 'What is the optimal treatment for Major Depression?' And *that's* Mr. Jones!

"Lip service" is paid to the idea that every patient is a little different and you should use your clinical judgment, but there is no guidance. It's a filler for the knowledge we don't have. Eventually, it diminishes clinical judgment and we have a phrase I really hate—"the Art of Medicine". This implies it's impressionistic and there is no evidentiary value to it. It sets up a contest between Art and Science and in this day and age Science is going to win. "

Q:" How were you able to get your arguments out in the form of a book?"

Dr. H: "A lot of it came from my involvement with the AAPP. I made some presentations on this topic around 2012, 2013, and in 2015 I was invited to write a book chapter about it for a volume called *The Oxford Handbook for*

(Continued on next page)

Interview: Douglas Heinrichs, MD

Continued

Psychiatric Ethics. The editor of that, who has been very involved with the AAPP, approached me and said it merited book-length treatment. The problem was that I was involved with a very busy practice. So, for the next number of years I did some bits and pieces, but it was very hard to get a block of time to write a book. I retired in 2022 and the first item on my agenda was to pull all my notes together and actually write the book."

Q: "How are you planning to publicize it?"

Dr. H: "The primary audience is psychiatric trainees and educators. The secondary audience would be philosophers of Psychiatry. But I think it's relevant to clinicians at any point in their careers—including non-psychiatrists. The premise of the book is that one of the reasons clinical judgment is devalued is that we have never articulated an actual methodology for it. We learn by imitating our supervisors. Our pick-up strategy is all unspoken. We have this clinical wisdom, presumably. But, Evidence-based Medicine lays out a highly articulated strategy in this age of people wanting to be scientific. Psychiatry also aims for that these days. The first thing you have got to do is to say there is a definable methodology, and it can be articulated, taught, and judged, and that it has evidentiary value that puts it on a footing with scientific activity."

Douglas Heinrichs, MD

Q: "What is the next step?'

Dr. H: "I am hoping it gets picked up in psychiatric training programs. I got to the book's methodology by looking at my own thinking on a range of cases and then trying to generalize to a pattern of thinking that lines up with what clinicians usually do. I spend a fair amount of time arguing for the value of this in training—how this can improve psychiatric education. Finally, I deal with its justification—is this science? There have been revolutionary changes in the philosophy of science in the past half-century, most of which have been lost on Medicine. We're still dominated by an old theory of how science works. A lot of the *current* thinking is that scientists practice based on constructing models of concrete problems in the world. Those models are seen to repeat so you get generalizable models. That's what Science is—not discovering the "laws of nature" that apply universally that we just apply deductively.

There is a very interesting literature that I had not been familiar with until I was researching the book, on the development of expertise in general. Particularly, Donald Klein has dealt with this question. He studied how military commanders, fire fighters, etc. develop expertise in situations of high ambiguity, with little time available, and with high stakes. And he developed a method that looked very much like what I ended up with. This happened independently—I didn't know about him until after I had put my theory together. All these methods start with the assumption that you have prototype, typical situations and the first thing a good clinician does is make a very quick judgment : 'Is this a *typical* situation or is it *atypical*?' If it's typical you kind of know what to do. If it's atypical, you have to construct a unique model for the situation and run a mental simulation of what you think is going to happen if you make that intervention. Then, if it passes the mental simulation, you try to implement it. If you get in trouble you have to go back to the drawing board. "

Q: "How does this apply to non-psychiatric clinicians, many of whom are treating patients with serious disorders?"

Dr. H: "The psychotherapeutic work they are doing can also be formulated in these terms. If you develop a model of your patient, it should show you the pieces of that model that you're not competent to deal with. Then you need to get help. Having the humility to know your limits is important and one way to recognize this is to build a POP model—patterns of propensity. There are certain propensities—biological, sociological, environmental-- that are linked together by hypothesized causal connections. You formulate a picture of how you get from point A to point B, using these connections. They give you suggestions as to where you might want to make an intervention. There could be multiple models. The question is, 'Does it work well enough?'

The people who write about philosophical models liken them to maps. A road map is great for showing you the relationship between towns. It's lousy for giving you a picture of the town—all you get is a dot. But, if you're using it to navigate, then it's perfectly fine. If you're trying to find your way around town, it's a lousy map. So, the map is only as good as the degree to which it fits the task you have assigned it."

