Dr. Dube

Okay, so I want to welcome Dr. Lisa Cosgrove today who is speaking as part of our rigor and reproducibility seminar series. She is a clinical psychologist, a professor at the University of Massachusetts, Boston, and a fellow at the Edmond J. Safra Center for Ethics at Harvard University. She has published over 50 peer reviewed journal articles and book chapters and has co-edited and co-authored casebooks on the ethical and medical legal issues that arise in organized psychiatry because of conflicts of interest. She received the 2014 distinguished publication award from the Association of Women in psychology for her paper industry's colonization of psychiatry for presentation today is entitled, industry influence on the DSM five TR, prolonged grief disorder and treatment resistant depression. Please join me in welcoming Professor Cosgrove.

Dr. Crosgrove 1:14

Thank you, thank you so much for asking me to talk on this subject. It's near and dear to my heart. And I really enjoy talking to a diverse group and not just preaching to the to the choir, so certainly feel free to push back on anything that I have to say. So, the main focus of today is talk is really on. What are the consequences of medicalization? What are the unintended I atherogenic consequences of understanding emotional distress as a disease? And certainly one of the main consequences is that it can be all too often all too easily to overdiagnosis, and overtreatment. And this is really important, certainly for a number of reasons. It's important at a public health level, but it's also important at an individual level, because I think we would all agree that at its best a diagnosis should open up a future not foreclose it and when we talk about AI Gnosis, we're talking about any diagnosis not limited to a psychiatric diagnosis. And so one of my concerns is, and I think this is particularly relevant in the last few years is how might being assigned a DSM diagnosis affect people's understanding of their complex life stories? That's why one of my favorite quotes here is by Zora Neale Hurston I'd been in sorrows kitchen and looked out all the pots then I stood on the peaky mountain, wrapped in rainbows. With a harp and a sword in my hands. Now sadly, I think if Zora Neale Hurston would have saved this today to a clinician she would be quickly diagnosed with bipolar disorder and likely prescribed a second generation anti psychotic. And so my point here is that the DSM ever since the third edition produced in the 90s in 1980, and continuing to the latest edition, the DSM five Tr in 2022. It facilitates would psychiatrists Sammy, to me, me, talked about as an acronym for formulations and I'll be talking about two of those today, treatment resistant depression and prolonged grief disorder. And as he points out, these acronym for me formulations can act in a very hypnotic way. And relatedly philosopher in hacking makes a similar point. Assigning a DSM diagnosis to someone changes the way people think about themselves. It classification changes people it reifies I think certain truths and then it deflects attention away, as I said from context and from people's complex life stories. Another consequence of medicalizing distress of course, is that it deflects attention away from the social determinants of health. And I would argue that medicalizing distress also opens the door for industry influence on the DSM and this was summed up by Bob Spitzer. In an interview in June 2011. He was asked so Bob Spitzer was the chair of the DSM three. And what's unique to the DSM three is the previous iterations of the DSM one and two really had a much more descriptive, almost narrative focus. What happened in with DSM three is that the APA really adopted the medical model. You developed a psychiatric taxonomy where diagnosis was really designed visa vie checklist and so he was asked, What do you think about this change? And he goes off the pharmaceutical companies were delighted with the DSM. Now, he wasn't implying and