Ohio Psychiatric Physicians Association

Insight Matters

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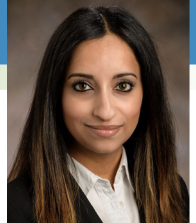
Protecting mothers, saving lives

The crucial role of psychiatrists in tackling maternal mortality



Nita Bhatt, MD, MPH, FAPA
President

As psychiatrists, we are in a unique position to help address the growing crisis of maternal mortality in Ohio and across the country. Alarmingly, maternal mortality rates have been on the rise, and in 2021, for the first time, mental health conditions became the leading cause of pregnancy-related deaths in the United States. Each mother lost is a devastating tragedy for her family and a stark reminder of the gaps in our healthcare system. We must recognize this as a call to action and respond with the collaboration, education, and advocacy necessary to make a difference.

The latest data from the CDC reveals a maternal mortality rate of 32.9 deaths per 100,000 live births in 2021—a dramatic increase compared to previous years. The disparities are particularly concerning for Black women, who are 2.6 times more likely to die from pregnancy-related causes than White women. Here in Ohio, we see similar trends, with mental health conditions such as depression, anxiety, and substance use disorders playing a significant role in maternal deaths. A report from the Ohio Department of Health found that nearly 60% of pregnancy-related deaths between 2017 and 2019 were preventable, and mental health factors were involved in many of these cases.

These statistics highlight an urgent need for psychiatrists to be involved in educating our colleagues from other specialties—obstetricians, primary care physicians, and emergency care providers—about the critical importance of addressing perinatal mental health. Issues such as postpartum depression, anxiety disorders, and substance use cannot be overlooked. Our involvement can help ensure that mental health conditions are recognized and treated early, potentially preventing tragedies down the line.

But beyond education, advocacy is key. We must push for policies that improve access to care, such as extending Medicaid coverage for postpartum care from 60 days to a full year—a move that has already shown promise in improving maternal health outcomes. While Ohio has made progress in this area, there's still much more work to do at the state and federal levels. Integrating mental health screening into routine maternal healthcare is another critical step. Just as we routinely check vital signs during prenatal visits, mental health assessments should be part of the standard care, allowing us to catch issues early and provide timely interventions.

As we look to the future, it's clear that psychiatrists have a vital role to play in reducing maternal mortality. By working alongside our colleagues in other specialties, advocating for stronger policies, and ensuring mental health is a core part of maternal healthcare, we can help prevent unnecessary tragedies. Every mother lost is not only heartbreaking for her family but a reminder of where our healthcare system needs to improve. Together, we can help build a system that supports every woman's mental and physical well-being, ensuring she receives the care she needs before, during, and after childbirth.

References

Researchers debate the nature of conditions we call “personality disorders”

Editor’s note

Awais Aftab, MD
Editor, *Insight Matters*

While working with people with DSM/ICD personality disorder diagnoses, I often wonder: on what basis do we get to say that their personalities are disordered in a way that the personalities of people with mood, anxiety, and psychotic disorders are not? The most common personality deviations I see in the clinic are high neuroticism and low conscientiousness (disinhibition), but we almost never characterize these as personality disorders since they are so commonly seen in emotional and behavioral problems.

Recently, the question of what distinguishes the conditions we traditionally call “personality disorders” from other mental disorders has become the focus of intense discussion in the academic community. The stimulus for the current iteration of this debate has been the development of the Alternative Model for Personality Disorder (AMPD) in DSM-5 and its two main components, Criteria A and B, which are crucial for refining the conceptualization and diagnosis of personality disorders (PD).

Criterion A focuses on *self and interpersonal dysfunction,* and it was developed with significant influence from contemporary psychodynamic theory. Criterion B, on the other hand, is centered around quantitative differences in personality characteristics. It utilizes a dimensional trait model based on the Big Five personality traits (neuroticism, conscientiousness, agreeableness, extraversion, and openness to experience), which is well-studied and has strong empirical backing. Resultantly, it characterizes the personality disorder along five axes of negative affectivity, detachment, disinhibition, antagonism, and psychoticism.

Despite the intent for Criteria A and B to be complementary, the field has seen a growing body of literature that pits these criteria against each other, particularly in their ability to predict clinical outcomes and perform other psychometric tasks. In particular, an argument has emerged in certain circles that Criterion A is redundant at best and problematic at worst and should be eliminated in favor of diagnosing personality disorders on Criterion B.

The argument is presented most clearly in García et al. (2024), where authors propose discarding Criterion A (which focuses on maladaptive ways of viewing oneself and others) and relying solely on Criterion B (which identifies maladaptive personality traits):

“The evidence has failed to show that Criterion A is any different from pathological traits or that it adds incremental validity over them, and the theoretical assumptions that it represents the core features of PDs, differentiates PDs from other mental disorders, and is a better indicator of dysfunction lack support**.** Although the AMPD classification is psychometrically and theoretically superior to traditional categories, it would gain feasibility and coherence if Criterion A is discarded. Criterion B traits, together with an assessment of their real-life consequences, would be a less speculative measure of severity.” (García et al. 2024)

Hopwood (2024) and Zavlis and Fonagy (2024) have responded with persuasive and devastating demonstrations that this line of thinking leads to a stark either-or conclusion: either all mental disorders are personality disorders, or there is no such thing as a personality disorder. Both these responses are preceded by an earlier 2022 article by Aidan Wright and colleagues in which they argue that personality disorders are better conceptualized as interpersonal disorders.

The proposal to *define* personality disorders in terms of their personality trait profiles seems unproblematic at face value, however "it presumes that the association between personality traits and PDs is somehow special, if not unique, and *that it is personality itself that is disordered* as opposed to a circumscribed psychological dysfunction, delineated in scope or time.

Three research literatures undermine these basic assumptions." (Wright, et al. 2022; my italics)

First, research shows that personality traits are not uniquely associated with PDs; they also strongly correlate with other mental disorders, sometimes even more so.

"Large meta-analyses of big five personality trait associations with DSM PDs and clinical syndromes (e.g., Kotov et al., 2010; Samuel & Widiger, 2008) suggest there is nothing special about the relationship between personality traits and PDs relative to other disorders (Krueger et al., 2014). If anything, trait associations with clinical syndromes are stronger than with DSM PDs. For instance, Kotov and colleagues (2010) report that across anxiety, depressive, and substance use disorders, the mean effect size for neuroticism was $r = .64$, which is more than twice the average association between neuroticism and PDs ($r = .31$) reported in Samuel and Widiger's meta-analysis. And similar patterns emerge for other traits (e.g., the average effect for conscientiousness across clinical syndromes [$r = -.45$] more than triples the mean association with PDs [$r = -.13$])" (Wright, et al. 2022)

Second, personality traits and other forms of psychopathology share the same structural space, suggesting that personality traits are not specific enough to define PDs uniquely.

"applying the quantitative empirical approach to adult psychopathology writ large results in a five-factor structure, including Internalizing, Detachment, Antagonism, Disinhibition, and Thought Disorder (Kotov et al., 2021; Wright & Simms, 2015), which are conceptually and empirically aligned with the basic Big Five model Neuroticism, Extraversion, Agreeableness, Conscientiousness, and Openness, respectively (Widiger et al., 2019). Thus, personality traits and all psychopathology, not just PDs, occupy the same structural space. At the same time, it must be emphasized that the two interpersonal factors of Antagonism and Detachment only emerge with the inclusion of PD diagnoses and/or features." (Wright, et al. 2022)

Third, the assumption that PDs are more stable and pervasive than other clinical syndromes is not supported by scientific evidence, as both PDs and other mental disorders exhibit similar levels of stability.

These points suggest that personality traits alone cannot adequately describe the dysfunction that characterizes PDs. While the trait model of Criterion B is empirically robust, it fails to specifically define PD pathology, making it insufficient as a standalone model for PD diagnosis.

Hopwood articulates this quite well: a trait-based conceptualization of personality disorders amounts to the argument that there is no such thing as a personality disorder. "Given that personality traits are not specifically associated with PD, that PD constructs cannot be distinguished from other kinds of psychopathology in terms of stability, and that trait-based models of PD do not specify the kinds of dysfunction that characterize PD, the argument that traits should be the primary criterion for diagnosing PD amounts to an argument that there is no such thing as PD. From this perspective, personality variance structures individual differences in the wide range of noncognitive mental health problems a person could have, inclusive of the kinds of problems that were listed in both the first and second Axes of *DSM-III* and *DSM-IV*, but there is no principled basis for distinguishing these Axes." (Hopwood, 2024)

Zavlis & Fonagy put it this way: Either all mental disorders are personality disorders or there are no personality disorders. "In other words, if personality disorder is merely a disorder of extreme personality traits, then all mental disorders can be cast as personality disorders because all mental disorders inherently entail personality extremeness. Of course, we all know better than to label every depressed, anxious, and autistic person as having a personality disorder simply because they score highly on measures of personality. Instead, we clinically understand that there is something different between these clinical cases and the classic "personality disorder" cases. And that something clearly is not reducible to personality traits." (Zavlis & Fonagy, 2024)

Criterion A was developed to address the need to define and distinguish PDs by operationalizing interpersonal dysfunction. It draws from a broad range of clinical literature that identifies self-definition and interpersonal relatedness as central to personality development and functioning. The Levels of Personality Functioning Scale (LPFS) was created to measure these aspects, dividing them into specific sub-domains: Identity and Self-Direction for Self-Functioning, and Empathy and Intimacy for Interpersonal Functioning. These sub-domains are intended to link PD diagnosis with clinical practice by providing descriptions of the types of dysfunction seen in PD patients.

Criterion A has its own limitations. The LPFS, while useful, does not provide a comprehensive or coherent system of interpersonal functioning. It lacks specificity and fails to articulate the processes underlying interpersonal dysfunction. As a result, existing measures of Criterion A often reflect general psychiatric distress rather than specific PD pathology, making it difficult to distinguish PDs from other mental health issues.

There are two ways to tackle this problem with criterion A. The first is to appeal to theoretical account of personality functioning and development, and then to demonstrate that aberrations in personality development actually distinguish the conditions we call "personality disorders" from rest of psychopathology. The primary candidate for such a framework is psychodynamic developmental theory, but its scientific status remains subject to considerable controversy in the field of psychology and so far, it has not been possible to empirically demonstrate a specific link between personality functioning and "personality disorders."

The other approach is clinical and pragmatic: to focus on what is most clinically salient about this group of conditions. Just as we characterize bipolar disorder as a disorder of mood and schizophrenia as a disorder of thought, we can characterize conditions we currently call "personality disorders" in terms of interpersonal dysfunction—problems in relating to oneself and others—instead of hypothetical ideas about personality processes.

"The rationale for highlighting the interpersonal nature of PDs diagnostically is clear clinically. For instance, from a clinical perspective, what is important is that people with a PD diagnosis are perceived as "difficult" (Gibson & Ferrini, 2012; Kernberg, 2007; Moukaddem et al., 2017; Nakamura & Koo, 2017; Riddle et al., 2016; Stone, 2007; Treloar, 2009). They tend to have complicated attachment histories (Crawford et al., 2006) and they have difficulties maintaining stable social support systems (Beeney et al., 2018). Perhaps most importantly, people with PD diagnoses will have a difficult time developing an alliance in psychotherapy, a fundamentally interpersonal process (Bender, 2005), and difficulties persisting with treatment (Busmann et al., 2019). Clinicians generally expect patients with an anxiety or depressive disorder to establish an alliance and engage in treatment. In contrast, clinicians expect their interactions with patients who have PD diagnoses to be challenging. Thus, common treatments for PDs have added features designed to provide structure and establish boundaries, deal with ruptures and impasses, support clinicians, and set expectations for extended treatments with elevated probabilities of dropout or reversals (Bateman et al., 2015; Caligor et al., 2018; Oud et al., 2018). This connection between diagnosis and best therapeutic practice is the clinical reason to reformulate the psychopathology of PDs with reference to their interpersonal essence more specifically." (Wright et al, 2022)

"we clinically understand that there is something different between these clinical cases and the classic "personality disorder" cases… that something appears to be a particular consequence of personality traits: maladaptive ways of relating. Clinically, the most striking feature of personality disorders has little to do with personality traits and much to do with the interpersonal consequences of those traits. These consequences include, but are not limited to, tendencies to view oneself and others in extreme and unstable ways (splitting), attachment and intimacy problems, and difficulties in forming therapeutic alliances or cooperating with others in any work-related capacity." (Zavlis & Fonagy, 2024)

The key feature distinguishing "personality disorders" from other mental disorders is not merely the presence of maladaptive traits but the interpersonal consequences of these traits. Personality disorders are marked by difficulties in relationships, such as attachment issues, instability in self-perception, and problems forming therapeutic alliances.