Q: "What are your thoughts about what happens when psychiatrists split the treatment with non-psychiatric therapists?"

Dr. H.: "I'm old enough to remember when we did it all and I personally think that's the best. But, I think it's certainly *possible* to have a dedicated team approach. However, *somebody* has to know enough about all those other interventions to create a coherent model. I think the psychiatrist is in the best position to do that."

Q: "I am concerned when the

(Continued on next page)

Interview: Douglas Heinrichs, MD

Continued

team is headed by someone else."

Dr. H: "Right—and I think that is a potential weakness because they are not in a position to incorporate the things we know how to do. The model has to incorporate them all, as a coherent whole. Psychiatrists need to take this seriously even if they don't want to *do* a lot of psychotherapy. They should understand it and how it interdigitates with the things they are doing."

Q: "The APA has been encouraging psychiatrists to work more as consultants to teams than to see their own patients. What do you think of that?"

Dr. H.: "It's obviously a pragmatic move, in the interest of cost containment and the availability of physicians. My own personal feeling is that most of the time it doesn't provide care that is as good. But I think it can be done competently if there is respect for a shared comprehensive model. You can develop a model together and say, 'Here is the piece I am going to address. How does my intervention impact yours—and *vice versa*."

Q: "It's essential for the team members to communicate."

Dr. H.: "Absolutely. I think the model gives a nice framework for doing that. Similarly, it serves as an aid to supervision, too. The other thing it does is that it says that what we are doing as clinicians--when we construct a model of an individual patient--is the paradigm of scientific activity in any field. That's where it starts. The generalizations come out of accumulated wisdom that comes out of individual models. You start with the individual, not with the 'law of nature' that you just deductively apply. It also encourages clinical humility. If you go back to the analogy of the maps—you can't decide if it's a good map or a bad map till you decide what purpose you have for the map. You can't decide if it's a good or bad model until you know the purpose, and the purpose is to meet the patient's goals. Patients should have a prominent role in saying why they are here and what they want."

Q: "I have noticed this is a frequent problem when I look over the work done by Residents—they don't ask the patients what they want."

Dr. H: "Absolutely! I include some glaring examples of that in my book. I think evidence-based Medicine encourages professional arrogance, without meaning to. It's really saying that when you diagnose patients as being depressed, based on our current knowledge, we can best tell you the right method of how to treat them. That's before the patient has any input whatsoever. Then we tack on something about considering the patient's values and preferences, as an afterthought.

If evidence-based Medicine is used as a tool for generating suggestions for our consideration, it might be of some value. But if it's seen as generating the answer, we're in serious trouble."

Q: "What are your plans for the future?

Dr. H.: "I've stopped providing clinical care completely. During all my years in practice I had this deep abiding interest in the interface of philosophy and Psychiatry. I never had the time to do much with that. I plan to do more writing, trying to get more people interested in that."

Q: "What have you enjoyed most?"

Dr. H.: "I started out thinking I would be an academic psychiatrist for my whole career. I got very disillusioned with that. What I discovered was that my greatest joy came from caring for individuals. That's why I wrote the book, because I valued that activity so much. I enjoyed being a generalist. I found Academic Medicine to be constricting—your success depends on knowing more and more about less and less. You become very specialized in something. I love the challenge of not knowing what sort of individual was going to walk into my office next and having to sort that out. Too often, people are limiting that activity to getting the *diagnosis* right—which is so "missing the point". The importance of the diagnosis varies from case to case. For some, it's pivotal for doing the right thing; in some cases, it's fairly peripheral."

Q: "The discovery of lithium made a difference in whether you were diagnosed with schizophrenia or bipolar disorder."

Dr. H.: "That's an important distinction. But, even with the patient with schizophrenia, it can vary. One of the examples I use is of a patient with schizophrenia, very stable on medication, who experiences the loss of his mother and he is having a tremendous grief response. The only real impact of his diagnosis at that point is that you have to keep an eye out that he doesn't decompensate, but what you're really providing has nothing to do with him having schizophrenia. It has to do with loss, and that's what your model should reflect. My goal at this point is to get the patient to deal with the tremendous loss. The diagnosis of schizophrenia can become a distraction if you focus on it.