I'm certainly not implying that the APA purposely did this. But I think it inadvertently This is what opened the door for organized psychiatry to play handmaiden to industry that is this shift to the to symptom checklist approach, and the medicalization and D contextualization of emotional distress. So, we had done a study back in 2006 Looking at the DSM four and DSM four TR, and then I, in 2013, the DSM five came out, and we replicated our study. So we looked at what are the financial associations between the DSM panel members and industry that is there are certain panels on the DSM panels for depressive disorders for bipolar disorders for schizophrenia and psychotic disorders, etc. And there are a number of individuals who are responsible for deciding if there should be any changes either in symptomatology or changes in terms of eliminating certain disorders or including disorders. So the DSM panel members and the taskforce members have a great deal of authority in terms of deciding what is or won't be included in what sometimes referred to as the Bible of psychiatric disorders. And so what I've done here with this slide is just tried to show you a comparison between the DSM four panels and DSM five panels. Now what's interesting and somewhat hard is after our study came out in 2006, the APA developed a disclosure policy that is they require the panel members and task force members to be transparent about their industry ties, and they had limits on those ties if they were to continue being on the panels, or Taskforce. Now, he gets a little beyond the scope of this talk, but I would say that those limits were somewhat spurious and not and not consistent enough and not they didn't really worked to prevent conflicts of interest. So for example, you could have unlimited research funding, you could have up to $10,000 in stock. And so the limits that they placed were not empirically based at all in terms of you know, if you have an unrestricted research grant from industry, there's no there's no research to show that that doesn't influence your decision making. That said, there was a decrease in some of the panels as you can see between the DSM four and DSM five for the mood disorders mood that went down significantly, but also, as you can see, some of the panel members, financial ties actually increased. So I would argue that transparency, that is disclosure of industry ties was not a robust enough strategy. To prevent the appearance at least of industry on the psychiatric taxonomy. So the DSM five TR came out just last year in 2022. And so we replicated our study. It's currently under review. Hopefully it will get published soon. And we use the open payments data, which was not available to us when we did our study in 2006. And then the one that came out in 2012. So what's interesting about open payments if you're not familiar with this is it's a publicly accessible open database, and you can enter any name of a physician, and now they've included just last year pas and nurse practitioners. You can include any names and you can see if they've received any payments from industry. So it's a way to certainly makes researchers job a lot easier than when we do the studies that 2006 and 2012. But also you can see the amount of money which was not possible before when we looked at disclosures we would only find the the relationship as someone had received a grant someone who was on the speaker's bureau, but we had no way to identify how much money was being made. And so just want to give just a brief glimpse, because this isn't it's under review. At BMJ, but has not been published yet. But just real briefly, what we found, unfortunately, is that almost the same percentage of panel members for the DSM five TR also had it industry ties and collectively they received over $14 million. You know, again, I want to really emphasize that, you know, these ties in my in my team's view are not evidence of wrongdoing. We're not saying that folks engaged in any sort of quid pro quo.