If personality disorders are defined solely by extreme personality traits (Criterion B), then every mental disorder could be considered a personality disorder. Conversely, if the diagnosis is based on the negative interpersonal consequences of these traits (the intent of Criterion A), then personality disorders could be more specifically characterized as "interpersonal disorders." This approach emphasizes the interpersonal difficulties often seen in PD patients. These interpersonal difficulties are central to the treatment of PDs and justify retaining the PD diagnosis to alert clinicians to these challenges.

Zavlis and Fonagy suggest that a map of personality traits and psychopathological domains would look something like this: high neuroticism linked to internalizing, emotional disorders; high disinhibition linked to externalizing, impulse regulation disorders; high psychoticism linked to thought disorders; and high antagonism and detachment linked to interpersonal disorders.

"… even when we categorise most psychopathologies in terms of personality, we still end up with the following (non-personality) categories: emotional disorders (high neuroticism), impulse disorders (high disinhibition), thought disorders (high psychoticism), and interpersonal disorders (high antagonism and detachment). Interestingly, the same themes emerge in factor-analytic studies of mental disorder domains, suggesting that the psychological themes of personality are inextricably linked to the psychological themes of psychopathology (Ringwald et al., 2023). These patterns suggest that

there is nothing privileged about the association between personality and the traditional personality disorders. Instead, all mental disorders are invariably associated with personality themes that match their underlying pathologies. In that sense, all mental disorders both are and are not personality disorders." (Zavlis & Fonagy, 2024)
All psychopathology both is and is not personality psychopathology.

A brief reference to psychoanalytic thinking can be useful here as well. In the Psychodynamic Diagnostic Manual-II (PDM-II), personality has a special place in the form of a separate "P Axis." P Axis includes (1) level of personality organization and (2) personality style or type. Personality organization ranges from healthy, through neurotic and borderline, to psychotic levels. Personality types or styles represent clinically familiar personality styles or types that cross-cut levels of personality organization (such as depressive, obsessive-compulsive, narcissistic, and borderline personalities). PDM-II is explicit that these personality styles are prototypes and fuzzy sets that can be approximated to varying degrees, and not distinct categories. The concept of personality style does not inherently connote either health or pathology, but rather core psychological themes and organizing principles. In the PDM-II, there is no hard and fast distinction between a personality type or style and a personality disorder: "The term "disorder" is a linguistic convenience for clinicians, denoting a degree of extremity or rigidity that causes significant dysfunction, suffering, or impairment. One can have, for example, a narcissistic personality style without having narcissistic personality disorder." (PDM-II, p 27)

In other words, according to the psychodynamic perspective, everyone has a particular personality organization and particular profile of personality characteristics, and this shapes the psychopathology they experience and exhibit. Personality is relevant to and colors all psychopathology.

References

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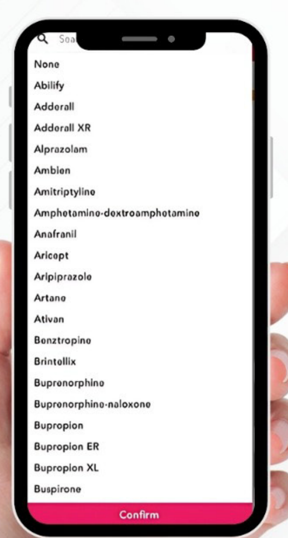

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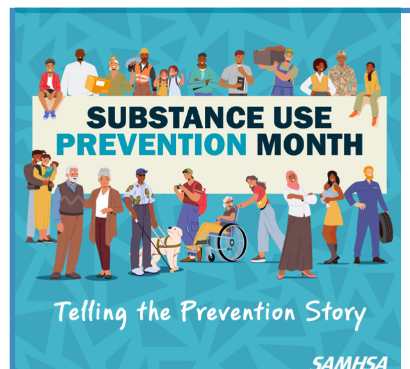

October is Prevention Month

October is Youth Substance Use Prevention Month and Substance Misuse Prevention Month. The Substance Abuse and Mental Health Services Administration (SAMHSA) shared a toolkit…Read More.

Call or text 988 or chat 988lifeline.org to reach the 988 Suicide & Crisis Lifeline.

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The trouble is deeper that we think because the trouble is in us

When I was 23, my dad died suddenly (heart attack, sleeping); my world split into Before and After.

Olivia Dahl, MD
PGY-4, Department of Psychiatry,
Case Western University/University
Hospitals Cleveland Medical Center

After:

Between my dad's legacy as a human rights attorney and my starting medical school, it felt natural to sublimate the pain of abrupt fatherlessness into advocacy. Determined to keep him alive in my actions, I built my burgeoning career into an homage to the dad I desperately missed. As a medical student, I founded a human rights initiative, established a medical-legal partnership to connect asylum-seekers with medical affidavits, and used my father tongue to care for immigrants. I spun medicine into a personal religion, an equitable system designed to save anyone who needed saving.

> "Your absence has gone through me
> like thread through a needle.
> Everything I do is stitched in its color."
>
> --*Separation*, by W.S. Merwin

Medicine-as-religion failed me as early as my first patient, R. A soft-spoken South African father, R was hospitalized for toxoplasmosis that tore through his AIDS-ravaged immune system and altered his mental status. After several weeks of treatment, he was stable and looking forward to leaving the hospital as soon as we coordinated outpatient access to antiretroviral treatment. One morning, however, he seemed off. I updated my senior resident with a new exam finding: R's sclerae were icteric. My senior shrugged and told me that "just happens sometimes" with Black people. Then R's temperature started to creep up and he started to seem confused. During rounds, I wondered about his new fever and the hypopigmented rash that had just cropped up on his abdomen. My attending dismissed the rash as eczema. When I reported hepatomegaly a few days later, our team ordered labs which resulted with liver enzymes so high they required extra testing to quantify. The icteric sclera, the confusion, and the rash—all of these signs pointed towards drug reaction with eosinophilia and systemic symptoms (DRESS), a systemic hypersensitivity reaction to sulfasalazine that was fighting his toxoplasmosis. Abruptly in need of an emergency liver transplant, R was transferred to a higher level of care. That was how I lost my first patient.

Losing R, I also lost faith in the secular religion that I'd fashioned to console myself after my dad's death. The utopic fantasy I had mistaken for medicine crumbled as I retraced why R's worsening clinical presentation went unnoticed for a week. I had tried, clumsily, to sound an alarm in the medicalese I didn't yet grasp, but the racist myth of differences in scleral pigmentation had hindered diagnosis of R's iatrogenic illness. Next, his rash went misdiagnosed because traditional medical education drills us to recognize dermatological conditions primarily on white bodies, and R's black skin did not demonstrate the cherry-red constellation that characterizes DRESS in white patients. As a Black man with only one family member within a two-hour drive of the hospital, R was one of the hospital's invisible patients. *My* religion would never invisibilize anyone, let alone an immigrant father like my own. The tragedy of R's decline forced me to face the discrepancy between the glitteringly optimistic Medicine I'd idealized (invented) and the endlessly disappointing medicine of real, garish hospitals, staffed by sleep-deprived, fallible clinicians.

Loss thickened the air around me—my dead dad, the deflated husk of the fantasy I'd mistaken for medicine, and my first patient. Even sublimation had lost its luster.

Before:

When I was disappointed or confused as a child, I went to my dad. He reassured me and showed me how reading and writing could iron confusion into understanding.

After (still, always):

Reading reminds me that the world is so much bigger than what I have lost.

With a parable, David Foster Wallace challenges us to question the “natural default setting” through which we perceive the world. Two young fish are swimming together, and an older fish passes by them and says “Morning, boys. How’s the water?” The young fish keep swimming for a bit, and then eventually one of them looks over at the other and goes, “what the hell is water?”

To be a fish swimming in water is a condition without moral consequence. To be a thinker, however, who neglects to question her psychological autopilot—that might threaten one’s status as a thinker. For me, it was only after years of therapy that I started to see the automated psychological machinery, the water, surrounding my loss.

My water was denial about my dad’s death and conviction that I could stay too busy for sadness to creep in, that I could indefinitely run from pain. My water was the tacit certainty that death could be packed into a tidy box and stuffed in the attic, stripped of experiential grief, and rebranded as motivation. My water was the unconscious delusion that a fantasy of utopic medicine could hold enough positivity and potential to counterbalance my fatherlessness, to protect me from sitting in sadness.

Examining the internal and external psychological conditions through which we and our patients move (or stagnate) is at the heart of psychiatry. If we are crawling through thick air, we should wonder how we might be contributing to or exacerbating our own misery. We should wonder how to fly. If our patients are swimming, we implore them to consider the water. We invite them to consider how the air might feel.

The obligation to closely examine automatic or unconscious assumptions extends far beyond my experiences or the bounds of psychiatry. James (Jimmy) Baldwin highlighted this collective obligation in 1962, cautioning that “the trouble is deeper than we think because the trouble is in us.” Dr. Eddie Glaude expands on Baldwin’s call for searing honesty, “Jimmy’s essays demanded a kind of honesty with yourself without sentimentality before you could pass judgement on the world as it is. Lies, he maintained, gave birth to more lies. He insisted that we see the connection between the disaster of our interior lives and the mess of a country that believed for some odd reason that if you were white, you mattered more than others. What we made of ourselves, in our most private moments, we made of the country. The two were inextricably related because the country reflected those intimate terrors that moved us about.”

I would add that what we make of ourselves in the automatic reflexes of our unconscious defenses, we also make of the country and the world. Forcing ourselves to sit in discomfort and examine the ugly truths of our internal programming—maybe that’s how we start to unravel the trouble in us. Maybe the “After” chapter of my life will be more bruising, but also more honest and transcendent.

SAVE THE DATE!

CPT Coding for Psychiatry

Presented by Diane Zucker

January 14, 2025 (in-person)

10 a.m. – 3 p.m.

Columbus, Ohio

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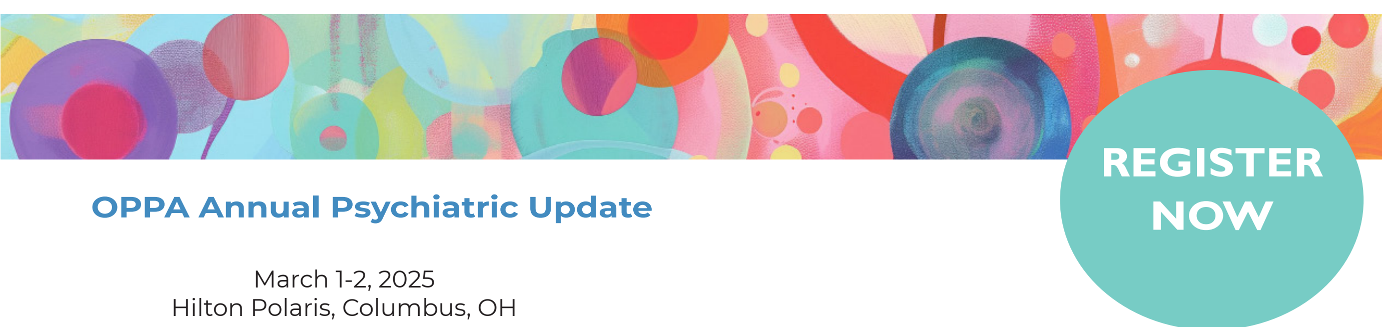


OPPA Annual Psychiatric Update

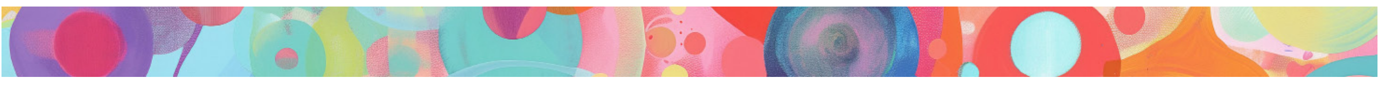
March 1-2, 2025
Hilton Polaris, Columbus, OH

Honoring the Past, Celebrating the Present, and Shaping the Future of Psychiatry

Join us for the 2025 Annual Psychiatric Update as the Ohio Psychiatric Physicians Association (OPPA) proudly celebrates its 75th anniversary! This milestone event will honor the rich history and remarkable evolution of the psychiatric profession, bringing together a vibrant community of clinicians, researchers, and learners from across the state. Held over the course of one and a half enriching days, the update will feature presentations by nationally renowned speakers, offering cutting-edge insights and the latest advancements in psychiatric care.