Psychiatrists should not think of philosophy as some esoteric abstraction. We are using our conceptual presuppositions all the time. If we don't examine them, we are going to make terrible mistakes that can have terrible consequences for our patients."

Ending Crime & Disorder on America's Streets

Executive Order Targets Homeless Individuals with Psychiatric Illness

by Dinah Miller, MD

Dinah Miller, MD

Ed's Note: This is a version of an article first published in *Psychiatric Times* on 8/12/25

Every night in the United States, more than a quarter million people have nowhere to sleep; they are both homeless and unsheltered. Many struggle with mental illness and substance use; others are impoverished with no place to go. Rates of homelessness are increasing and there is not enough supported housing nor shelter beds to meet the needs of people with nowhere to stay.

In late July, President Trump issued an executive order entitled "Ending Crime and Disorder on America's Streets." Although this might sound like an order related to criminal activity and policing, it is not. Its agenda is to institutionalize unhoused people, with the proposed intention of making cities safer. There is no attempt to address violent crime that is not perpetrated by people who are homeless, yet the order targets every person living on the street with a history of substance use or psychiatric disorder--regardless of whether there is a history of criminal behavior. In addition, it does not include a mechanism for addressing the problem of homelessness for people who do not have either condition.

With no statistics or references, it states that the overwhelming majority of people who are homeless have a history of drug addiction, and that many of those are also mentally ill.

Section 1 reads, "Shifting homeless individuals into long-term institutional settings for humane treatment through the appropriate use of civil commitment will restore public order. "It continues with an action plan, which includes terminating policies that stand in the way of civil commitment for those who are mentally ill and dangerous or living on the streets. It goes on to assert that several cabinet members will direct the assessment of grant funding and give priority for funding to states that: 1) enforce prohibitions on open illegal drug use, 2) prohibit urban camping and loitering, 3) maximize the use of both inpatient and outpatient civil commitment, and 4) track homeless sex offenders. Individuals with serious mental illness are not to be released because of a lack of space in forensic facilities or hospitals.
Although it does not explicitly provide for housing or funding for more hospital beds, it does call to abolish current housing options: "These actions shall include, to the extent permitted by law, ending support for 'housing first' policies that deprioritize accountability and fail to promote treatment, recovery, and self-sufficiency." It further targets facilities with "safe consumption sites" or needle exchanges. Finally, it requires the collection of health-related information from those individuals who receive federal funding for homelessness assistance and requires it to be shared with law enforcement.

I have many concerns about this executive order. There is the assumption that people with mental illness are dangerous, perpetrating a stigma that we have fought for so long to dispel. It calls for civil commitment based on homelessness and not on individual actions, as it calls for unhoused people to be rounded up and involuntarily confined before they have committed any crime.

Our current laws generally provide for hospitalization only for the duration of an acute episode, and the average length of a hospital stay is approximately 2 to 3 weeks. Our current system does not provide for much long-term institutionalization. Hospitals, jails, and shelters are often filled to capacity. Presumably, President Trump would house those with chronic mental illness and homelessness in state hospitals, but there is no mention in this order of funding new facilities or increasing bed capacity. Instead, the order seeks to defund Housing First facilities that have been found to improve housing stability in vulnerable populations.

It is shameful that people are left to sleep on the streets, whether they are there because they are ill, addicted, or impoverished. A radical plan to provide housing is very much needed, but it should be addressed with sensitivity. Instead, this executive order invokes fear of people with psychiatric illnesses, it talks of indiscriminate incarceration of people who have not committed a crime, and it calls for collecting and sharing sensitive health information with law enforcement.

And it proposes no actual solutions.

The Perils of Patient Portals

by: Mark S. Komrad, MD.

Mark S. Komrad, MD

Here is a recent call I got from a patient:

"Doctor, I am really concerned. I got my lab test results through the Quest patient portal, and my BUN is pretty high—27. I stayed up really late last night on Google, and am quite worried that my kidneys may be failing. I looked up some of the symptoms, like darker urine, which can also be a symptom of liver failure, it says. I'm really upset."