Dr. Crosgrove 10:46

corruption at all, rather than create what physician Joe [Unknown] has called Pro industry habits of thought that I think are very difficult, if not impossible to eradicate. So again, it's not that there was a purposeful quid pro quo relationship, but rather, when you have these long standings and significant industry ties, they encourage way of thinking and an implicit bias that leads towards pro industry findings and pro industry habits of thought. And so the point here and why I love the title of this book by Carol Tavares and Elliot Aronson Mistakes were made, but not by me. You know, it's part of the human condition to have implicit biases, but not be aware of them. In fact, it's interesting social psychologists have done research where they've interviewed folks that have received industry funding and they've asked just directly, do you think this affects your research at all your agenda? The questions you ask the way you analyze, disseminate, research, etc, and by law by and large folks will say no, not at all. However, Joe down the hall was a lot of industry funding. I'm not so sure if his research is effective. And I find this interesting because it is part of the human condition to be able to acknowledge that perhaps implicit biases occur, but we're not vulnerable. To them. So, the circling back to the larger focus of today's talk, the medicalization of distress, and even minor changes in the DSM can have a really profound effect on diagnosis and treatment. And I just want to give a very brief example of this before I shift attention to prolonged grief disorder and treatment resistant depression. So the DSM five, which came out 2013 replaced the more stringent criteria of a mixed episode with a mixed features specifier now I know I'm getting into the weeds a little bit here, but just bear with me, because it would work. The point I'm trying to make here is that for a diagnosis of major depressive disorder, you could have a you could acknowledge that there were some features that might look a little bit like hypomania, but they wanted to make sure that you were clearly distinguishing between any sort of variation of bipolar disorder and major depressive disorder. And then I noticed on Medscape psychiatry that a few years ago, they release, researchers released the first ever guidelines for mixed depression. Well, this caught my attention because I've been teaching psychiatric diagnosis for over 20 years, and I knew there was no such diagnosis in the DSM. So I thought how could you come up with a guideline when there's no condition? So I became curious about this. And just very briefly, I looked at we looked at what were folks recommending for this mixed depression. Well, interestingly, they were recommending second generation on Pat and very expensive anti-psychotics for mixed depression. And you can see here that the two main ones that they were recommending as a first line are very expensive. anti-psychotics And this is a direct quote from their guideline. They're saying mixed depression is under-diagnosed, especially in children. So you have to ask every patient every time. They also said, when a patient has accepted treatment for years and remains very well, he or she should be is strongly advised to continue indefinitely. And this worries me because I don't think we have any evidence to suggest that there's a good risk benefit ratio for someone being on but Teuta from age eight to eight and we also looked at was there any industry connections between the guideline development panel and industry and not surprisingly, we found that the majority of the guideline panel members had multiple and significant ties to those very products that they're recommending in the guideline. So that's just a brief example. And now I'll segue into how these small changes in the DSM can actually have a profound effect on overdiagnosis and overtreatment. So on the left-hand side of the screen you see what was written in the DSM four and DSM four TR for major depressive disorder with the APA is saying here very explicitly, that's a direct quote. The symptoms are not better accounted for by bereavement. In other words, what they're doing is they're highlighting to the clinician, hey, if someone's lost a loved one, they might on the surface meet the criteria for major depressive disorder. But we want to make sure that we're not over diagnosing major depressive disorder when it's better to understand that the person is dealing with a very difficult, certainly challenging issue that is grief, but that's not a mental disorder. Now what was changed in DSM five and 2013 was the elimination of the bereavement exclusion so they took out that and they actually added a statement that I think, could encourage clinicians to give a diagnosis of major depressive disorder to someone who's in the throes of grief and then they really overstepped their bounds when they said and recovery from bereavement. Could be facilitated by antidepressant treatment. The reason I say I think they overstepped their bounds is because it's a diagnostic manual, not a clinical practice manual and statements shouldn't be made about depression, antidepressant treatment or other forms of treatments. Now, they did take out the facilitated by antidepressant medication in the 2022 DSM five TR version, but the main point of this slide is that here's the seemingly small change, they eliminate the bereavement exclusion. Now, this slide may be a little bit hard to see but what's interesting is that early on, you know 15 years ago, I. He was going off patent was running a trial for what was then proposed to be included in the DSM, uncomplicated, or complicated bereavement rather and then using Cymbalta. Now, what's interesting here is that there's no posting, it was just stopped two years after the trial started. And of course, if a pharmaceutical company is getting positive results, you can better believe they're going to be publishing those results, not just on clinical trials.gov But they're also going to be publishing it in medical journals. So that's how my hunch would be is that they didn't find that Cymbalta was effective for grief. So now we come to 2022 when the DSM five TR was published, and a newly included disorder in the DSM five is prolonged grief. disorder. And what's very interesting to me to hear is that they're conceptualizing PGD as a maladaptive pre action that's analogous to addiction. And this is a direct quote from the protocol for naltrexone, which is in clinical trials for prolonged grief disorder, that researchers say are saying that we need to understand prolonged grief as an addiction. That is the person who's lost the loved one is craving the person that's died and that craving is akin to feelings of withdrawal as if it's from a drug. And this is another quote PDD may be conceptualized as a reward dysfunction disorder, which of course is how we're currently conceptualizing from a neurobiological standpoint, people who are struggling with addiction, with a deceased person as the rewarding stimulus for whom the person that's bereaved. urines and so again, the direct quote, that at its core, prolonged grief is a disorder of attachment and craving.