This year's gathering promises to be an exceptional educational opportunity, fostering collaboration and knowledge-sharing among professionals at all levels. Whether you are a seasoned psychiatrist, an emerging researcher, or a student passionate about mental health, the 2025 Annual Psychiatric Update will provide valuable learning experiences and networking opportunities to enhance your practice and understanding.

As a highlight of the event, we invite you to join us for a special 75th Anniversary Gala on Saturday evening. This elegant celebration will not only commemorate OPPA's significant contributions to the field but also provide a chance to connect and reflect with colleagues in a festive atmosphere. We look forward to seeing you at this momentous occasion, where we will honor the past, celebrate the present, and envision the future of psychiatry together. Don't miss this incredible opportunity to be part of a landmark event in the psychiatric community!



General Information

WHO SHOULD ATTEND

This program is designed specifically for Psychiatrists, Residents, Medical Students and other Physicians, including Primary Care and Pediatricians, as well as Psychologists, Nurses, Social Workers, Counselors and other Mental Health Care Professionals.

REGISTRATION

The preferred method of registration is online at www.ohiopsychiatry.org/annualpsychupdate. If you register by mail, please complete the registration form on page 17 and send with payment to: Ohio Psychiatric Physicians Association, PO Box 400, Dublin, OH 43017. Make check payable to OPPA. Your registration is not confirmed until payment is received. Non-member psychiatrists who join OPPA/APA by March 1, will receive $150 applied to OPPA dues (please select this option on the registration form and a representative from OPPA will contact you with further details.)

HOTEL ACCOMMODATIONS

A limited number of rooms have been set aside until February 7 at the rate of $182 single/double, plus applicable tax at the Hilton Polaris, 8700 Lyra Drive, Columbus, OH 43240. To reserve a room please contact the hotel ASAP at 1-888-864-8055 and ask for the OPPA's room block or go to https://www.hilton.com/en/attend-my-event/cmhpohf-913-14994e7a-fe0b-433b-bc5b-1a4d16c88d6a/

AMERICANS WITH DISABILITIES ACT

If you need assistance related to sight, sound, or mobility, please contact the OPPA office as soon as possible so that we may accommodate reasonable requests.

SYLLABUS

In an effort to go green, an electronic syllabus will be posted online and made available to every registered attendee prior to the event. We will not be handing out printed copies onsite. If you wish to pre-purchase a printed and bound syllabus the cost is $15. Please be sure to select this add-on when you register.

MEALS

A breakfast and lunch buffet will be provided on Sat., March 1 and a breakfast buffet will be provided on Sun., March 2.

CANCELLATION POLICY

If you are not able to attend, we encourage you to send someone in your place. Refund of the registration fee, minus a $50 administrative charge will be allowed if request for cancellation is received in writing by Feb. 10, 2025. After this date no refund will be made.

SPONSOR A MEDICAL STUDENT

In an effort to give medical students more opportunities to experience psychiatry, including being mentored by a practicing psychiatrist, and receive cutting-edge psychiatric education, the Ohio Psychiatric Physicians Foundation (OPPF) encourages meeting attendees to "sponsor" a medical student by paying the registration fee for a medical student to attend the OPPA Annual Psychiatric Update. This is just one of the ways the OPPF is working to encourage students to consider psychiatry as their specialty.

Your support can be accomplished in one of two ways:

1) If you have a specific student whom you wish to sponsor, simply complete the registration form, making sure to include the student's contact information; or

2) If you do not have a particular student in mind, we will pair you up with a medical student who has indicated an interest in attending if there is a sponsorship available – simply complete the registration form, leaving that information blank and you will be contacted by the OPPA office closer to the time of the actual meeting. If you are unable to attend the meeting, you may still sponsor a student by making a tax-deductible contribution to the OPPF for this purpose.

In order to make this a tax-deductible contribution, the registration and the sponsorship must be processed in two separate transactions. If paying by check, please mail two checks. Please make the sponsorship check payable to Ohio Psychiatric Physicians Foundation (OPPF) and your event registration check payable to OPPA.

MEDICAL STUDENTS

Students, enrolled in an Ohio medical school program, may apply for a sponsorship by completing the Medical Student Sponsorship Registration. Students will be notified by February 10, 2025 if there is a sponsorship available. Priority will be given to students who have not attended in the past. There will be time at a designated student breakfast to meet with other Ohio medical students and to learn from residents and others about psychiatry residency and career opportunities.

SATURDAY, MARCH 1

TIME	Please note: The opinions expressed by presenters are their own and do not necessarily reflect the views of OPPA.
7 – 8:30 a.m.	Registration/Visit Exhibits
7:15 – 8:15 a.m.	**Buffet Breakfast**
7:15 – 8:15 a.m.	Medical Student Meeting/Breakfast
7:30 – 8:15 a.m.	**OPPA Annual Business Meeting and Installation of Officers**
7 – 5 p.m.	Poster Displays
8:25 a.m.	Welcome and Opening Remarks - Awais Aftab, MD and Karen Jacobs, DO, 2025 Program Co-Chairs
8:30 – 9:45 a.m.	***Paradigm Shifts and Seizmic Changes in Psychiatry Since the OPPA was Founded 75 Years Ago*** **Henry Nasrallah, MD, DLFAPA |** Professor of Psychiatry, Neurology and Neuroscience, University of Cincinnati College of Medicine No medical specialty has undergone as dramatic a transformation as psychiatry since the OPPA was founded in 1950. Here is an overview of major changes: •From Freudian theoretical dominance to empirical neurobiology •From non-existent diagnostic system to DSM schemas •From lifetime institutionalization and lack of treatment to myriad pharmacological and neuromodulation therapies. •From total ignorance about brain changes in psychiatric disorders to advanced structural and functional neuroimaging techniques •From guesswork about heritability of mental illness to molecular neurogenetics, GWAS, risk genes, CNVs, mutations and epigenetics •From behavioral changes in psychotic and mood disorders to cortical and synaptic neuroplasticity •From psychodynamic jargon to neuroscience terminology •From 1 board certification to 6 •From theory-based psychodynamic psychotherapy to evidence-based cognitive behavioral therapy •From intense stigma of mental illness to increased understanding and less stigma •From physician prescribing to nurses and psychologists prescribing •From clinical "hunches" to biomarkers and precision psychiatry The evolution of psychiatry as a medical and scientific discipline will continue unabated. Psychiatrists will morph into behavioral neuroscientists at the OPPA's 100th anniversary!
9:45 – 10:15 a.m.	**Break and Visit Exhibits**
10:15 – 11:15 a.m.	***Top 10 Research Updates From the Past Year*** **Christopher Aiken, MD, DFAPA |** Editor in Chief, The Carlat Psychiatry Report and Assistant Professor, NYU School of Medicine Dr. Aiken will cover clinical trials that are changing how we practice, including updates on lithium, benzodiazepines, alcohol use disorder, stimulants, and treatment resistant depression.
11:15 a.m. – 12:15 p.m.	***What's new with the old? An update on emerging research in Older-age Bipolar Disorder (OABD)*** **Martha Sajatovic, MD, DLFAPA |** Professor of Psychiatry of Neurology, Willard Brown Chair in Neurological Outcomes Research, Rocco L. Motto Professorship in Child & Adolescent Psychiatry, Director, Neurological and Behavioral Outcomes Center, University Hospitals Cleveland Medical Center, Case Western Reserve University School of Medicine Older Age Bipolar Disorder (OABD) refers to patients with bipolar disorder (BD) aged 50 and over. Given rapid and unprecedented changes in global demographics, there has been increasing attention paid to expanding the limited evidence base on epidemiology, assessment recommendations and understanding therapeutic options for this highly vulnerable group of patients. OABD represents a complex subgroup of BD, with a distinct clinical phenotype including poor physical health and impaired cognitive functioning, all limiting and complicating treatment and recovery. Within the OABD "umbrella" are individuals who have onset of illness in young adulthood (the most common age of onset) as well as those who have illness onset later in life. Research on OABD has been scarce, prohibiting evidence-based guidelines tailored specifically to OABD across the globe. Newer research, including recent findings from the Global Aging & Geriatric Experiments in Bipolar Disorder (GAGE-BD) project will be presented in order to provide a better understanding of BD across the life-span.

SATURDAY, MARCH 1

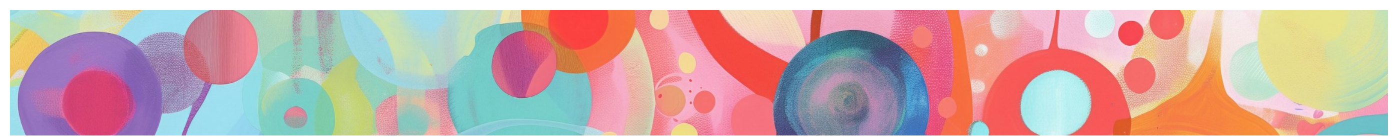
TIME	
12:15 – 1:15 p.m.	**Buffet Lunch**
1:15 – 2:30 p.m.	***Jeopardy*** Similar to APA's national residency team competition known as MindGames, OPPA will host its own version of this fun experience for residents and other participants to test their knowledge on patient care, medical knowledge, and psychiatric history while earning bragging rights and raffle tickets for the winning team!
2:30 – 2:45 p.m.	**Break and Visit Exhibits**
2:45 – 4 p.m.	***School Shooters: Troubled Teens or Cold Blooded Killers?*** **Phillip Resnick, MD, DLFAPA |** Professor of Psychiatry at Case Western Reserve University School shootings have increased sharply in the last few years. The goal of this presentation is to help psychiatrists recognize potential school shooters in their own practice and to improve their skills in assessing students who have made threats to attack schools. Participants will learn to identify red flags for high risk. Prevention by schools of these tragedies will also be discussed.
4 – 4:15 p.m.	**Break and Visit Exhibits**
4:15 – 5:15 p.m.	***Bringing Improvisation to Life: Experiences to Build Resilience, Address Loneliness, and Enhance our Curiosity and Everyday Experience*** **Jeff Katzman, MD |** Director of Education, Silver Hill Hospital; Director, Silver Hill Academy of Research and Education (SHARE); Professor Adjunct, Yale Department of Psychiatry; Professor Emeritus, University of New Mexico, Department of Psychiatry We live amidst an epidemic of loneliness and many in our world feel disconnected. Loneliness correlates with multiple medical and psychiatric presentations and is often a clinical challenge. Simultaneously, many clinicians themselves feel burned out and overwhelmed, and the call for resilience can further deepens this feeling. This presentation will underscore the potential role that the guidelines from improvisational theatre can have to impact our lives, our teams, and our patients, and will feature both didactic and experiential components.