It turns out that she had normal renal and liver function, was otherwise healthy, but was not hydrating optimally in the summer heat. So, I was able to quickly reassure her.

Patient portals are innovations that arose out of the VA's "Blue Button" initiative in 2010, implemented by Barack Obama, to give patients online access to their records. The original impetus was particularly driven by VA patients who were seeking to download their medical records in support of their applications for service-connected disability. However, it was also driven by the promotion of autonomy, self-determination, transparency and patient rights that have been significantly accelerating in the last 50 years. The advent of electronic medical records made them accessible from any location over the internet. Soon, "patient portals" became widely available in many healthcare settings, allowing patients to access a wide variety of information like their lab results, procedure notes, and clinical encounter summaries. It also developed into a two-way communication channel for patients to have written exchanges with their clinicians.

Like any technological development in health care, the consequences of electronic health records, particularly patient portals, have been both positive and negative. For example, patients have been able to enjoy rapid access to test results, to have digests of their health encounters, and to better their ability to contact their clinicians. In turn, clinicians can access patient information from any location, and answer patient questions without playing "phone tag" or leaving confidential answers on voicemail.

However, some of the difficulties have been significant, like in the above example. Patients often get to see their lab findings before the doctor does. A physician with a heavy caseload is no match for one patient poised on the patient portal, anxiously awaiting results. Results are not presented in the context with explanation, support, and reassurance. This leaves patients to go down the "rabbit hole," engaging "Dr. Google" and the "overnight med school "of the internet. Medical training and experience teach us to put findings in the wider context--to separate "signal" from "noise." An on-line exploration to interpret a specific result or diagnostic term cannot furnish context, nuance, and discernment. Not even AI can; at least not yet.

Also, there is much misinformation on the internet, coming from so many sources—"wellness influencers" (see the excellent Netflix dramatic series based on a true story, *Apple Cider Vinegar*]), those with non-mainstream training (e.g. naturopaths), and even some bona fide physicians who have gone far off the reservation (e.g. physicians promoting Lyme Disease as the inevitable answer to most unexplained symptoms). Now there are even misappropriations of mainstream physicians' identities through deep fakes of them purveying significant medical misinformation on YouTube (NYT article:)"The Doctors are Real but the Sales Pitches are Frauds"].

Psychiatrists in particular see patients with anxiety, paranoia, cognitive impairment, hypochondriasis, etc., which can accelerate an anxious and misinformed journey sparked by a patient portal discovery. I have seen this many times. For this reason, when I order tests, I tell my patients they will likely see their results before I do. I advise them to not consult Dr. Google before they discuss results with me. Sometimes, though, I'll get patients coming to me to interpret test results that other clinicians have ordered, because I tend to be much more easily accessible to my patients than their non-psychiatric doctors.

The other problematic consequence concerns the volume of on-line communication with clinicians. This was meant to be a time-saving device for clinicians, sparing them a return phone call, but many doctors feel overwhelmed by patients contacting them through portals. It is so much easier to initiate a text through a portal than to make a phone call; it's not necessary to leave a message with a secretary, service or voicemail, and wait for a call-back. Because if this ease, the *volume* of portal contacts has escalated enormously — by 57% since pre-pandemic (AMA: "What's Adding to Doctor Burnout? Check. Your Patient Portal]"). Patient portals are a form of texting and the wait-time for a reply is far shorter than for an

(Continued on next page)

The Perils of Patient Portals

Continued

e-mail or phone message. Many harried doctors send their staff to the portals for *them* to handle the volume, and often they need to return to the doctor to complete an answer. Patients get frustrated if they don't hear back soon, or get a cursory answer that requires a follow-up question.

Many colleagues deliberately do not provide patient portals for communication; they set limits for on-line contact, or prefer to just let patients text or e-mail them. There are challenges with that approach. In my own experience, because patients know that they can contact me by text or e-mail directly, my policy actually slows down the process a bit. They sense that contacting me in this more direct way instead of through a portal is somewhat more intrusive, so their threshold for crossing that communication bridge is higher. We psychiatrists may have more opportunity to guide patients than other kinds of physicians, and perhaps we can better explore their communication behaviors towards us that occur in- between visits.