Dr. Crosgrove 19:43

And that is the basis upon which they're grounding the trial for now trek zone. Because if grief is like an addiction, then maybe we can use a drug that's used for addiction. To disrupt these core urinary symptoms. You know, I think we would all agree that this is problematic, but I just want to say a few words about it go into a little bit more detail about why the researchers are conceptualizing it this way, and it's really interesting from a from a marketing perspective, and that is that you're taking the side effects the adverse effects of a drug, and you're using them as a possible positive outcome for another condition. Now we saw that with Vyvanse, and binge eating disorder, when by Vance Of course, the psychostimulant went off patent, the Shire, the manufacturer of Vyvanse, heavily marketed binge eating disorder and Vyvanse as a treatment because we know that one of the side effects of psychostimulants is that they can decrease appetite. So that's another example of taking a adverse effect of a drug and then using it as a possible positive outcome for another condition. And here we see this with naltrexone. So we know that naltrexone unfortunately can for some people reduce the ability to feel connected to other people, but obviously people struggling with addiction, particularly addiction from opioids, the positive benefits of naltrexone out can outweigh that adverse event, but what you see here is that we're taking the researchers are taking a adverse effect or a negative side effect and suggesting that this could be a positive effect. Because if Naltrexone is reducing feelings of social connection, then perhaps we could give naltrexone to people who have prolonged grief disorder, and that will reduce their positive associations with the person who's deceased. Now, as I mentioned, I think we would all agree that there are many problems with conceptualizing grief as a reward system, dysfunction disorder, and the suggestion that naltrexone could be used is problematic at a philosophical, ethical and also empirical level, right? How could this drug selectively target the bonds with the person who's deceased, but not target other social bonds that you want the person to have? So it's problematic at certainly many, many levels and I look forward to hearing your thoughts or questions about this. So I also wanted to give another example and that is treatment resistant depression. You know, treatment resistant depression is not yet codified in the DSM, but it's gaining a lot of currency in the public health literature, in the research literature, etc. Even though as you can see here, there's no consensually agreed upon definition of TRD. For example, how many antidepressant trials should be given to a person or should psychotherapy be a part of the treatment regime before the person is identified as having treatment resistant depression? And there's very little although I would say it's growing a bit. There's very little discussion about whether TRT is actually a valid construct. I would argue, though, that the question remains, is this the best way to conceptualize the problem here that is when people are not responding to antidepressants? Is it that the disorder is resistant to treatment? Or perhaps should we acknowledge that antidepressants are not as effective as we originally hoped that they would be and I would argue Relatedly that the problem here is that we're importing an infectious disease model into the mental health field where it's really not appropriate. I would argue that we don't have strands of depression that analogous to bacterial infections are resistant to antidepressants. Now not only is this problematic I think at a conceptual level, but it's also problematic because it really fuel. is a bit of magic bullet that could easily cure treatment resistant depression. And in fact, Janssen in my opinion sort of games, the breakthrough therapy designation of the FDA Innovation Act, where you're lowering the regulatory bar for approval of drugs and in many cases, that's good and we need to have that bar a little bit lower to get potentially life saving and important interventions on the market. But I would argue that the the approval for Spravato (esketamine) was done without adequate safety data, without adequate information on the long term effects at all. And I think it's interesting and important to know that the National Institutes for Health and Clinical Excellence recommended against its use for those very reasons. They said very explicitly just last year, you're only looking at a small number of people and we know that esketamine could have long term effects that could be deeply problematic could be related to, you know, we could be exposing people to a treatment that could ultimately lead to them needing to have this treatment over the long term in ways that could have a lot of very poor risk benefit ratio. It's also noteworthy that the ketamine clinics particularly in the United States, but I bet this is going to be happening in higher income countries across the world are really growing. I just found this report recently, where business report said that in the US market, it's become over a $3 billion market and that they're expecting it to grow significantly being driven primarily by the increase in the prevalence of major depressive disorder. And you can see on the right hand side of the screen that you know companies for profit companies are popping up encouraging psychiatrists to start ketamine clinics. So I always like to say a few words at least about what's the solution, okay, if I'm going to name all these problems, I think we have an ethical responsibility to try to come up with some solutions, at least however partial or optimistic they might be. So one solution, I would say is that psychiatry really needs to embrace a notion of epistemic humility, that is being more upfront about the limits of the current state of knowledge and adopt what philosophers [unintelligible] has called a gentle medicine posture as a possible solution. So if the field of psychiatry were really to adopt this, this posture of gentle medicine, one of the things that I think would need to be done would be to acknowledge that psychotropics, particularly antidepressants have been over prescribed and their harms have been lost over. And that's an important point that I want to emphasize. I think the question do antidepressants work is a wrongheaded question. It polarizes the debate, you get people saying you're anti psychiatry, if you're questioning harms, and it doesn't leave, it doesn't animate our political or our treatment intervention imaginations. So I think a better question is, how might we acknowledge uncertainty and one way we could do this would be to acknowledge that psychotropics, particularly antidepressants have been over prescribed. Historically, their harms have been glossed over and we need to stop searching for magic bullets and focus more on the upstream causes of ill health. And that's why I love this quote by Audrey chat in the social determinants of health, which she points out is that yes, we need to increase access to services, although that's necessary and significance. You know, just improving access to the availability of health services is not going to enhance population health. What we need to do is we need to better compensate for the disparities in access to the social determinants of health. And that's why I see the structural competency movement in psychiatry as being one very viable and important solution. The structural competency movement is training psychiatrist in training to understand those upstream causes of ill health to understand the relationships among race class and symptom expression. And I think it's a really helpful way to shift from an intra individual model to a more population based health model.