SATURDAY, MARCH 1 - Evening

TIME	FUNCTION
	OPPA 75th Anniversary Gala & Silent Auction (See page14for more details. Schedule and activities subject to change slightly) • Cocktail Hour • Silent Auction • OPPF Annual Meeting & Awards • Special Guest Speakers • Dinner • Entertainment/Dancing

AUCTION

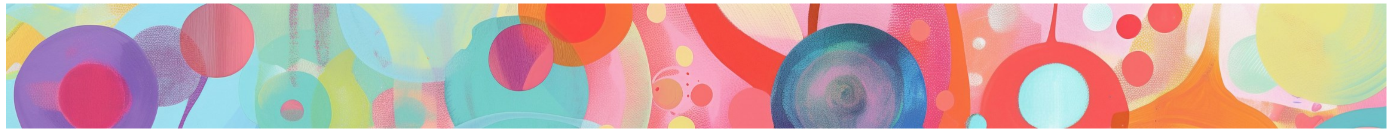
75TH ANNIVERSARY
Ohio Psychiatric Physicians Association
1950-2025



SUNDAY, MARCH 2

TIME	FUNCTION
8 – 8:55 a.m.	**Visit Exhibits/Buffet Breakfast**
9 – 10 a.m.	***Changing Views of Psychiatric Diagnosis and Classification*** **Awais Aftab, MD |** Case Western Reserve University, Cleveland and Southwest General, Middleburg Heights Psychiatric classifications work within certain assumptions about the nature of mental illness that are taken for granted. This presentation will provide an overview of the historical development of Kraepelinian and neo-Kraepelinian psychiatric classifications and will examine how questions of classification, especially the tension between description and hypothetical-conjectural methods, have intersected with questions about the nature of psychiatric disorders in modern history. Ongoing controversies, including the rise of dimensional approaches, currently exemplified by HiTOP and by ICD-11's adoption of a dimensional model of personality disorders, will also be examined, and the talk will conclude with preliminary remarks on future directions.
10 – 10:30 a.m.	**Break and Visit Exhibits**
10:30 – 11:30 a.m.	***Removing the Mask: 2.0 - How a Surgeon's Mental Health Story Can be a Catalyst for Improving Mental Health Care*** **Carrie Cunningham, MD, MPH |** Associate Professor of Surgery at Harvard Medical School, Section Head of Massachusetts General Hospital Endocrine Surgery Unit, Boston, Massachusetts In this session, Dr. Cunningham will discuss the current mental health crisis among health care professionals. Through her owned lived experience, she will discuss the current state, barriers to care, and a multifaceted approach to enacting change in mental health awareness, reducing stigma and increasing resources for those who are struggling in our community.
11:30 a.m. – 12:45 p.m.	***Psychodynamic Psychopharmacology: Person-Centered Approaches to Pharmacologic Treatment Resistance*** **David Mintz, MD |** Director of Psychiatric Education, Associate Director of Training, and Team Leader, Austen Riggs Center, Stockbridge, MA Though psychiatry has benefited from an increasingly evidence-based perspective and a proliferation of safer and more tolerable treatments, outcomes are not substantially better than they were a quarter of a century ago. Treatment resistance remains a serious problem across psychiatric diagnoses. One likely reason is that that the systems within which psychiatrists are working often create pressures to adopt a reductionist framework, neglecting the fundamental role of psychosocial factors in shaping pharmacotherapy outcomes. Psychodynamic Psychopharmacology is a psychodynamically-informed, patient-centered approach to psychiatric patients that explicitly acknowledges and addresses the central role of meaning and interpersonal factors in pharmacologic treatment. While traditional objective-descriptive psychopharmacology provides guidance about what to prescribe, the techniques of Psychodynamic Psychopharmacology inform prescribers about how to prescribe to maximize outcomes, not only in terms of addressing symptoms, but also in ways that support the patient's development, increase in the patient's personal authority, and foster general wellbeing. This presentation will touch on the evidence base connecting meaning, medications, and outcomes, and will review psychodynamic concepts relevant to the practice of psychopharmacology. We will explore how psychodynamic issues may interfere with optimal outcomes, particularly in patients with a history of early adverse experiences. Then we will consider techniques for identifying and addressing treatment-interfering dynamics.

Please note: The opinions expressed by presenters are their own and do not necessarily reflect the views of the Ohio Psychiatric Physicians Association (OPPA).



Speakers

Awais Aftab, MD

Case Western Reserve University, Cleveland; Southwest General, Middleburg Heights

Click HERE for Biography

David Mintz, MD

Director of Psychiatric Education, Associate Director of Training, and Team Leader, Austen Riggs Center, Stockbridge, MA

Click HERE for Biography

Christopher Aiken, MD, DFAPA

Editor in Chief, The Carlat Psychiatry Report and Assistant Professor, NYU School of Medicine

Click HERE for Biography

Henry Nasrallah, MD, DLFAPA

Professor of Psychiatry, Neurology and Neuroscience, University of Cincinnati College of Medicine

Click HERE for Biography

Carrie Cunningham, MD, MPH

Associate Professor of Surgery at Harvard Medical School, Section Head of Massachusetts General Hospital Endocrine Surgery Unit, Boston, Massachusetts

Click HERE for Biography

Phillip Resnick, MD, DLFAPA

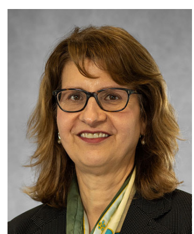
Professor of Psychiatry at Case Western Reserve University

Click HERE for Biography

Jeff Katzman, MD

Director of Education, Silver Hill Hospital, Director, Silver Hill Academy of Research and Education (SHARE), Professor Adjunct, Yale Dept. of Psychiatry, Professor Emeritus, Univ. of New Mexico, Department of Psychiatry

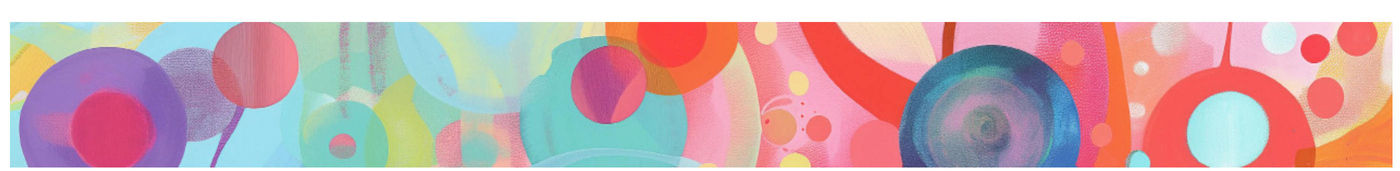
Click HERE for Biography



Martha Sajatovic, MD, DLFAPA

Professor of Psychiatry of Neurology, Willard Brown Chair in Neurological Outcomes Research, Rocco L. Motto Professorship in Child & Adolescent Psychiatry, Director, Neurological & Behavioral Outcomes Center, Univ. Hospitals Cleveland Med. Ctr., Case Western Reserve Univ. School of Medicine

Click HERE for Biography



Join us for a fun and entertaining evening of networking with colleagues, both seasoned and new!

Celebrate OPPA's 75th Anniversary in style, enjoy a delicious dinner, dance, and take home some amazing silent auction items. It's the perfect opportunity to connect, celebrate, and make lasting memories. Don't miss out on this special milestone event!

Saturday, March 1, 2025 - Hilton Polaris, Columbus

Purchase a Table

- Listed among table sponsors in program
- Purchase a table for 10 and sit with friends for this fun-filled evening!

$950

Give $75 for 75

- Listed among contributors in program brochure

Whether you're an individual member, prospective member, clinician, family member, business colleague, and anyone who knows someone with a mental illness, including substance use disorder, we appreciate all you do to support and improve the lives of so many!

$75

Bring a Friend

- Bring a friend incentive! Exciting news! When you invite a friend to the Gala, both of you will receive a raffle ticket for use during the Gala! It's a fantastic way to enjoy the event together and increase your chances of winning some incredible prizes!

**Tickets to the 75th Anniversary Gala are sold separate.

Silent Auction

Join us in celebrating OPPA's 75th Anniversary with a Silent Auction and Raffle on Saturday, March 1, to benefit OPPA's Foundation. The Silent Auction will take place in the evening, during OPPA's anniversary gala, offering a variety of exclusive items and experiences for attendees to bid on. Throughout the day, we will also be selling tickets for numerous raffle baskets, giving everyone the chance to win exciting prizes while supporting a great cause.

Attendees are welcome to donate an item for the Silent Auction! Your donation may be tax-deductible, and your generosity will help raise funds for the Ohio Psychiatric Physicians Foundation. Our mission is to advance the field of psychiatry and improve mental health care for all Ohioans. We appreciate all donations with a minimum value of $50. To donate an item or cash, please click HERE to complete the donation form.

Thank you for your support and contribution to this important cause!

Keep checking the OPPA website to see silent auction items as they are donated!

OPPF Silent Auction

Saturday, March 1, 2025

We are excited to announce that the Ohio Psychiatric Physicians Foundation (OPPF) will be holding a silent auction fundraising event on Saturday, March 1, 2025, at the Hilton Polaris in Columbus, Ohio

We need your help!

To help make the Silent Auction a success, we need your donation! Donating items for the auction is a great way to support the OPPF and participation in the auction is a lot of fun! Items from members as well as companies with which you might do business are both welcome. The value of **your donated gift is tax deductible** as allowed by law, and your particular tax situation. You will receive a thank you letter from the Foundation stating the estimated value of the donation (as indicated by you) and that no goods or services were exchanged for the donation. Your generous donation will benefit the Foundation, and those that suffer from mental illnesses through the programs that OPPF offers.

Recognition
For your donation, you will receive:
- Acknowledgement on the Auction Bid Sheet
- Listing of your donation and name on the OPPF webpage and in the event program (you may choose to remain anonymous if you so desire)

To donate, simply complete the form below or online and send your donation to: OPPF, 6457 Reflections Drive, Ste. 130, Dublin, OH 43017, ***no later than February 1, 2025***. The sooner we begin to receive donations, the sooner we can help to build interest by mentioning them on the website. Although we prefer that donations be received in our office no later than February 1, if your donation is large or not easily/safely able to be transported, and you wish to bring your donation with you on the day of the event, please contact the OPPF staff so arrangements can be made. **Questions? Please contact OPPF Staff Member, Michelle Mazza at (614) 763-0040.**

Please provide information as you would like it to appear on the bid sheet and the OPPF webpage:

Name of item: ______________________________
Estimated value of item ($US) ______________________________
Minimum bid you would recommend ($US) ______________________________
Donor Name (your name or company) ______________________________
Description of Item ______________________________
____

Contact Information (not for publication)
Name ______________________________
Address ______________________________
City/State/Zip ______________________________
Phone: ____________________ E-mail: ____________________

Thank You for Your Generosity!!

If you are not sure of what to donate, following are some suggested items which have been contributed to our silent auction in the past: artwork (created, purchased or donated), books (those signed by an author might be very popular), wine, sports memorabilia, gift certificates to a restaurant, for services (such as a trip to the spa) or supplies (office supplies, art supplies, etc.), weekend get-a-way to a bed and breakfast, week-long vacation get-away if someone has a vacation home, etc. Any donated items will be much appreciated and will benefit the Foundation in achieving its mission!

Registration

Register online:
www.oppa.org

(614) 763-0040

Ohio Psychiatric Physicians Association
PO Box 400
Dublin, OH 43017

(614) 481-7559

1 Contact Information

Please print

Name ____

Degree ___ MD ___ DO ___ PhD ___ APN ___ LISW ___ LPCC

___ Other (please specify) ____________

E-mail ____

Address ____

____

City/State/Zip ____

Phone ______________________ Fax ______________

2 Registration Information

MEMBERS

Registration Type	Early Bird Rate By Dec. 1	Regular Rate	Late Rate After Feb. 15
Annual Psychiatric Update (March 1-2, 2025)			
OPPA Member	❐ $225	❐ $275	❐ $325
OPPA Resident-Fellow Member	❐ $150	❐ $175	❐ $200
75th Anniversary Gala (per person)**	❐ $100	❐ $100	❐ $100
Please select your entrée:	❐ Grilled Salmon ❐ Roasted Chicken with Lemon Piccata Sauce Special Dietary Request: ❐ Vegan ❐ Vegetarian ❐ Gluten Free		

Registration Total $ ____________

NON-MEMBERS

Registration Type	Early Bird Rate By Dec. 1	Regular Rate	Late Rate After Feb. 15
Annual Psychiatric Update (March 1-2, 2025)			
Non-Member Psychiatrist, other Physician, APRN, Physician Assistant or Psychologist	❐ $375	❐ $400	❐ $450
Non-Member Resident-Fellow	❐ $225	❐ $250	❐ $275
Counselor, Social Worker or Other Clinician	❐ $250	❐ $300	❐ $350
75th Anniversary Gala (per person)**	❐ $100	❐ $100	❐ $100
	❐ Grilled Salmon ❐ Roasted Chicken with Lemon Piccata Sauce Special Dietary Request: ❐ Vegan ❐ Vegetarian ❐ Gluten Free		

Registration Total $ ____________

3 Payment Information

Registration Total $ ____________
(from the left)

Additional Options

75th Anniversary Gala Sponsorship

❐ As a friend of OPPA, I would like to donate $75 in support of it's 75th Anniversary. $75

❐ I would like to support the OPPA 75th Anniversary by sponsoring a table (includes dinner tickets for 10* people). $950

**OPPA Staff will contact you for names and meal selections of the individuals sitting at your table.*

❐ Bring a Friend Incentive (see page 14 for details).

