Chronic Suicidality and Cultural Barriers to Care

Interview transcript with Dr. Stephen Sisselman and Dr. Anitha Iyer

ANITHA IYER

Thank you everyone for those who are watching this video, really appreciate you making time and finding us on this space. Today I'm here with Dr. Stephen Sisselman, of the Sisselman Medical Group, who was a presenter at our Mind Matters session in July of this year.

Mind Matters is a program that Mount Sinai Health Partners has been offering since last year where we create a learning collaborative based on the Project ECHO model where primary care physicians, for the most part, will, or internal medicine folks, or family physicians, will present cases that involve behavioral health needs where there's some value in consultation from peers, and a group of folks on our team including psychiatrists, psychologists, social workers, and folks from provider communications will provide feedback. We also receive feedback and consultation from other primary care physicians and internists and family physicians on the call so it becomes a real collaborative live consultation opportunity.

My name is Anitha Iyer, I am a clinical psychologist with Mount Sinai Health Partners and it has been a pleasure to watch Mind Matters grow here at MSHP. Really delighted, Dr. Stephen Sisselman, to have you here with us today. I'm wondering if you could take a couple of minutes to introduce yourself and tell us a little bit about your practice before we shift gears to talk about the case that you shared with us in July.

STEPHEN SISSELMAN

Sure thank you. My name is Stephen Sisselman. I'm a board certified internist on Long Island. I practice with my wife, Jill Sisselman, she is a family physician. We have two offices one in Commack, one in Massapequa.

Like many of our colleagues we see a lot of patients during the COVID era and many of them, even more so than before COVID-19, really with mental health complaints if not the primary complaint then certainly second or third on the list. Whether it's depression, anxiety, insomnia and we have certainly found a lot of help and comfort in the Mind Matters program in really learning how to deal with these things.

We're not psychiatrists, we're not psychologists, we're not social workers, but we do spend a lot of our time counseling our patients. Patients come to their primary care physician for headache, backache but also depression, anxiety, insomnia and we are often the first line for these patients and it's important that we practice competently, that we know the tools and our skill set, know what we know but it's better to know what you don't know and we want to narrow that gap of what we don't know and Mind Matters has been tremendous.

All of the case presentations have been wonderful and I'm happy to be a part of it.

ANITHA IYER

Well thank you so much. I really want to underscore what you said about primary care physicians, family physicians, internists as being the first line.

The data certainly bears that out when you look at nationally how many people seek mental health care, at least first line care, from their primary care physicians or their family physicians and the whole idea behind Mind Matters based on this Project ECHO model, was to create the space for those who are already providing that care to begin with.

So to create that community of mutual support and not only are you providing first-line care but you're quite often going above and beyond in providing that care, right, and really kind of finding creative ways to support patients when there are access barriers, particularly for therapy, often guided by insurance and such, and you're also frequently taking on patients with more complex illness when there is inadequate capacity for psychiatry perhaps, again, maybe perhaps due to capacity challenges in the area or insurance-driven challenges, and so it's important to note, for those

listening, that the extent to which primary care physicians and family physicians and internists get creative in supporting behavioral health and go above and beyond is important to note and the case that you shared with us in July is no exception.

I mean you shared in detail how, really you sounded like you spent pretty much a chunk of your afternoon or several couple of hours at least, on this one patient, essentially coordinating across multiple layers of care that he was already engaged in, and some layers of care that or support that perhaps were not yet set up, so I want to hear some more about it, but just for those listening, you presented a 20 year old cis Korean-American male who lives with his parents, was commercially insured, is a student, and no prior medical or psychiatric history except for currently you have diagnosed him with Major Depressive Disorder, ADHD, as well as anxiety and he endorsed, in addition to several symptoms of depression, sometimes severe episodes of depression, he endorsed what sounds like chronic suicidal ideation at this visit with you, where he had been having these thoughts with unidentified means and living with it for eight years. And it sounded like he sort of finally worked up the courage to talk about it with some pointed questioning from you, so I'm curious if you could –I hope I'm remembering those details correctly—but I'm curious if you could kind of add some more to that.

STEPHEN SISSLEMAN

He came to me for the first time and, with many of our patients, while they're filling out paperwork in the waiting room and amongst these sheets of paper is a PHQ-9 which we have all new patients fill out, a depression screen. When I come into the room, I want that right on top because it's, if for no other reason, it could be an interesting starting point for discussion. And luckily 95, 98% of the time there's not much to it but he, this individual, had checked the highest three points.