Dr. Crosgrove 29:37

So I wanted to make sure that we had enough time for discussion. So I'll just open it back up to Cathy.

Dr. Dube 29:48

Excellent, really fascinating presentation. Thank you so much, Lisa. That was great. So I'd like to open the floor for questions discussion, we have a nice small group so we can we can have some lively discussion. He's got he's got a thought. I have lots of thoughts. Terrific. Thank you so much for listening.

30:00

I was I loved your comment about the epistemic humility. I mean, we could all do with a dose of that.

To get down on institutional level is really difficult because, you know, as though it can be passed down by the institution to the people who are part of the institution, it just doesn't work. Well. It can't be encouraged that way. But I mean, it's, it's in teaching the students themselves and their interactions with them that that that sort of stuff can be built and the gentle treatment I mean, gentle treatment requires time. You know, and time requires money. You know, and everybody's trying to do this on a slimmer and slimmer budget.

I mean, interactive psychotherapy. i You mentioned, I mean, I when I was doing my training, the DSM two, DSM two was still what we use, and then the DSM three came along, and it's like, wow, this is really looking. It's really looking like hot stuff here. You know, it's, it's taking a quantum leap into sort of more into a more operationalized view of the whole problem, but it's come with these, it's come with this massive downside as well, you know, and so the DSM two was, in fact, the more expressive of that it was 10 of humility. I think there was more of a sense of like, we don't really know what the hell's going on here. You know, we're muddling along. And that's what we're continuing to do. I mean, we're all muddling along here. And we're trying to try to create the impression that it's like, not knowing and and you want to get you want to view patients with some sense of content coming to this person. It's not just sort of a muddling along and spending his life like a lot. But, and then that gives us sort of a cultural tolerance for not knowing and for uncertainty, and we're not good at that either. So that's a mouthful. Anyway, thank you very much.