Name(s) ______________________________

____

Medical Student Sponsorship $125

❐ I would like to sponsor AND mentor an Ohio Medical Student to attend the OPPA Annual Psychiatric Update, March 1-2, 2025

❐ I am unable to serve as a mentor during the meeting but would like to sponsor an Ohio Medical Student to attend the OPPA Annual Psychiatric Update, March 1-2, 2025 $125

❐ I am unable to sponsor a student at this time but would like to serve as a mentor at the OPPA Annual Psychiatric Update, March 1-2, 2025

**To make this a tax deductible contribution see details below*

Student Name ______________________________

Email ______________________________

If you do not have the name of a specific medical student, we will be happy to match you with a student who has expressed interest in attending if a sponsorship is available.

❐ I am a non-member psychiatrist and want to receive $150 off my OPPA dues when I join the OPPA/APA by March 1, 2025.

Grand Total $ ____________

Method of Payment:
❐ Check payable to OPPA (registration fees)
❐ Check payable to OPPF (student sponsorship)

If you wish to pay by credit card please register online

**Tickets to the 75th Anniversary Gala are sold separate. Click HERE for more details about the event or go to www.ohiopsychiatry.org/annualpsychupdate.

*In order to make this a tax-deductible contribution, the registration and the sponsorship must be processed in two separate transactions. If paying by check, please mail two checks. Please make the sponsorship check payable to Ohio Psychiatric Physicians Foundation (OPPF) and your event registration check payable to OPPA. If you are paying by credit card, you will see two transactions on your statement.

UNLOCK THE POWER OF SPRAVATO FOR TRD PATIENTS

ALIGNING WITH YOUR CARE PLAN!

Who is a good candidate:

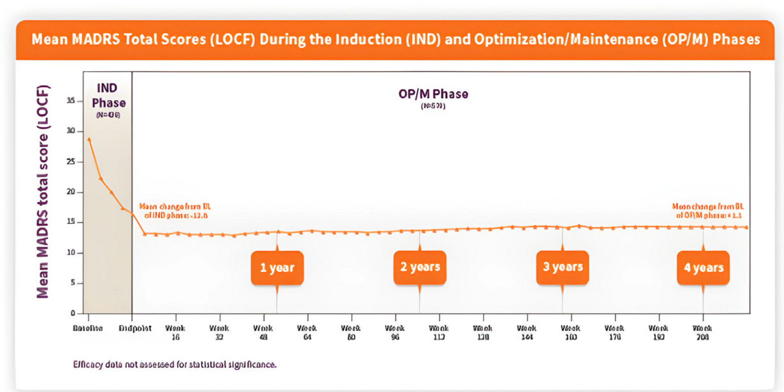
- Patient has been diagnosed with MDD
- Patient is 18 or older
- No comorbid psychotic diagnoses (schizophrenia, schizoaffective disorder, and some cases of bipolar disorder)
- At least 2 failed medication trials (Medications include any SSRI or SNRI)
- Must be on an oral antidepressant for the duration of SPRAVATO treatments

We Have Made the Referral Process Simple!

To refer a patient, simply scan the QR code above or visit optimumtms.com and navigate to "Providers - Refer a Patient."

Proven Efficacy

In an ongoing, long-term, open-label safety study, MADRS scores were consistent through interim analysis at **4 years**[1,2]



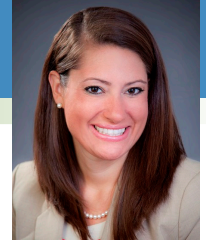
4-year safety trial was composed of 2 phases: a 4-week IND phase and a variable OP/M phase.[1,2]

- Of the 1006 patients studied in this cohort, 68.9% were treated with SPRAVATO® for at least 30 months

BL=baseline.
LOCF=last observation carried forward.
MADRS=Montgomery-Åsberg Depression Rating Scale.

500 E. Main St., Suite #110| Columbus, OH 43215 | (p) 614.933.4200 | (f) 614.407.7622
optimumwellnesssuites.com

Legislative Update


Monica Hueckel
OPPA Lobbyist

Legislators are on summer recess, but advocacy work continues as we gear up for the fall when our elected officials return to the Statehouse after the November elections. OPPA continues to work on its priority issues in the lead up to the upcoming lame duck legislative session. As a reminder, any item that does not pass through both chambers successfully by the end of the year must restart the legislative process next year with the beginning of the new 136th General Assembly.

Update on Priority Issues:

1. **Certified Mental Health Assistants (CMHAs):** As a reminder, OPPA successfully brokered a deal this summer on Senate Bill 60, legislation which seeks to create a new allied practitioner called the certified mental health assistant. As you likely recall, our initial position on this legislation has been Active Opposition, as we have numerous significant concerns about factors such as education, training, lack of specificity, and protection for patients and physicians. Since this bill was introduced, OPPA has worked tirelessly and our advocacy efforts helped keep the bill from passing out of committee as written three separate times, and the bill language being removed from the budget bill last year. Additionally, while it was communicated to us that continuing to stop the bill in its entirety was not possible, we were asked to identify our top ten major concerns and potential solutions for these concerns. These efforts have recently resulted in a series of changes being made to those concerns. All ten issues we identified were addressed in the newest version of the bill, which is a huge win for our state's psychiatrists and our patient populations.

   The OPPA, in partnership with OSMA, was successful in making the following changes:

   - Added language requiring all CMHA educational programs follow ARC-PA accreditation standards.
   - Added language established a committee within the medical board, made up of physicians who are appointed through recommendation from OSMA and OPPA, who will review all CMHA program curriculums before curriculums are sent to Ohio Department of Higher Ed for accreditation.
   - Added language ensuring all CMHA programs are master's level programs with a minimum of 30 credit hours.
   - Added language ensuring all CMHA must have a 4-year undergraduate degree before applying for a CMHA program.
   - Reinstated specifics around 9 additional areas of course work to supplement mental health education.
   - Clarified that the scope of practice would be limited to that of the supervising physician and ensuring the serviced rendered by the CMHA are within the supervising physician's regular area of practice and expertise.
   - Removed language that would have given broad authority to the medical board to establish scope of practice expansions.
   - Clarified provision is not necessary to ensure liability coverage of CMHA, the Ohio Department of Insurance confirmed a CMHA will be covered.
   - Provision added that required reimbursement through Ohio's Medicaid Program.
   - Added an additional 500 hours under which a CMHA must be under direct supervision.
   - Removed language that would have allowed a CMHA to pink slip a patient.
   - Removed language that would have allowed a CMHA to refer a patient to a physical therapist or athletic trainer.

- Added language that requires the State Medical board to promulgate rules around additional quality assurance standards a CMHA will have to follow.

In exchange for these amendments being made, OPPA has agreed to take a new position of Interested Party on the bill moving forward. While we still would have preferred the bill not to move forward at all, it became clear to us that this outcome was simply not going to happen. We are grateful that our amendments were accepted, and the bill did not pass out of committee without this new language. We will continue to educate lawmakers about this proposal in the coming months. SB 60 has passed out of the Senate Workforce and Higher Education Committee, and also out of the full Senate. The Senate vote was 20-11, which is indicative of our great work in educating elected officials about our concerns with this legislation thus far.

The bill will now move into the House. It must successfully move through the House committee hearing and voting process and be voted out of the full House before it can become law, and if it does, there will be an extensive regulatory process to follow before any CMHA program can officially be up and running. OPPA will continue to follow this proposal very closely regardless of how far it progresses before the end of this year's lame duck session. It is unclear whether it will be able to advance through the rest of the process in the remainder of 2024.

2. **Prior Authorization "Gold Card":** Earlier this year, a substitute version of the prior authorization gold card legislation, HB 130, was recently introduced and accepted, and now, our coalition of dozens of medical and patient advocacy groups in support of HB 130 (including OPPA) are working to continue to support movement of the legislation through the legislative process. There was additional progress on this bill this spring as it had another hearing in the House Insurance Committee. As expected, HB 130 has encountered a lot of pushback from the insurance industry, and we are pleased that while we made some compromises in the substitute bill in order to help improve the chances of this legislation advancing, it remains a strong prior authorization reform effort which retains the core goals that inspired its original introduction.

   As a reminder, the general aim behind the prior authorization "gold card" legislation is to further streamline the prior authorization process and remove some of the administrative "roadblocks" of prior authorization so that physicians and medical staff can focus more on patient care.

3. **Non-Medical Switching:** This OPPA-supported legislation was also amended this year. The original version of HB 291 sought to ban non-medical switching entirely and received strong opposition from the insurance industry which was, in part, preventing the bill from moving forward. The new version of HB 291 allows for potential changes by the insurer if the cost of a medication increases by 5% or higher in calendar year. Hopefully, this compromise will help this issue make progress, and OPPA is encouraged that substitute HB 291 would still prevent non-medical switching in the majority of circumstances faced by our patients.

4. **Psychiatric Deterioration/Involuntary Treatment for Mental Illness:** OPPA has continued its work in support of House Bill 249, concerning involuntary emergency admission/treatment for mental illness. This legislation had several additional hearings in the House Behavioral Health Committee in May. As you may recall, this bill's main purpose is that it would allow an individual, with a known previous history of dangerousness to self or others, to be evaluated sooner than currently allowed.

5. **Hospital Violence:** OPPA recently joined a coalition which is supporting HB 452, a proposal concerning hospital violence prevention. Our coalition, made up of numerous hospital and health care organizations, submitted a proponent letter supporting this legislation last month. The bill passed out of both the House Public Health Policy Committee and the full House right before the legislators left for their summer recess. We will continue to provide support for this bill during its journey in the Senate.

6. **Anti-Vaccination:** OPPA also joined a coalition advocating against a proposal that would prohibit discrimination against an individual for the refusal of certain medical interventions for reasons of conscience, including religious convictions. Our large coalition, made up of many healthcare and business organizations, has mobilized to emphasize our serious concerns with discouraging public vaccination uptake and with prohibiting certain safety policies in health care facilities.

   While HB 319 is mainly targeted at vaccinations, it would also, for example, prevent health facilities from implementing policies such as those that require readily accepted vaccines in the clinical environment (like tuberculosis) or require unvaccinated employees to wear a mask during flu season in certain areas of a hospital. The bill specifically

includes vaccine requirements for college admission and employment, and has at this point has several hearings. We will continue to watch this legislation carefully for movement when legislators return.

7. **Co-pay Accumulator:** OPPA has been working to support HB 177, which has passed out of the House Public Health Policy Committee. This legislation would require insurers and PBMs to count all payments made by patients directly or on their behalf toward their deductibles and out-of-pocket cost. OPPA will advocate for further movement on this issue in the coming months.

8. **Psychologists – Prescribing Authority:** OPPA continues to monitor the legislature carefully, but there has still been no activity on the issue of prescribing authority for psychologists during this general assembly as of now, and it is unlikely to surface at this point in time.

Please stay tuned for more updates on these and other issues after the summer recess.

Empowering minds; Shaping futures; and
Fostering a culture where every voice is valued.

ADVOCACY BOOTCAMP

for Psychiatrists, Residents, Fellows, and medical students

Monday
Nov. 11, 2024
7-8 p.m. EST
Virtual via Zoom

Have you been wanting to become more involved in advocating for your patients and your profession, and just don't know how to get involved? Then, this member forum is for you!

During this one-hour virtual event, we will cover:

- The specifics of how policy is made in Ohio.
- A variety of ways you can participate in the process.
- How advocacy can be as simple as: helping review language in a medical board rule on telehealth; or meeting with your State Representative and/or Senator, to testifying in person on a key legislative proposal.
- Your questions about how to become an advocate.