For those of you familiar with PHQ-9s, 27 is the highest total that you can get if you select the highest acuity to each of the questions, and that's exactly what he had done, so certainly startling to start a new patient encounter with a new doctor to just kind of drop that there.

So of course I took my regular history, whether it's past medical history, past surgical history, allergies, family history. I happened to know his father who was a patient and we connected those dots. During the encounter he told me he was seeing a therapist and he had been diagnosed with depression, anxiety, and ADHD.

He was not on any medications but when we started talking about the high number on that PHQ-9, we got to talking and he told me he had a rope in his room that he thinks about using every single day, but never acted upon it, knows it's there. But I had never come across something like that, an acute crisis situation, and a new patient visit, and as we discussed during the case when I presented it, I got lucky that his psychologist was working in the building.

I went down there, grabbed the psychologist, the three of us spent 15, 20 minutes in the room talking to the patient, I had the patient go get this rope from the house and bring it to me, which he seemed eager to do, and I think it was kind of symbolic in his desire to want to get better. I had called both of his parents, who are Korean, and it dawned on me then that there's a stigma to talking about mental health and this became a branch point for conversation during the case, and I think there were a number of questions regarding this that came up after.

What is the impact of ethnicity on mental health, discussing mental health? And this is one of the things that I turn to the Mind Matters professionals to talk about because I had no experience with this previously, but we all take it for granted that a parent is going to want to be immediately engaged and involved, and be almost shocked by their doc, by the son's doctor, calling them to say, “hey are you aware of what's going on at home?” and them really kind of brushing it under the rug, that it was no big deal.

And I was just floored by the response that I got from the father, who was someone who I knew. I did a little googling and a little research that there are barriers to wanting to discuss mental health in some families based on their ethnicity and this was a new thing to me.

ANITHA IYER

I really appreciate you, in the midst of sharing all the kind of concrete strategies that you adopted to coordinate this young man's care, including connecting with this therapist and having that three-party conversation and such, and then the parents, I appreciate you highlighting the cultural nuance that came to the surface. It's easy to miss that, it's easy to assume the parents don't care, perhaps, but I appreciated the way you shared it. That you kind of paused to wonder what are you picking up because you knew this father as well, he was someone who's comfortable with you, and I appreciate the way you, in fact, one of the questions you brought to the group, was whether there are any cultural barriers that you should be aware of. That you wanted consultation from the groups around culture processing and working around cultural barriers.

I appreciate that as a psychologist, but also as an Asian-American, where cultural stigma around mental health is often the biggest hurdle one has to overcome to be able to access care. There's papers written about folks in Asian-American countries where they don't want to be seen going into any sort of mental health facility because of what “shame” it might bring upon the family, and you know that their siblings may not be able to come under that escape, from under that cloud, and so on.

So having now reflected on some of the feedback and discussion we had around cultural nuances and shame and stigma, we also talked in our meeting about deference to you, as the authority, and how the parents may respond to you as the physician, a “you tell me what to do” sort of cultural kind of relationship with your physician, and the respect that physicians command in Asian-American cultures.

I’m curious having now reflected on some of the feedback what your thoughts are about some of that cultural piece, and the barriers that you still have to navigate as you care for this young man.

STEPHEN SISSELMAN

It certainly potentially complicates the care, and what's so important with mental health is to have a strong social support system. And as a

adolescent 20 year old male, to feel like you can't talk to your parents, again, as you say for fear of perhaps bringing shame to the family to ask for help, for that to be thought of as a sign of weakness, is just something that we don't experience in my day-to-day life as a parent having two kids who have gone through some of the ins and outs of mental health, one of my kids especially.

I couldn't imagine not being there for them and not having a totally transparent open dialogue about how they're feeling, and how incredibly important it is to have that because if your kid is hurting and your kid needs help, to not feel like you're there for them. And what came out of further conversations with my patients, and one of the more important things that was part of his treatment, yes, medication, and yes continued therapy, but having an understanding with his parents eventually that “yes, I have a problem, I need you guys to help me” and for the parents to be there for him in an increased capacity than had been present in the previous five, seven, eight years when he was really, really struggling at home was, to me, the most remarkable part of the case to have that improved relationship with his own parents.

But to think that that was absent and as, just we all know, is so critical to the therapeutic process. So yes, the cultural barriers as you say, I learned a lot about it, and tried to research a lot about it. You have to think about it when you're treating patients, whether it's infection, no matter, or heart disease, or cancer; the ethnicity, the background of the patient. All of these are important factors that we need to take into consideration.