Dr. Cosgrove 31:49

Thank you, and I forgot to say and I want to emphasize that I'm not just in dating psychiatry, I'm in dating my field clinical psychology as well in that in the need for epistemic humility, and, you know, what's that saying? You know, never ask a barber. If you want a haircut never asked us clinical psychologist opinion psychotherapy never asked a psychiatrist if you need medication, right. We all have appealed interests. And as you said, we could all use a big dose of epistemic humility.

32:21

Totally agree. Hi. Dr. Cosgrove, Lisa, awesome talk awesome. You know, in the fall I teach lifespan growth and development undergrads and in the spring, social determinants of health to doctoral students from, you know, several disciplines and you know, I have psychologists myself, I call myself a transdisciplinary, nurse since educated as a child and family nurse, right? I've integrated behavioral social sciences, etc.

Dr. Crosgrove 32:56

And everything and so so many so many take home messages. I'm so glad. I'm so glad Catherine that this is recorded. We good to access it again, really wonderful. take home messages, you know, recently inside relate as you probably know, the FDA just approved and this came up in classes we're talking conception to end of life we talk about lifespan development, but postpartum depression. And as questions emerged on that, and so I knew that there was a medication that was FDA approved this summer. So I do my homework. I always come back to them. We don't know all the answers. And it's right. They recommended it based on the results I guess of two RCTs and it's zero Anil zu r a n o l o n e zero law appear to be well tolerated with minor side effects and its rapid acting.

34:02

It's an analog of a neuroactive progesterone metabolite and you know, again, though, I don't know how the information on this has been disseminated, you know, and, and if those that might be eligible are aware. And then the other piece as you know, all of you know here that COVID The prevalence of adverse effect it states including depression, anxiety, has increased substantially across the life course. children, adolescents, emerging adults, and I teach.

And so, yeah, the topic is, you know, so important and I had no idea about the industry connect, so thank you. That was windy too, but so much to say.

Dr. Crosgrove 34:57

And thank you, Laura. Yeah, it's, it's mind boggling. You know, the more research I do on this, I tell my students, I'm getting older women are retired soon, you know, you've got to, you've got a lot of work to do. But in all seriousness, the other thing that concerns me is the way in which social media is really encouraging, particularly adolescents and young adults to understand their experience visa vie these DSM diagnoses. And I was talking to two of my doc students, and they had to have sort of this informal in service about how do you break into someone when they don't have a diagnosis? She, the clinicians were finding it challenging when because people are looking on tick tock and they're convinced that they have, whatever it is that they have, and you would think you would be relieved to find out, you don't meet the criteria, but instead and it's not just about drug seeking, it's about a sense of identity that they feel they were embracing, which is another layer of work we need to do and I don't know quite how to address that.

36:11

We all need that humility across disciplines and professions. I like that. I made a note of that.

Dr. Dube 36:19

Other thoughts?

36:22

I had a question. Do you have any observations or thoughts about the upstream utility, the upstream effects of ill health, the upstream determinants of ill health I mean, to say race and class it's kind of pretty broad brush. Where do you see it operating in terms of like, what we've when we've worked with families, for example, and doing family therapy and looking at the socialization processes that come from parenting practices and the habits, the inheritance the habits and beliefs that run through families for generations? What are your observations about this thing, which is so widespread in our culture?

As you said, you know, it's like, as a culture, we're not doing well in terms of like mental wellbeing is coming out and anxiety and depression statistics and what do you see as the sort of like, really intimate drivers of that rather than sort of like it's easy to go for, like institutional or sort of cultural institutions, you know, derivatives, like race and class, but when you see this sort of operationalizing it down to sort of parent child connection and interactions that might be driving this sort of thing. Or if they are if you think they are I think they are?

Dr. Cosgrove

I think that's a great question. I have just started to do a dive into the literature on and some of you folks certainly might know more about this than I do on medical legal partnerships, which are an attempt to identify what people have referred to as the health harming legal needs of folks. So and this will circle back to your question about parent child relationships and community. So if people are in, you know, precarious housing, they can't they're not finding pathways to citizenship. That's going to create such stress on the family, right. So I would see the medical legal partnerships and the attempt at addressing those health harming legal needs as perhaps another layer upstream to try to address them and improve the parent child relationships. So that's, that's one thing. That's one example that I would give. I'll want to hear what other people have to say.