As the Nobel economist Milton Friedman noted, "One of the greatest mistakes is to judge policies and programs by their intentions rather than by their results." Patient portals have had many unintended consequences and we might need to guide our patients in how to use them in order to keep them from getting misinformed and ourselves from becoming overburdened.

Early-Career Psychiatrist WhatsApp

The MPS ECP WhatsApp Group is a way for members who are within 7 years of completing their training to communicate and collaborate with each other. This group is similar to our MPS Listserv but dedicated to *only* our ECP members.

The purpose of the WhatsApp group includes:

- Peer Support
- Resource Sharing:
- Case Discussions
- Networking Opportunities:

Fill out this form to join and, once approved, we will send an invite link for access to the group.

Panel Discussion About Climate Change

By Bruce Hershfield, MD

Bruce Hershfield, MD

On September 11th, the MPS, along with the Community Diversity Coalition, with sponsorship by the Maryland Foundation for Psychiatry, held an on-line discussion about how climate change is affecting our patients and our lives.

First, Cheryl Holder, MD, an internist and HIV specialist, gave an overview of how climate change is impacting our health. She told us about how greenhouse gases block the removal of heat from the earth's surface, and added that 8.5% of that comes from healthcare. The increased temperatures are affecting kidney function and causing the rate of stillbirths to rise. Higher temperatures increase the presence of pollen (affecting asthmatics) and cause mosquitoes to have a larger range. Particulate pollens are more prevalent in communities that have a lot of minorities. She pointed out that a majority of Latinos in the USA live in Florida, Texas, and California and she mentioned the financial disparity between white and black households. She urged us to engage, participate, and advocate.

She was followed by Dr. Lise Van Susteren, who is a co-founder of the Climate Psychiatry Alliance. She talked about climate "tipping points" and said they are causing an explosion of refugees and the rise of authoritarianism. We could see dramatic rises in sea levels and the transformation of the Amazon rainforest into savannah. The elderly, the sick, and the poor are especially vulnerable. She told us that 2/3 of USA respondents believe humanity is doomed. She remarked that "not everything that counts can be counted". She closed by urging us to make political and personal and professional efforts, pointing out that new sources of energy could make a big difference.

Finally, Gwen DuBois, MD, MPH, who is President of Chesapeake Physicians for Social Responsibility, talked about the greenhouse effect. First mentioned by Edward Teller in 1959, its importance was hidden by fossil fuel companies that used the same tactics that "big tobacco" used. She told us about the medical waste incinerator in Curtis Bay—the biggest in the country—and about the problem with dust in that area.

She reminded us we could start doing something by looking at our own "carbon footprints", in our personal habits and in our offices.

Book Review: *The Invisible Ache—Black Men Identifying Their Pain and Reclaiming Their Power*

By Courtney B. Vance and Dr. Robin L. Smith

by: Rachna S. Raisinghani, MD

Rachna Raisinghani, MD

As a psychiatrist, I have long witnessed the subtle, unspoken suffering that hides behind achievement, competence, and control—particularly among men of color. In *The Invisible Ache*, actor Courtney B. Vance and psychologist Dr. Robin L. Smith illuminate that phenomenon with unflinching honesty. Their collaboration gives voice to the psychic pain of Black men—a pain often minimized, misdiagnosed, or ignored altogether by both society and the healthcare system. At its heart, it is a call to recognition: an insistence that the emotional wounds of Black men are not invisible at all, merely unacknowledged.

Vance grounds the book in his own story—the suicide of his father, the quiet grief that followed, and the inherited scripts about masculinity and strength that shaped his life. His vulnerability is disarming. He revisits how he learned that stoicism and control were synonymous with manhood, even when those same traits kept him from processing unbearable pain. For psychiatrists, these narratives will feel familiar: Men who describe their distress somatically or who couch depression in language of fatigue or frustration; men who apologize for tears or who equate vulnerability with failure.

Dr. Robin Smith complements Vance's story with depth and direction. A therapist and ordained minister, she contextualizes his experiences in the framework of trauma, intergenerational transmission of pain, and systemic racism. Her language is both compassionate and clinical, blending spiritual insight with psychological grounding. She introduces the concept of the "invisible ache" as both a personal and collective condition—an embodiment of historical injustice, compounded by cultural expectations of invulnerability.