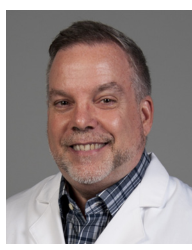
"OPPA's Member Forum Series" is dedicated to empowering individuals through dynamic educational and leadership opportunities. This new series focuses on enhancing leadership skills, encouraging continuous learning, and fostering an inclusive culture where every voice is valued. Participants will have the chance to engage with thought leaders, share experiences, and gain insights that can be applied to both personal and professional development. Together, these initiatives support a vibrant psychiatric community committed to growth and excellence.

Residency program spotlight

Summa Health/NEOMED
Akron, OH

Residency Program Spotlight is an initiative by the OPPA Resident-Fellow Members Committee which will feature a different Ohio psychiatry residency program each quarter, and will include an introduction by the program director and testimonial from a resident in the program.

Pooja Khaira, MD
Chair, Resident-Fellow Member Committee



Program director: David W. Deckert, MD
Number of residents: 19. Approved for 20 beginning in July 2025
Residents recruited from Ohio medical schools: 18

A message from the Program Director: Welcome to the Summa Health/NEOMED Psychiatry Residency Training Program! We enjoy working together in a community hospital system in Akron Ohio that truly values residency education and enthusiastically supports excellent mental health care, so much so that we have a newly built home on the Akron City Campus in our state-of-the-art Juve Behavioral Health Pavilion! We are proud to offer residents this superior environment of care for our inpatient care units, outpatient offices, Intensive Outpatient and Partial Hospitalization Programs, ECT, TMS, Ketamine and Sublocade Programs, A Center for the Treatment and Study of Traumatic Stress, and multispecialty Integrated Care. We hold close to our hearts a prioritization of a balanced training in psychotherapeutic arts as well as a strong emphasis upon psychopharmacological treatments. Our residents, themselves a diverse group now and historically, gain exposure to a diverse patient population in terms of demographics and diagnoses. Uniformly, our residents are favorably impressed with the quality of their education, the special mentoring and teaching of our devoted faculty, and their clarity and confidence that they have been thoroughly prepared for careers in all areas of psychiatric practice.

Resident Spotlight

Name: Dominique Cox, MD

What do you love about the Summa Psychiatry Residency Program?: As a PGY2 resident, I feel I've had the perfect amount of autonomy to foster growth as a psychiatrist-in-training without feeling overwhelmed or unsupported. I especially love the contrast between the practicing styles of each of our attending psychiatrists. They all utilize evidence-based psychiatry in their own unique way, allowing us to develop quite a diversified skill set. We have attendings who are psychotherapy focused, teaching us the intrinsic value of our words and body language to a patient's healing. We have some who are interventionally focused, giving us exposure to ECT, TMS and Esketamine. We even get training on how to safely manage MAOi's, an old class of psychotropics that's making a comeback. Our program truly has one-of-a-kind training and our eclectic graduates are to show for it! I'm looking forward to PGY3 and PGY4 year where I can further explore more niche areas of psychiatry, such as forensics, community psychiatry and integrative medicine.

The 1916 murder trial of Arthur Waite, DDS, and the perplexing concept of constitutional inferiority

Emil R. Pinta, MD, DLFAPA
Professor Emeritus,Ohio State University
Co-author,*The Ohio Psychiatric Association and Medical Education in Ohio*

Psychiatry is no stranger to perplexing diagnostic concepts. In the nineteenth century, the term "moral insanity" is a noteworthy example. Although generally equated in modern terminology with antisocial personality disorder, in the mid-1800s, it also included what today would be called impulse-control disorder, brief psychotic disorder, and other personality disorders (Ray; Workman).

The 1916 murder trial of dentist Arthur Waite, who was accused of poisoning his in-laws by various means—including introducing bacteria into their mouths during dental procedures—received national news coverage. It led to another term described in newspapers of the day: constitutional inferiority (CI). Aligned in many ways with moral insanity, this diagnosis did little to aid diagnostic clarity.

Background and murder plans of Dr. Waite—the "playboy poisoner"

Arthur Warren Waite was born on Dec. 2, 1889, and raised in Grand Rapids, Michign. While in high school, he became acquainted with Clara Peck, the daughter of a pharmaceutical millionaire. He received a dental degree from the University of Michigan, but later stated that he passed exams by stealing test papers.

Waite matriculated to the University of Glasgow, where he forged a post-graduate certificate and became a dentist for a large mining company in South Africa. He was discharged after being accused of stealing money from the company. He returned to Grand Rapids and began a courtship with Clara Peck; they were married on September 9, 1915. Her parents provided an apartment for the couple in New York City (NYC).

Waite Tennis Champ

A good athlete, Waite joined a tennis club and won a Manhattan tennis championship. Tall, good-looking, charming and a sharp dresser, he was deemed the "playboy poisoner" in the news. Shortly after his marriage, he began an affair with an aspiring opera singer, after he told her he had connections with opera companies abroad. Many of his friends thought he was a successful surgeon because he frequently asked to be taken to hospitals, saying that he had an urgent operation to perform.

He obtained access to bacteriology laboratories at Columbia University and other labs for sham research projects, where he isolated cultures of typhus, diphtheria and tuberculosis. During a visit by his mother-in-law just several months after his marriage, he spread bacteria on her food, gave her a nasal spray filled with bacteria, and injected bacteria into her mouth during a dental procedure. She died on January 30, 1916, of a "sudden illness," diagnosed as kidney failure. Her body was cremated, after Waite convinced family members she had expressed a desire for cremation.

Waite invited his grieving father-in-law to stay with them in March, with the intent of killing him in a similar fashion. However, various bacteria applications were unsuccessful. Waite then poisoned him with arsenic and suffocated him after rendering him unconscious with chloroform. His father-in-law died on March 12, 1916, just six weeks after his wife. Waite's wife, Clara, was devastated! But, before his father-in-law could be cremated, a suspicious, distant relative sent a telegram to the family urging to have his body checked for poison, and arsenic was discovered.

Waite eventually confessed to both murders, saying that an "Egyptian deity" had taken control of his body. He later recanted this story, thinking that a jury in an insanity defense would not believe that someone with a sane mind could commit the acts he had done. Waite's wife filed for divorce and began using her unmarried name (NYT).

Summary of trial and principal expert witnesses

Waite entered a plea of not-guilty-by-reason-of-insanity (NGRI) for the death of John E. Peck, his father-in-law. At the time, New York recognized only the strict M'Naghten "knowing right from wrong" criteria for an insanity defense and specifically disallowed the irresistible-impulse rule (Keedy).

Waite at Trial Recess

The trial, which began on May 22, 1916, bore similarities to a "trial of the century" nine years earlier: the 1907 NYC murder trial of multi-millionaire Harry Thaw for the fatal shooting of architect Stanford White (see *Insight Matters*, Fall 2022, "The brain storm defense, etc."). Both involved the insanity defense, both involved parties who were known to New Yorkers and both received extensive newspaper coverage.

Four of the five expert witnesses in the Waite trial had been experts in the Thaw trial. However, the Thaw trial had a total of 16 expert witnesses, leading to a prolonged "battle of the experts" and a trial that lasted over 11 weeks, ending with a deadlocked jury. The Waite trial had a total of five experts and lasted six days with a jury deliberation of less than 90 minutes!

Morris J. Karpas, MD and Allen Ross Diefendorf, MD were the two expert witnesses for Waite's defense. Karpas was chief of the New York Neurological Institute, a neurology faculty member of Cornell University, and a charter member of the prestigious New York Psychoanalytic Society. He published extensively and was regarded as a rising star in his field but died at age 39 in 1918 in France during WWI. Diefendorf had extensive forensic experience and was a former superintendent of the Connecticut State Hospital in Middletown. In the Thaw trial, he had testified for the prosecution.

Diefendorf testified that Waite was "amazingly egotistical" and "utterly devoid of emotion or feelings," with "no sorrow or shame" for what he had done. Both Diefendorf and Karpas testified that Waite was "morally depraved" and had "moral idiocy"—a term for moral insanity that emphasized an arrested development of morality and conscience. Karpas emphasized that Waite lacked a rational motive for the murders because he was already living in comfortable surroundings. Both maintained that his mind was unsound and didn't know the nature of the act when he murdered his father-in-law. Diefendorf testified he had knowledge of his actions, but it was "an insane knowledge of the act."

Smith Ely Jeliffe, MD

Three experts testified for the prosecution with the opinion that Waite knew right from wrong when he murdered his father-in-law. Smith Ely Jelliffe, MD, who had testified for the defense in the Thaw trial, provided the essence of the prosecution's expert testimony. He was in the neurology faculty of Columbia University and a neurology consultant at New York City Hospital. In 1929, he was elected president of the American Neurological Association. He testified that Waite knew right from wrong at the time of the murder, had "moral sense" but "chose not to be guided by it." The other two experts for the prosecution were in basic agreement with Jelliffe's assessment.

Waite also took the stand and related numerous incidents of deceit and lying over the course of his life. He explained that his whole life consisted of "lying, cheating, stealing and killing."

In his instructions to the jury, the judge informed that "moral depravity is not insanity" and "habitual criminal behavior does not excuse responsibility." The jury deliberated for less than 90 minutes before returning a verdict of first-degree murder on May 28, 1916. Waite accepted the verdict with a smile, commenting that the jury took longer than he expected! He died by electrocution at Sing Sing Prison on May 24, 1917 (NYT).

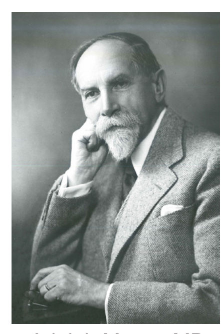
Meaning and evolution of constitutional inferiority

Two days after the trial, a lengthy letter-to-the-editor, written anonymously by "a well-known psychiatrist," appeared in the *New York Times* (NYT). Its title was "The explanation of moral insanity—it is one of three kinds of constitutional inferiority—Arthur Waite only an extreme case" (Anonymous).

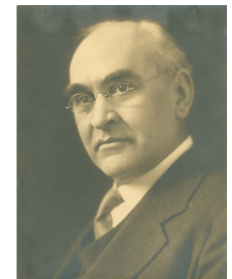
The letter explained that constitutional inferiority refers to a person inferior in character, of which there are three general types: intellectual, emotional and moral. Those with intellectual inferiority are the "feebleminded:" those with emotional inferiority are "unstable, excitable, and poorly controlled:" and those with moral inferiority are "without conscience." It then described "moral inferiority" with essentially the same characteristics of today's antisocial personality disorder, explaining that persons with this disorder can present with a "mask of sanity" and be charming and superficially sociable. It concluded that those with constitutional inferiority are legally sane and responsible for their behavior.

Only several weeks after he testified as an expert for the defense in the Waite trial, Karpas presented a paper titled "Constitutional Inferiority" at the annual meeting of the American Medical Association in June 1916. The paper was published in the *Journal of the American Medical Association* (JAMA). Similar to the above NYT letter, Karpas distinguished three types of CI: 1) Intellectual 2) Emotional and 3) Volitional. He maintained that in the volitional form, all impulses (egotistical, immoral and sexual) are yielded to and characterized by a lack of moral sense, leading to "antisocial deeds." However, he believed that those with CI were not legally responsible for their behavior because a "moral defective" cannot be truly responsible when he is "constitutionally incapable of differentiating between right and wrong" (Karpas).

But where and when did the term "constitutional inferiority" originate? Adolf Meyer, MD (1866-1950), one of the most influential psychiatrists of his day, is generally acknowledged to be the first to have used the phrase. The earliest reference is found in his 1903 collected papers, where he referred to CI as an "arrested development" in adolescence due to "disease or mismanagement of early childhood." In 1905, he expanded on CI as a "group of psychoses [a term then synonymous with mental disorders] arising from peculiar make-up and developmental defects" that were not included in other classifications (Winters). Said differently, it was a broad diagnostic term in an unspecified category—a category today that would likely be personality disorders. The term "constitutional" referred to traits present at birth or early in the development of the child.


Adolph Meyer, MD

William Alanson White, MD, superintendent of St. Elizabeths Hospital in Washington, DC and a future president of the American Psychiatric Association (APA) in 1924, described CI in his highly regarded 1907 text, *Outlines of Psychiatry*. He described CI as a predisposing factor for mental illness in individuals who "never seem to be quite able to successfully cope with conditions; they are the failures of life, the cases of constitutional inferiority." This brief description continued unchanged through the 13th edition of his book in 1932. Importantly, he distinguished cases of CI from those with "more pronounced defects of character, such as criminals, who lack ordinary moral inhibitions and are properly classed as moral imbeciles" (White 1907; White 1932).