38:40

I work myself as the chief medical officer and really, really amazing overview? I think what's going through my head is why? Why is this happening?

But one hypothesis could be it's the pharmaceutical industry's influence on the on the world, but other good hypothesis could be we are really trying to make the behavioral condition at parity with physical health by codifying things and putting the measurement and the rigor which we want to try to put it in as well. So I think there's a balance somewhere in between, where we know we don't have enough enough, there are health conditions, accepting the current payment models in Nutshell. And the way we measure quality in any field is suboptimal behavioral health is definitely suboptimal. So I don't know how we can strike that good balance that one quick comment. And second really quickly, I think the under investment in social determinants of health, all of our current payment models allows us to only fund it through the healthcare systems, whether it's accountable care organizations, or so on. So ultimately, we are still giving more control to the healthcare delivery system instead of kind of real community based organization. So just if you have any suggestions how we can kind of rebalance this and think outside the box, would love to think through this.

Dr. Crosgrove 40:05

No, those are those are really good points.

You know, and as you all know, you know, a prescription serves many purposes, right? It's at many psychological purposes. It it, it doesn't require pre authorization.

And it gives the physician or prescriber a sense that they're doing something it gives the patient a sense of being taken care of. So it's a it's a really complicated issue. And then as you're noting to the issue of prior authorization and the way that in many ways we're handcuffed with our current health care system.

I don't have I wish I had, you know, better answers, I think, you know, a concrete example of the way in which we could really embrace epistemic humility in our research is to be transdisciplinary and to be able to put down our guild interest. So an area of research that I want to dive into more deeply is this growing body that's showing that programs like housing first, where you provide more and better and safer housing, have better health outcomes for folks then giving them even simultaneously mental health interventions.

I think we really just need to, to be, again, to be able to be willing to say that the interventions that we're so quick to embrace are not the best ones. Just real briefly, a classic example of this I saw was when the who came out a few years ago with their campaign. Let's talk about depression. So on the one hand, it's a great hearted attempt to destigmatize have people tried to get some help that they might need but one of their campaigns was directed towards people in Syria. And so it was showing, you know, people in camps in Syria being shown like different kinds of faces, smiley faces, sad faces, and I just thought, oh my god, you know?

Yes. Are people struggling? Absolutely. But to to to think that we'd have a psychological or psychiatric response to one of the biggest humanitarian crises in history. That doesn't answer your question, I guess. You know, one of the things my student is doing who's working with Muslim communities is trying to figure out how to get folks pathways to citizenship as part of her role as a clinician. It's, you know, there's no, there's no protocol for this and she's just sort of paving the way but I think doing things like that, so she's putting down or clinical psychologist hat and really looking at, you know, how can I be of help so it's, it's been more of a social worker than perhaps a clinical psychologist but she's doing a hell of a lot of good in in putting on that other hat.

43:11

Thank you. Thank you. Again, very provocative and very, very informative conversation. Thank you.

43:17

Sunn, do you have any comments or questions or Julie?

43:25

No, I am just soaking it all in.

43:30

Yeah, I found this really informative, made me think about a number of things I've never considered.

So I greatly appreciate it.

Dr. Crosgrove 43:41

I'll just give one really another brief example of again, this is going to see and it is unduly optimistic because how do you how do you really put bring to fruition policy changes that are meaningful, but there was this brilliant study a few years ago looking at Indian suicides in India and we know that those are some of the highest in the world. What the researchers did, which was brilliant is they used machine learning techniques to try to identify what variables were most associated with the suicides. And what did they find? They found not surprisingly that how indebted the farmers were and what kind of crop was grown, particularly if it was a GMO type crop. And so instead of arguing for CBT, or fluoxetine, they said we need to have some changes in policy that would stabilize the farmers. Now on the one hand, that's great. The other question though, is how do you really do that? Like, that's a great, I think, brilliant suggestion, but then changing policy is obviously very hard.