These are topics we, as clinicians, often grapple with: racial identity, masculinity, fatherhood, hesitancy to engage in therapy, and the shame attached to emotional need. Smith's discussion of therapy is particularly resonant—she dismantles the notion that seeking help diminishes strength, reframing it as a radical act of self-preservation.

As a woman who is originally from South Asia, I found myself reflecting on parallel experiences within my own community—where silence, endurance, and self-sacrifice are valorized, and emotional expression is often stigmatized. While the historical and cultural contexts differ, the underlying message resonates: mental health cannot flourish in the absence of vulnerability. The book reminded me how easily systemic and cultural forces conspire to make suffering invisible—and how Psychiatrists must strive to see what others overlook.

From a clinical standpoint, it highlights the importance of cultural humility and the need to move beyond symptom checklists toward understanding. Smith's sections on grief and identity could easily serve as discussion points in supervision or cultural formulation sessions.

Vance's voice gives permission—both to his peers and to those of us who work with them—to name emotions that have long been suppressed. For psychiatrists working with Black men, this book underscores the necessity of safe spaces, trust-building, and a therapeutic stance that honors rather than challenges cultural identity.

More than a memoir, it's an invitation to action. Exercises on naming emotions, acknowledging intergenerational pain, and developing language for internal states could easily be integrated into psychotherapy or group work.

It underscores the invaluable role that women, whether as maternal figures, supporting spouses or compassionate therapists, can play in giving men the space and acceptance to be vulnerable and to seek help.

If the book has a limitation, it lies in its scope. The transitions between personal narrative and didactic reflection can feel uneven, and the range of male experiences—across class, sexuality, or immigration—remains somewhat narrow. Some sections may verge on the therapeutic rather than analytic, relying on spirituality and affirmation where deeper structural critique might be warranted. Yet, it succeeds in its mission: to bear witness and to begin a conversation that has been long deferred.

Few texts I've read so effectively capture the human side of what we treat—the affective weight behind the DSM categories of depression, trauma, or adjustment disorder. It offers a reminder that the "invisible ache" exists not only in Black men, but across communities where silence has become key to survival. *The Invisible Ache* is an opportunity to examine our blind spots. How often do we

(Continued on next page)

misread guardedness as resistance? How often do our diagnostic frameworks miss the cultural context of pain? How can we create space for vulnerability in patients who learned that vulnerability is unsafe?

Ultimately, this book left me both humbled and hopeful. Humbled by how much emotional labor remains unspoken among our patients—and, perhaps, among ourselves. Hopeful because Vance and Smith show that healing is possible when pain is named, shared, and understood.

Psychiatrists often talk of insight as a therapeutic goal. *The Invisible Ache* extends that insight to society itself. It challenges us—not just as physicians, but as human beings—to look beyond symptoms, to listen differently, and to believe that even invisible pain deserves to be seen.

Retirement & Me

I've Got Nothing to Do and All Day to Do it

By John W. Buckley, M.D.

Retirement—if you live long enough—is unavoidable. It's not about conceding the tennis match or heading off for a night's rest. It's about stopping the work you've been doing…leaving behind the familiar tasks and settings and personal contacts—even the travel routes.

There are some early hints. The supermarket clerk calls you "Sir" or Ma'am". When you turn 64 ½ your mailbox fills up with ads for Medicare supplement plans. Winters seem longer. The hints slowly pile up.

My own retirement came when I was 81. My solo suburban practice, in an office on a hospital campus, had dwindled because of COVID. A knee replacement nudged me to set a date. Many of my patients, along with the referring doctors, had also aged. My last day came in late July, just before I needed to renew my malpractice insurance.

Closing an office and closing a practice both require plans. The advice about how to do them is available from many sources. It leaves all the effort to the retiree. There is always a loose end that is not on the list.

For recently active patients, I wrote a brief summary of treatment (like a hospital consult note, always shorter than one page), copied pertinent lab results and consultations, and handed it to them. It was usually

enough to serve as a referral letter for continuity of care and as an update for any PCP. The MPS e-mail list helped me find peers who were willing to pick up patients who needed to find new psychiatrists.