William A. White, MD

Despite these differing opinions, CI became the approximate nosological successor to moral insanity in the early 1900s. Later, the term "constitutional psychopathic inferiority (CPI)" took hold. The phrase "psychopathic inferiority" was taken from writings of the German psychiatrist Julius Koch, MD (1841-1908), who in the 1890s suggested it as a better term for moral insanity (Gutmann). This did little to lessen the confusion. Articles of the time found it difficult to differentiate CPI from other disorders, and the diagnosis often included a spectrum of conditions (Johnson; Huddleston).

In 1939, another term, "psychopathic state," came into being. It was derived from lectures by David Henderson, MD, professor of psychiatry at the University of Edinburgh, and became equated with criminal behavior and a lack of moral code (Henderson).

Eventually, "sociopathic personality disturbance, antisocial reaction" was introduced in 1952 in the APA's first *Diagnostic and Statistical Manual (of) Mental Disorders* (DSM-I) as one of several personality disorders. The DSM added that the disorder included previous "constitutional psychopathic state" and "psychopathic personality" (APA). The term became "antisocial personality disorder" in DSM-II (1968), which continues through the current DSM-5-TR (2022).

Conclusions

Psychiatric diagnosis was—and remains—an inexact science that is constantly undergoing change. There was little consensus regarding the classification of mental disorders in the 1800s and first half of the twentieth century, and a myriad of diagnoses existed with little uniform criteria. Such was the case for moral insanity, CI and their progeny. The APA's DSM-I in 1952 was an earnest effort to make sense out of confusion and prevent the taxonomic disarray of the past.

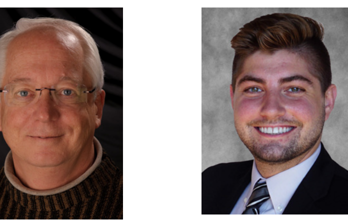
However, today's DSM is not necessarily the final solution to taxonomic problems of the present. There are operational concerns regarding its utility and reliability, and conceptual concerns regarding its terminologies and the validities of its diagnostic constructs (Aftab; Regier;Young). Still, most will agree there is practical value in using a collective nomenclature so that everyone speaks the same diagnostic language—with the understanding that the language, like that of the past, might someday become extinct.

As a final note, "celebrity insanity trials"—such as those of Harry Thaw and Arthur Waite—often increase public awareness of psychiatric disorders. This was the case for CI in the aftermath of the Waite trial. Similarly, the first appearance of "dementia praecox" in the media was during the Thaw trial in 1907 (Noll).

References

Member News

Candidates for 2025 election announced



President-elect

S.R. Thorward, MD, DLFAPA
Columbus
(Unopposed)

Treasurer

Grant Gase, DO
Columbus
(Unopposed)

APA Rep.

Nita Bhatt, MD, FAPA
Columbus
(Unopposed)

APA Rep.

Tamara Campbell, MD, DFAPA
Cincinnati
(Unopposed)

OPPA Members may file petitions to place additional candidates on the ballot. The Executive Director of the OPPA must receive such petitions no later than December 1, 2024. At least 25 signatures are required on behalf of the candidates. The names of all candidates and their biographical information and position statements will appear in the Winter 2025 issue of *Insight Matters* as well as on the OPPA's website.

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Join the Movement!
Follow OPPA on Instagram and be part of our mission to advocate, educate, and raise awareness about the importance of mental health.

TOGETHER, WE CAN MAKE A DIFFERENCE IN OHIO'S MENTAL HEALTH LANDSCAPE!

Council notes

July 24, 2024

Nita Bhatt, MD, President, chaired the meeting. Council took action on the following items:

- Approved minutes of the April 12, 2024 meeting.
- Approved appointment of Thomas Roach, DO (Toledo) to the Nominating Committee for a two-year term (2024-2026).

Congratuations!

Member Achievements

Ruby Castilla-Puentes, MD, FAPA
Elected President of APA Caucus of Hispanic Psychiatrists

Rathisha Pathmathasan, DO
Recipient of the APAF Edwin Valdiserri Correctional Public Psychiatry Fellowship

Member News

Membership Report

July 24, 2024

New Resident-Fellow Members

Max Aveis MD Cincinnati **UC**
Hannah Bachman DO Cincinnati **UC**
Kapil Belbase MD Cleveland **MHMC**
Shane Berger MD Dayton **WSU**
Jeffrey Boward MD Toledo **UT**
Yash Bhattarai MD Cleveland **MHMC**
Samuel Cain MD Dayton **WSU**
Emily Carroll MD Cincinnati UC
Alex Collins MBA MD Cleveland **CCF**
Andrea Costin MD Lakewood **UHCMC**
Dominique Cox MD Akron **NEOMED**
Adannekwu Dibor MD Cleveland **MHMC**
Dimitri Fiani MD Cleveland **CCF**
Christopher Gomez DO Cleveland **UHCMC**
Eric Hess MD Cincinnati **UC**
Lamia Himed MD Cincinnati **UC**
Jasmine Issa DO Akron **CCF-AG**
Melody Jan MD Cincinnati **UC**
Hanadi Janajrah MD Cleveland Hts **MHMC**
Tyler Jones DO Cleveland **UHCMC**
Alexis Lynch MD 4182 Dublin **OhioH**
Geoffrey McLatchey DO Dayton **WSU**
Alison Anderson MD Cincinnati **UC**
Kevin Medernach DO Cincinnati **UC**
Michael O'Connor MD Cincinnati **UC**
Hannah Palme DO Columbus **ADENA**
Ripal Patel DO Cincinnati **UC**
Briana Saltstone MD Cleveland **MHMC**

Resident Fellow Members (Continued)

Paige Shea DO Columbus **OSU**
Pareena Singh MD Akron **MHMC**
Andrew Snider MD Cincinnati **UC**
Sanyam Tomar MD Cleveland **MHMC**
Adriana Von Rago MD Cincinnati **UC**

New General Members

Stephanie Linscheid MD Columbus **GM**

Admin Reinstatements

Andrew Dobry MD Fairborn **RFM**
Joel Ellison MD Dr Cincinnati **GM**
Nihit Gupta MD Liberty Township **GM**
Christopher Hasseltine MD Centerville **GM**
Charles Haverty III DO Columbus **GM**
Abigail Lanz MD Bellevue KY **RFM**
Kimberly Lowder MD Westerville **RFM**
Claire Meikle MD Cincinnati **RFM**
David Noga MD Akron **GM**
Madhvi Patel MD Columbus **GM**
Thomas Roach DO Toledo **GM**
Mirica Sanders DO Beachwood **GM**
Steven Seese DO Canal Fulton **GM**
Emmily Shanks DO Crest View Hills KY **RFM**
Sylvester Smarty MD Broadview Hts **GM**
Austen Smith MD Columbus **GM**
Steven Wilkening MD Cincinnati **GM**

Reinstatements

Ramsey Ahmed MD Brookfield **GM**
Debbie Amann MD Cincinnati **GM**
Tiffany Bell DO Westerville **GM**
Jessica Ee Columbus **GM**
Kristen Fite MD PhD Independence **RFM**
Natalie Klag MD New Albany **GM**
Chris Robards MD Cincinnati **GM**
Griffin Stout MD Dublin **GM**
Nimisha Thuluvath MD Beavercreek **GM**

Dropped – Failed Scheduled Payment

Maximo Lockward MD Youngstown **GM**

Status Change – RFM to GM

Joshua Taylor MD Beachwood

Transfers from Ohio

Ryan Bernal MD **RFM**
Charles Haverty MD Colorado Springs CO **GM**
Jonathan Hester MD Uniformed Services **GM**
Syed Hussaini MD Chicago IL **RFM**
Baris Olten MD 2110 Augusta GA **RFM**
Zachary Wickline DO Aurora CO **RFM**
Christine Wilder MD Center City MN **GM**
Steven Wilkening MD Memphis TN **GM**

Transfers to Ohio

Mohamed El Zein MD Cleveland **RFM**
Jacob Wardyn MD Cleveland **GM**
Christopher Racine MD Delaware OH **GM**

OPPA Members particpated in APA's State Advocacy Conference. Pictured from left to right: Julie McCormack, MD; Poojajeet Khaira, MD; Stephanie Linsheid, MD; and Heather Wobbe, DO.

OPPA President, Nita Bhatt, MD (second from the left) pictured with Abinav Singh, MD, Ramaswamy Viswanathan, MD, APA President, and Pooja Khaira, MD, APA Area 4 RFM Deputy Representative.

OPPA Members at the APA Mental Health Services Conference in Baltimore, MD. Pictured from left to right: Gaelle Rached, MD, MSc; Rathisha Pathmathasan, DO; Heather Wobbe, DO; and Poojajeet Khaira, MD.

RFM News & Resources

PRMS Resident Owlery Newsletter

"Resident Owlery" was developed by Professional Risk Management Services (PRMS) to provide psychiatry residents in training with 'owl you need' to help manage your risks as you prepare to start your psychiatric career. Featuring risk management resources, educational articles, and the latest announcements and events from PRMS, this quarterly newsletter shares relevant news and useful tips to help keep psychiatrists, your patients, and your practice safe.

The latest issue from PRMS covers matters such as treating VIP patients and pointers for managing risk when treating patients with suicidal behaviors. The current issue can be found HERE or on PRMS' website, along with all previous issues.

APA 100% Club

The 100% Club is an exclusive organization within APA that was established to encourage residents to join APA/OPPA. There are four levels: Gold (100% of general psychiatry residents are APA members); Silver (90-99%) and Bronze (80-89%), as well as the Platinum level which recognizes programs that have been part of the 100% Club Gold level for the past five consecutive years.

There are numerous benefits for residents, training directors and training programs including SET for Success – featuring more than 60 free courses on the APA Learning Center, special practice resource gifts, recognition in *Psychiatric News*, and so much more. Have your residency training program join the ranks today!

The **deadline for enrolling your general psychiatry residents is Dec. 31, 2024,** to qualify your training program for 100% Club membership for the current training year. Eligibility requirements, description and benefits for each level are available on the APA website.

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WENDY FAULKNER, CPHRM, AIC, AIC-M
ASSOCIATE DIRECTOR, CLAIMS

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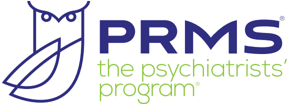

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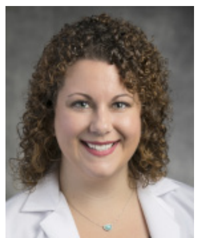
Starting the academic year off strong

Starting with their July meeting, the Cleveland Psychiatric Society (CPS - the local Cleveland branch of the OPPA) brought psychiatrists from around the greater Cleveland area together as a panel of community leaders. This panel was able to show the breadth and depth of career options available to psychiatry residents and fellows.



Samantha Imfeld, MD
Assistant Professor at University Hospitals and Positive Education Program Medical Director

There was a strong turnout for the meeting, including medical students, to learn more about careers in Forensic Psychiatry, Ambulatory Psychiatry, Child and Adolescent Psychiatry, Psychedelics Research, Private Practice, Community Mental Health, and Administrative Roles/Program Directorship. We greatly appreciate the support of our early career and senior psychiatry CPS members who participated and allowed for this panel to take place for trainees in the region.

Rolling into the fall, excitement built surrounding the upcoming Second Annual PRITE Jeopardy competition, where teams of three residents from Cleveland Clinic Foundation, MetroHealth, and University Hospitals all take on one another and an attending team. The goal of this event was to use healthy competition to build collegiality between the three psychiatry residency programs in Cleveland…all while preparing for PRITE. In a winner-take-all, two-round demonstration of psychiatry knowledge, MetroHealth came to the event with the hopes of hanging on to their bragging rights as last year's winners. The stakes were high – with the prize being an LED – lighted brain trophy and a gift certificate to the ever-popular Cleveland Bagel shop.