ANITHA IYER

Absolutely yeah, and it's hard to find any resources really sometimes for mental health, but to find sort of culturally humble providers is quite hard, and I’m glad that this young man has you, that you're, in the midst of everything else, reflecting on these sort of softer aspects of his care.

I'm switching gears a little bit. Another question that came up, more on the clinical, kind of concrete clinical side, was about what impact, if any, do you think his history of loss of consciousness has? I think you had referenced

that, what impact, if any, you think that has on his mental health symptoms?

STEPHEN SISSELMAN

I'm going to give that question a little context. When he came to me as part of that initial encounter, one of the things he had mentioned was that he was in a fight a couple of weeks before and was literally punched unconscious, and do I think that that's important? Sure, I mean I think any history of head trauma is going to be important no matter what, but I think his suicidal ideation existed certainly for years before that.

I think it showed his propensity to maybe get into trouble, a little physical contact, and maybe not caring so much about what was going to happen, and engaging in this particular behavior, getting into fights, I think is a warning sign, and I think that part of it probably is more important.

I don't think he has any lasting head trauma. I wouldn't call this a post-traumatic situation; he doesn't suffer from post-traumatic headaches, there's no PTSD, I don't believe, associated with this event, but certainly interesting, and just to complicate things a little bit more, as if it needed to be complicated, but yeah I think it's more about kind of like engaging in unhealthy behaviors is a kind of bucket.

ANITHA IYER

I really appreciate you contextualizing that in that way around sort of concrete head trauma and sort of the associations. You know obviously sustained head trauma has impacts on impulse control and such, but it sounds like your sense is that in this young man's case he's perhaps engaging in behaviors that are injurious to him somehow.

We certainly see that sometimes in folks with chronic suicidal ideation, in fact it's reminding me, your analysis of this, is reminding me of Thomas Joiner, who's a pretty well-renowned suicidologist. I think he's at the University of Texas and has a book called *Why People Die by Suicide*, and he begins the book by talking about his own father's suicide. And one of the warning signs, which is, I appreciate you framing this as a warning sign, he

talks about how his father used to get hurt a lot randomly and he describes this as folks building an appetite to some extent, tolerance for the pain, learning to reverse code our body's natural instincts to want to preserve yourself from pain and exposure to pain in this way, to kind of build tolerance for it.

So I really appreciate you highlighting that episode, not for the fact that he was knocked unconscious, but for perhaps why he was seeking it out to begin with. Glad that after that episode though he went to the right person and was able to articulate.

STEPHEN SISSELMAN

Interestingly, perhaps with that history you know the next logical question is what about alcohol use, what about drug use? And there really was none of that in his history and you wouldn't be surprised if there was but there wasn't and, again, I'm gonna circle back to the culture, the ethnicity, because I do think that's less likely in in a Korean population, but that doesn't mean that that he couldn't have been mixed up in experimenting with drugs or using drugs for the similar reasons—the desensitization to bad things.

ANITHA IYER

Right yeah, no absolutely, and it's, they really appreciate you calling out that sensitization, that process. It isn't something that folks do overnight.

I'm curious, there was another question about what your thoughts are on when it's appropriate to handle these presentations, when a patient presents in the kind of risks that this one did, when it's appropriate to handle it on your own and when you might have taken him to the ER or sent him to the ER or called 911. Curious about your thoughts on that.

STEPHEN SISSELMAN

Yeah I mean that's a difficult question and I think every situation needs to be looked at in its own way. Every case is unique every patient is unique, of course, and as a clinician it's very good to go with your gut and when the

hair on the back of your neck is sticking up it's usually doing so for a reason.

So when you're keyed into a heightened acuity of the case you have to act and, again, I got lucky his psychologist was within walking distance of my office so I was able to engage him, and he really down escalated the acuity right away, reminded me he's had this rope for eight years he's never needed it, he's never used it, perhaps we're overestimating the acuity and I thought about that, and if in the back of my mind if I thought that he was an immediate harm to himself I wasn't going to certainly let him leave my office to go get the rope.

The fact that he was so eager to do that and seemed committed to wanting to get better, I took that as a sign that we were going in the right direction, and we were going to build a solid foundation of trust, and he was on the up and up with me from that point forward.

And he brought me the rope, I showed it during the presentation, and I still have it here. It's always a good reminder of what's possible, and you never know what's going to walk through the door.