44:53

Yeah, yeah. Thank you, Lisa. That was a great presentation. I really appreciated it. I'm a sociologist and a social demographer. So a lot of the points you're making, you know, really speak to me and I think, you know, the way I have been trained, I work in a more interdisciplinary field now, mostly involving aging populations, particularly aging, racial, ethnic minority populations. And so I think, you know, there's a lot to learn there. I'm wondering if you could speak a little bit about or speculate as to you know, the over underestimation of certain psychiatric or psychological diagnoses for populations, for example, for African Americans, you know, I know that there's been some discussions about whether the existing I guess instruments on in surveys sort of national level surveys are really addressing or capturing kind of the extent to which they experience psychological distress, or other types of diagnoses. And so, can you speculate, speculate a little bit about what you think could be helpful for understanding or better estimating, you know, capturing in national surveys, you know, appropriate diagnoses for privily for minority populations?

Dr. Crosgrove 46:25

Oh, another great question, and I wish I had a cogent answer. I'll say this. I think we have an untapped resource. And that's people who experienced harm in the psychiatric system, or experienced some negative effects, or maybe those that even didn't experience anything, any negative effects, but those folks who identify as having lived experience or who've been assigned diagnoses that perhaps they felt were not helpful if we bring people in to the to the table and have conversations that can be really, really informative. And I think in ways that would, we'd be less, less likely to, you know, continue the harms of structural racism if we included more and more people in the table and then the other piece, I don't know if you've read this book, it's really good. I use it in a couple of my classes, parts of it. It's called the protest psychosis. And it's by Jonathan mensal, who is one of with Helen Manson, who is one of the Hanson who is one of the co founders of the structural competency movement. He's a psychiatrist but he's a he's a historian, too, is I don't know, technically or officially but um, what he did was really interesting he went to, he was able to find records actual records that were not destroyed because this was a pre digitization of inpatient psychiatric hospitals, from in, in a few states, from the 1920s, to the 1950s and early 60s, and what he showed was that schizophrenia was a diagnosis that was predominantly given to white middle class women. And the symptomatology was different. And then, and then he shows and it's a very powerful visual how, with the civil rights movement, and we started thinking or you know, psychology psychiatry, and certainly the pharmaceutical company played a role in shifting those symptoms that we would identify as being, you know, indicative of someone with schizophrenia, to being belligerent to being angry. And there's this ad for how all that shows this African American looking at looks like somebody that would be part of the civil rights movement, but as as a indicator of someone that would need Haldol. So I think the two things you know, the bringing a more diverse group to the table, particularly people who identify as having lived experience, and then again transdisciplinary work looking at the ways in which our criteria for symptomatology changes in response to to the current culture

Dr. Dube 49:32

Other questions or thoughts? We set a couple minutes left

we reached the end of our of our inquiries

All right, well, I'm going to call it -- this was excellent.

Excellent discussion. Excellent presentation.

I'm left with a lot of questions in my head that are fascinating -- and that naltrexone stuff is like crazy.

But I just want to thank you Dr. Cosgrove for an awesome presentation. We will be hosting this seminar on our website. I'll send around I hope we have did everybody get the emails today? Are you on that email list? Not everybody. So we'll send it through. We'll alert everybody of the existence of the link to the video through the same channels that this was originally promoted. And hopefully that'll get everybody.

Thanks. Okay.

Dr. Cosgrove

Thank you so much. It was an honor. Really, I really appreciate your asking me and I love your questions. And thank you very, very much.

Dr. Dube

Well, thank you and I wish we had a larger group of live people but I think that this size group actually worked out pretty well.

Great, thank you to everyone. Have a great afternoon.

Bye bye.