This year, each team put in a great effort and worked on their strategies for the game. The CPS executive leadership team worked on their Ken Jennings hosting abilities and upgraded to a new buzzer system to reduce last year's "buzzer confusion," as each team brings a lot of energy and quick response times. In the end, MetroHealth pulled ahead to win with a smart strategy in Final Jeopardy and were able to take home the trophy for the second year in a row. With this exciting start to the training year, CPS looks forward to continuing its planned events, which bring opportunities for our local psychiatrists to grow professionally and strengthen relationships. If you are an OPPA member living or working in the Cleveland area, get in touch with CPS by emailing clevelandpsych@gmail.com.

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THE HENRY AND AMELIA NASRALLAH ANNUAL OPPF RESEARCH AWARDS

Ohio Psychiatric Physicians Foundation

Call for submissions

Deadline December 31, 2024

The OPPF encourages scholarly work in Ohio by presenting annual research awards in three separate categories: General OPPA Members; Resident-Fellow OPPA members; and APA Medical Students. The award will be given to the best research article in each category. These awards are supported by The Henry and Amelia Nasrallah Endowment Fund.

Criteria for all submissions

The article must have passed peer review and be published (or accepted) and in press at any time between Jan. 1 and Dec. 31, 2024. Original research papers are preferred, but critical review articles are also acceptable. Only one article may be submitted per candidate. Manuscripts that have not yet been accepted for publications will not be considered.

General Member Research Award

All psychiatric topics are acceptable for the competition. Only submissions by first and last authors will be considered (with first authors given preference).

Resident-Fellow Member Research Award

The article may be authored by the resident/fellow alone or in combination with a faculty member, however, the resident must have significant contribution with a letter from the main author indicating how the resident/fellow contributed for the paper to be considered (first authors will be given preference).

Medical Student Scholarly Paper Award

The author of the entry must have completed the work and been enrolled in one of Ohio's medical schools when the work was completed. Faculty and residents can be co-authors, however, the medical student must have significant contribution with a letter from the main author indicating how the medical student contributed to the article for submission to be considered (first authors will be given preference). The article can be any article type (a case report, a case series, a scholarly review, an evidence-based review, or a data-based original research paper).

Please note: members of OPPA who are affiliated with medical schools in Ohio are encouraged to inform medical students interested in psychiatry about this award throughout their four years. Mentorship in identifying a topic and preparing an article for submission is also encouraged.

Award Selection

The OPPF Board of Directors will appoint a selection committee comprised of OPPA members to judge the entries.

Award Announcement

The selection committee will review qualifying submissions in all three categories and will send their recommendations for a winner and runner-up in each category to the OPPF Board of Directors. The OPPF president will announce the awardees in mid-February via an email to all OPPA members. The OPPA quarterly newsletter (*Insight Matters*) will profile the awardees and runners-up in all three categories in the issue following announcement of awardees.

Receiving the Award

The winners and runners-up will be invited to attend the OPPA Annual Psychiatric Update which will be held in Columbus on March 1-2, 2025 where each winner will be announced. Each winner will receive $250 and a plaque. Each runner-up will receive an award certificate. The registration fee to attend the Annual Meeting will be waived for the winners and the runners-up in each category.

Submission Process

The following must be received via electronic submission to oppf@oppa.org no later than 11:59 p.m. on December 31. Submission materials must be received as attachments to a single email and should include the following:

1. A cover letter signed by the submitting author, verifying that s/he personally conducted the study and/or wrote the paper being submitted (with some input or help from co-authors where applicable). Either an electronic signature inserted into the cover letter or an electronic scan of the completed cover letter is acceptable.
2. The article in either a PDF or Word format.
3. Note: Incomplete submissions will not be considered.

Your Year End Giving Makes a Difference

As we step into the season of giving and you ponder the impact of end-of-year contributions for tax purposes, we urge you to consider making a donation to the Ohio Psychiatric Physicians Foundation (OPPF). Your generous support will directly advance OPPF's vital mission, fueling Public Education, Professional Education, and Research Support through targeted programs. Your contribution will make a tangible difference in the lives of many.

1. Enlightenment Awards: Recognizes outstanding activity or presentations that enhance the public's access to treatment and understanding of mental disorders, or decrease the stigma associated with mental illness.

2. Consider Psychiatry Campaign: Encourages medical students to specialize in psychiatry as their medical specialty. OPPF, in cooperation with OPPA, encourages mental health professionals to sponsor and mentor Ohio medical students at the OPPA Annual Psychiatric Update.

3. The Henry and Amelia Nasrallah OPPF Research Awards: Presented annually to Ohio medical students, residents, and general members for research that advances the understanding of mental disorders.

OPPF is a 501c3 organization, and gifts to the OPPF are tax deductible in accordance with state law.

Four Easy Ways to give to OPPF

1. Make a secure on-line donation with credit card;
2. Print the OPPF Contribution Form and mail with a check to PO Box 400, Dublin, OH 43017
3. Register your Kroger Plus card and every time you shop, OPPF will be receive a percentage of your purchase (instructions on the OPPF website);
4. iGive.com (see details on the website). http://www.iGive.com/OPPF

Call for Nominations Enlightenment Award

Deadline Jan. 31, 2025

The Ohio Psychiatric Physicians Foundation (OPPF) is accepting nominations (until January 31, 2024) for this year's OPPF Enlightenment Award. The award recognizes outstanding activities, presentations or publications during 2023 which enhance the public's access to treatment and/or enhances the public's understanding of mental disorders or decreases the stigma often associated with mental illness.

Nominations: Visit the OPPF webiste to complete the OPPF nomination form. Nominations must be received **no later than January 31, 2025**.

Award Selection: Entries will be reviewed by the OPPF Enlightenment Award Committee and OPPF Board. The Enlightenment Award will be presented in conjunction with the Ohio Psychiatric Physicians Association Annual Psychiatric Update which will be held on March 1-2, 2025 in Columbus. Awardees will receive a plaque and will be featured in the OPPA quarterly newsletter, *Insight Matters*.

Call for Poster Display Abstracts

The Ohio Psychiatric Physicians Association (OPPA) and Ohio Psychiatric Physicians Foundation (OPPF) invite all OPPA members, resident/fellows and medical students to participate by submitting an abstract for consideration to display a poster during the upcoming Annual Psychiatric Update to be held on March 1-2, 2025.

In 2025, all abstracts meeting the specified requirements will be accepted and scored by judges. If an abstract ranks in the top 20 of all submissions, the presenting author(s) will be asked to create a poster to be displayed at the OPPA meeting. At least one author will be expected to register, attend the meeting, and display their poster. Authors are encouraged to be available during break times to showcase and discuss their poster with meeting attendees. Please note that posters will be for display purposes only and will not be judged on-site.

PURPOSE

Creating a clear, concise, and informative abstract is crucial for effectively summarizing your research and preparing a visual poster for display, whether onsite at the meeting or digitally on the OPPA website.

SUBMISSION GUIDELINES

- General members and residents/fellows members must be an OPPA member; medical students must be members of APA.
- Submission areas may include research reports, research-in- progress, case reports, and posters that have already been presented elsewhere within the past year.

GENERAL DISCLOSURE POLICY

Every author must complete a Disclosure of Financial Interests form through the OPPA's online submission site. Each author must make every effort to ensure meaningful disclosure of limitations on data (e.g. ongoing research, interim analysis, preliminary data, or unsupported opinion).

DEADLINES

Oct. 1	OPPA begins accepting poster abstracts
Dec. 31	Deadline to submit abstracts by 11:59 p.m.
Jan. 2	Poster judges score qualifying abstracts
Jan. 15	Primary author(s), will be notified of the scoring of the abstracts
Feb. 28	All poster PDFs must be received by OPPA/OPPF for posting on the website

REQUIRED INFORMATION FOR ASTRACT

- Title
- Key Contact (name, affiliation, phone number and email address)
- Information of all author(s) (name, institution name, and email address)
- Name of person(s) who will be on-site (if abstract chosen)
- Abstract (500 words or less), which will be scored by judges—it is helpful to include the following section headings for organization:

  Background, Methods, Discussion, Conclusion, and References
- The disclosure form must be completed by all authors at the time of the abstract submission.
- All submission materials must be completed online.

  Click HERE to access the submission form or go to: www.oppa.org/foundation, under Awards section.
- Incomplete submissions will be not be accepted.

REVIEW PROCESS AND SCORING

- Abstract submissions will be reviewed for acceptance and scored by the judges, based on the following criteria: educational value, quality of writing, topic diversity, type of research (cohort vs. case-controlled vs. quality improvement, vs. literature review). Note: **Original research will score higher than literature review.**
- Top 20 highest-scoring abstracts will be displayed as a poster on-site at the OPPA Annual Meeting (as well as on the OPPA website as a PDF).
- Authors of abstracts that do not score in the top 20 are encouraged to create a poster PDF for display on the OPPA website.

Sponsor a medical student to attend the Psychiatric Update

The Ohio Psychiatric Physicians Foundation (OPPF) is pleased once again to offer student sponsorships that will allow medical students to attend, *free of charge,* the 2025 OPPA Annual Psychiatric Update, March 1-2, 2025 at the Hilton Polaris in Columbus.

This presents a valuable opportunity for medical students to enhance their understanding of the psychiatry profession, connect with current professionals, and receive cutting-edge psychiatric education. The Ohio Psychiatric Physicians Foundation (OPPF) believes that providing such opportunities can offer medical students an insider's view of psychiatry, potentially influencing their career paths.

Heather Wobbe, DO addresses a room full of medical students during the 2024 OPPA Annual Psychiatric Update

Sponsor a Medical Student Today!

To make a tax-deductible contribution to OPPF's overall programmatic support of medical student education, including sponsoring one or more students to attend the OPPA Annual Psychiatric Update, please complete the online OPPF contribution form. Interested students should promptly email oppf@oppa.org. Sponsorships are limited and will be allocated on a first-come, first-serve basis. Awardees will be notified via email by Feb. 10, 2025.

We Need YOU!

Are you ready to seize an exceptional leadership opportunity? Do you have the passion to leverage your professional expertise, strategic acumen, philanthropic drive, and community network for a noble cause? Look no further! If you are committed to enhancing the health and well-being of Ohioans through advancing psychiatric education and research, then we need you!

The Ohio Psychiatric Physicians Foundation (OPPF) is seeking visionary leaders like you to join our esteemed board of directors. Since 1968, our dedicated board has been the driving force behind our foundation, spearheading scientific, educational, and charitable initiatives to advance the understanding, detection, care, and treatment of mental illness and substance use disorders.

If you are eager to be considered for our board, please contact OPPF President Alyse Stolting, MD at oppf@oppa.org.

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Classifieds

Inpatient Psychiatric Opportunity - Columbus, Ohio
Mt. Carmel Behavioral Health, located in **Columbus, OH**, is seeking a add a **Full-time Board-Certified General Adult Psychiatrist** to their psychiatric team. The facility is a an 80-bed acute treatment center specializing in treating men and women who are experiencing behavioral or mental health crisis. Mount Carmel Behavioral Health is a partnership between Mount Carmel Health Systems and Acadia Healthcare. Three-five years' experience is preferred, board eligible candidates will be considered on a case-by-case basis.The ideal candidate will have the ability to develop camaraderie with multiple teams and excellent communication skills. Experience developing and working with advance practice providers would be a plus. **Opportunity expectations and highlights:** Engaged Leadership Team; This opportunity is primarily a Monday-Friday opportunity; Assist in the development and monitoring of advance practice provider team; Collaborate with the management team on improving/innovating client care; Practice autonomously while providing leadership to staff to create a positive working environment; Oversees the compliance of the agency's behavioral health services to applicable community standards of care and to State and Federal laws and rules and other regulatory requirements; Demonstrates and reflects a commitment to the mission and values of Mount Carmel Behavioral Health by affirming the uniqueness, worth and dignity of each person who seeks our support; Excellent compensation package includes competitive salary, CME, sign-on bonus, relocation expenses and other benefits. Mount Carmel Behavioral Health is centrally situated in Columbus, Ohio. This position offers a suburban lifestyle with easy access to the vibrant entertainment and restaurants of Columbus. Ideal location to live and raise a family. For more information, please contact: Cyndi Tussing, Physician Recruitment, (614) 638-6428 (cell) or email Cynthia.tussing@mchs.com.
Not an H1B or J1 Visa opportunity

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