And I didn't know that day either, there are times where I have enlisted Suffolk County Crisis Prevention, and they're a pretty good group and they'll come to your office and they will sit with the patients in an exam room and spend—I've had them spend an hour and a half here with a patient at the end of the day even, and I've sent everybody else home and we set up shop here, and if they think the patient needs a higher level of care then we'll work towards having transport to an emergency facility, but I think more often than not that could be done as long as you have the resources in place. You try not to, you don't want to overstep, but you also don't want to miss something serious.

Of course if you think the patient is a certainly a potential harm to themselves in the here and now immediate, you don't want to send them home and say follow up in two weeks. So you have to know what you're dealing with. It's important, incredibly, to have resources around.

In this case I didn't think that we needed to go to an emergency department, but there are times where you have to say, “Look did someone drive you here? If not, you're by yourself. I want you to call your husband, wife, friend, roommate, whoever it is, and I want them to come here and we'll talk together and we'll decide what the next steps are,” but those next steps are usually going to an emergency department where, above all, the patient is safe, that you have to make those arrangements.

ANITHA IYER

Yeah I so appreciate you noting and emphasizing the case-by-case kind of nature of this, because certainly going to the emergency room when you don't need to and against your will because someone made you go, like that sometimes backfires and then they won't tell you about it the next time. But when they need to be there they need to be there, so I appreciate you highlighting that nuance, and also appreciate you noting the Suffolk County Crisis Prevention service.

I'll just use this moment to share that there are free phone-based crisis prevention services that are typically either state- or county-funded, pretty much in every county in New York City, New York State, and they can connect you to mobile crisis teams or respite centers or come, as you said, meet in person, do an assessment and escort to an emergency room if they determine that that's the right next step.

And for folks who are curious about the New York City single point of access for that it's NYC Well. Suffolk County, you have the crisis service at Suffolk County, I think it's called Response if I’m not mistaken, and then there's also one and—

STEPHEN SISSELMAN

Nassau County of course has its own, right it's important to be able to know what your resources are.

ANITHA IYER

Another question was just about how often you follow up with patients where you are concerned about behavioral health needs that are perhaps acute or unmet or they're making you uncomfortable for some reason.

STEPHEN SISSELMAN

Yeah I mean, again, it depends on the situation right. Whenever I'm starting a new medication for depression, anxiety, I'm gonna have a short follow-up. It's gonna be a week, it's gonna be two weeks. I'm not saying I'll see you in three months, here's 90 days of Lexapro.

I don't do that. I think so many things can happen in three months. I prefer somewhere in the one to four weeks, depending on the acuity. If it's something like the patient we were discussing, he came back two, three days later so you have to have an understanding with the patient. And patients want to know that they're not alone during this process, so that they need to know that they could reach you, whether it's by phone, coming in. And when you say "I want to see you in a week" they say, "oh okay I'm sick, I have a problem, and he wants to see me back in weeks, so I'm going to do that."

And I think patients appreciate the close follow-up and it doesn't, listen, it's not going to be an hour appointment the next time. It could just be a med check, how are you doing, are you getting any nausea, any GI side effects from this, and did you make the phone call for the therapist? Or if I think a psychiatrist is ultimately going to be needed for med management, did you make that phone call? You'd be surprised. Very often they haven't made those calls.

So by reiterating that, reminding them "Look, I'm gonna prescribe this for you today but I really do think that this should be managed best by a psychiatrist, so I need you to make that phone call. Because you're not gonna get an appointment tomorrow. It could be two, four, or six weeks, and the sooner you call, the sooner you're going to get that appointment."

ANITHA IYER

I appreciate you saying that. It's very validating when your physician tells you “I'm just calling to check up on you.” That the feeling of support and how far that goes.

Curious about your experience as a treatment provider, as a physician. Like we're all human right, and so how does, how do these moments, these interactions, situations impact you, and what tips do you have that work for you to take care of yourself?

STEPHEN SISSELMAN

To take care of myself? Well I’m a firm believer that everyone can benefit from some kind of counseling, right, so whether you're a doctor, a nurse, a teacher, a lawyer, whatever you do for a living it doesn't matter—we all at some point need someone to talk to, and it's not always best served your life partner.

So we can all benefit from someone to talk to. So I speak from experience when I say therapy sometimes is so incredibly needed and useful and beneficial, and I don't mind saying I speak from experience, because I think we all have been there and we all, as caregivers, we're probably more prone to feeling certain ways, right, and you need to take care of the caregiver too.