Saying goodbye to my patients was easier than I had anticipated, but the first weeks without a "job" were strange. I lacked the sense of purpose I'd had…forever. I joined the local senior center. I wondered about "my" patients, while resisting the urge to call them or their new psychiatrists. I had random memories of people from my distant past—not school mates, but patients whom I had failed in one way or another. Sometimes, I would wake from a dream, trying to solve a clinical problem. I had a new appreciation of the Styx lyrics: "I've got nothing to do and all day to do it".

At the senior center, I was identified as "retired". At medical appointments I was "Mr." or "John". The friendly banter at the senior center usually included stories of recent joint replacements, coronary stents, or concerns about the parents of the retirees who were in their 90's.

My wife and I had signed on to the waiting list at a continuing care retirement community. We felt by doing this that our children could make their own plans without worrying about housing the old folks. We waited for the call for 18 months. Then it came. We sold our old farmhouse and moved into a two-bedroom apartment, joining 500 others in what would be our "forever home".

I have stopped commenting to my wife about it being the Hotel California. I have met very pleasant retirees, enjoyed the food, learned from the lectures, and adjusted to looking forward to many of the activities. I have not yet competed in the two most popular sports (bocce and canasta), though I have enjoyed playing pickleball.

At this point, I am an independent resident in an old age home…still licensed and still waiting for my next career. I am still nimble enough to dodge the many rollators coming at me in the long corridors.

LETTER FROM THE EDITOR
Meeting Dr. Wills

by: *Bruce Hershfield, MD*

Bruce Hershfield, M.D.

I first met Dr. Marketa Wills, the new CEO and Medical Director of the APA, on-line with the board of the Senior Psychiatrists, then in-person in Biloxi when she came to the Southern Psychiatric Association meeting. She spent two days with us in Mississippi and I –and many others—got a chance to sit and talk with her. She lectured about "Charting Our Course Ahead: The Future of Psychiatry" and handled our questions with a lot of understanding about the dangers we are facing. She recently visited the Johns Hopkins Bayview Center to learn about the psychedelics research that is going on in the Baltimore area. I see she is also lecturing around the country about "Mindfulness and Meditation", so many more people will get to know her.

I believe the most important question the APA now faces is whether we should cooperate with the government when it is attacking science, Medicine, and universities. Inevitably, it has begun attacking us—as when it recently went after SSRI's for allegedly causing mass murders, and for vaccinations and Tylenol for allegedly causing autism. The APA's statements in response to these allegations clearly stated the facts.

Dr. Wills made it clear in Biloxi the APA plans to try to reach agreements with the government, as it has always done in the past. This is the path that some of our institutions, like some universities and big law firms, have been taking. I hope she is right. It certainly appears to be more reasonable than to oppose it, which could be a catastrophe. Of course, cooperating can also turn out to be a slow-moving catastrophe, as the world learned at Munich.

I told her about what General Winfield Scott said when Lincoln came to Washington to be inaugurated. General Scott told him he had dined in the White House with every President since Jefferson and he thought he —Lincoln— would turn out to be the best.

We have had excellent Medical Directors during the time I have been a member. She may turn out to be the best of all. It's not clear what challenges we will have to face, but we should do it bravely and we should do it united. We need to support her efforts to lead us in all the ways we can.

MARYLAND PSYCHIATRIC SOCIETY

Officers

President	*Ronald Means, MD*
President-Elect	*Tyler C. Hightower, MD, MPH*
Secretary-Treasurer	*Michael A. Young, MD*
Council Chair	*Theodora Balis, MD*
Executive Director	*Meagan Floyd*

Editorial Advisory Board

Editor Bruce Hershfield, MD
Email: bhershfiel@aol.com

Members:
Shyam Hitarth Bhatt, MD, MPH
John W. Buckley, MD
Zhuoheng Deng, MD
Bruce A. Hershfield, MD
Tyler C. Hightower, MD, MPH
Kim Jones-Fearing, MD
Sue E. Kim, MD
Idris Leppla, MD
Rachna Raisinghani, MD
Elizabeth Ryznar, MD, MSc
Gilliam Schweitzer, MD
Nancy K. Wahls, MD
Robin Weiss, MD
Elizabeth Wise, MD

Layout and Design *Jora Hritz*

THE MARYLAND PSYCHIATRIST IS PUBLISHED BY THE MARYLAND PSYCHIATRIC SOCIETY. MATERIALS FOR PUBLICATION SHOULD BE FORWARDED TO THE EDITOR. THE VIEWS EXPRESSED IN ***THE MARYLAND PSYCHIATRIST*** REFLECT THOSE OF THE AUTHOR AND NOT THOSE OF THE MPS, APA OR EDITORIAL BOARD.