So I'm a believer in that, but in in primary care when you're dealing with high blood pressure, diabetes, high cholesterol, all of these things that we can't cure, we can treat but we know we can't cure, other than an acute infection, mental health is something where you can make such an important difference so quickly.

And when you have someone who's sick in a mental health capacity and you help make them better and they come back to you and they say doctor “thank you, you listened to me, you heard me, you helped me,” I get no better job satisfaction from what I do every day than those patient encounters.

It makes me feel great, and it keeps me going. That's what I need every now and then, some of those thank-yous, and you don't get it. The people who have an abnormal EKG and you send them to the cardiologist and they had a blockage and they wind up with bypass or stent, they're not coming back and saying thank you for listening to me. It's the mental health people who are the most appreciative that you were there for them, I think, and that's what puts a smile on my face and keeps me going.

ANITHA IYER

That's so great to hear. I appreciate you emphasizing that this is not an easy line of work to be in because you absorb so much and we certainly see that in the data. Like the kind of experience of physicians in terms of emotional health, there's higher rates of depression, anxiety, suicidality.

In fact, in our September Mind Matters session we're going to be highlighting how clinicians can take care of themselves, and a resource that Sinai has set up, certainly for employees of Sinai, for mental health in real time mental health services, and I can certainly say that I'm a better clinician because I have been in my own therapy, so I really appreciate you emphasizing all of those—

STEPHEN SISSELMAN

I was actually at that Grand Rounds in Manhattan, before COVID-19, when that program was announced and I thought it was fantastic that such a thing exists and it was great. Remember when we used to do Grand Rounds in person?

ANITHA IYER

Those were the days, yeah. That was before my time at Sinai but they sound amazing. Yeah perhaps one day soon.

But I will say that I think COVID-19 certainly, I think, laid bare what the experience of a human being who goes back. It's really like wartime trauma, to some extent, to go back into the trenches day after day, and you're absorbing, and if there isn't a place for you to go and take care of

your own thoughts and feelings associated with that experience then you're pouring from an empty or an emptier cup each time, right. And so I really appreciate you noting that and emphasizing that.

Before we conclude I wanted to ask if you have any updates about this young man or any reflections on the meeting in the in the couple of months or a month since it's been since the last time you presented that you wanted to share?

STEPHEN SISSELMAN

Well as far as the patient, he continues to do well. He's on his Lexapro 10 milligrams a day, he's seeing a therapist. He never got around to making that appointment with the psychiatrist, but I think over nine months now that he's been on SSRI therapy, and I've been there seeing him monthly now, and his therapist sees him I think now twice a month, he seems to be very stable.

He represents himself as certainly improved and very thankful and has an improved relationship with his family, with his parents, and feels that he can now go to them and talk about how he's feeling and was never able to do that before which is which is great and, again, just a plug for the Mind Matters team, to be able to talk about it with you professionals, people who are at this higher level of care that we wish we had in mental health, and it's just so great to be able to bounce something like this off of this team.

And even last week's case, the amount of stuff that I learned and took away from dealing with insomnia in the mental health world, and even in the general medicine world, is just so important. People come to you, they want benzos, and it's nice to be able to have other tools to be able to use to deflect that, and what else is going on, and really using your skills, taking a thorough history and physical examination. And, as in the case that that was presented, this particular patient had 19 reasons to have insomnia and not everybody is going to light up like a Christmas tree like that patient did, but it's great to be able to have this resource, and you guys are just so wonderful. I've said that before and so thank you very much but it's great to be a part of this and associated with this and it's a great help to us.

And, as you've said, COVID-19 definitely changed so much of our life. It specifically created this overwhelming drought of mental health availability and at the same time created so many more patients who need it and deserve it, and, as primary care, we're often stuck in the middle. And the more we know and the more tools we get to be able to help our patients, the more successful we're going to be and the healthier our population is going to be.

ANITHA IYER

You said it better than I could, I really appreciate again yours and Dr. Jill's support for Mind Matters. Glad that it is useful and glad that you're, with your support, we're building a community, just really appreciate all of your insights on this case. I imagine there are folks in the primary care community that watched it and could immediately relate to cases on their own, in their own practices, that are not dissimilar and I hope they got some takeaways that they can kind of reflect on and apply.

We really appreciate your time Dr. Sisselman. Wish you the best and hope to see you at the next Mind Matters.

STEPHEN SISSELMAN

Yeah and you will, thank you.

ANITHA IYER

Thank you.

Watch the July 2022 Mind Matters meeting with Dr. Stephen Sisselman