SUBSCRIPTION RATES: $25 PER YEAR PAYABLE TO THE MARYLAND PSYCHIATRIC SOCIETY.

SEND ALL CORRESPONDENCE TO:
MARYLAND PSYCHIATRIC SOCIETY, INC.
1211 CATHEDRAL STREET
BALTIMORE, MD 21201
PHONE: (410) 625-0232; FAX: (410) 625-0277
EMAIL: MPS@MDPSYCH.ORG
WEB: WWW.MDPSYCH.ORG

$150,000

TO DEFEND YOUR LICENSE AND LIVELIHOOD

WE DEFEND YOU

Because of our extensive experience protecting psychiatrists, PRMS® knows that you are more likely to face an administrative action than a lawsuit. That is why our comprehensive malpractice policy includes a separate $150,000 defense limit for license

KATHI HEAGERTY, BSN, JD
SENIOR LITIGATION SPECIALIST

More than an insurance policy

(800) 245-3333
PRMS.com/**150**
TheProgram@prms.com

PRMS the psychiatrists' program®

Insurance coverage provided by Fair American Insurance and Reinsurance Company (FAIRCO), New York, NY (NAIC 35157). FAIRCO is an authorized carrier in California, ID number 3715-7. www.fairco.com. PRMS, The Psychiatrists' Program and the PRMS Owl are registered Trademarks of Transatlantic Holdings, Inc., a parent company of FAIRCO.

Donate to the Dr. Wonodi Award Fund!

To donate to the award fund, please pay online or send a check to *The Maryland Psychiatric Society 1211 Cathedral Street, Baltimore, MD 21201* and designate that the funds be reserved for the *Dr. Wonodi Award*. Donations are not tax deductible as a charitable contribution.

MPS ADVOCACY FUND

Psychiatry faces legislative and regulatory opportunities and threats in our state. The MPS works for you by advocating with lawmakers and the executive branch. To sustain government affairs activities and legal counsel for our role as the voice of psychiatry, we need financial support from all Maryland psychiatrists. **Every contributor, every member strengthens our collective position!**

To support the MPS over and above your membership:

1. **Visit: https://mdpsych.org/contact-us/**
2. Click on the yellow "Pay Now" button
3. Enter your credit card information

2026 State of Psychiatry in Maryland

January 28, 2026 6:00PM UNTIL 9:00PM

PANEL DISCUSSION FROM 7:00PM - 8:30PM LED BY MPS PRESIDENT, RONALD MEANS, MD

@ THE CONFERENCE CENTER AT SHEPPARD PRATT

2 CME Credits

Rishi Gautam, MD
Chair of Psychiatry, LifeBridge Health

James Potash, MD, MPH
Psychiatrist-in-Chief, Johns Hopkins Medicine

Jill RachBeisel, MD
Dept. of Psychiatry Chair, University of Maryland School of Medicine

Elias Shaya, MD, DLFAPA
Regional Medical Director, Behavioral Health - MedStar North

Harsh K. Trivedi, MD, MBA
President and CEO, Sheppard Pratt

Learn from some of the leading behavioral health experts in the state of Maryland who will address challenges and successes with delivery of behavioral health services in the current financial and political environment.

$20 Entry Fee

All Residents and Fellows can attend for free

LIGHT REFRESHMENTS WILL BE PROVIDED

REGISTER HERE

Contact: jhritz@mdpsych.org

Accreditation and Designation Statement

In support of improving patient care, this activity has been planned and implemented by American Psychiatric Association (APA) and The Maryland Psychiatric Society (MPS) APA is jointly accredited by the American Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

The APA designates this live activity for a maximum of 2 AMA PRA Category 1 Credit™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.