WWW.PSYCHNEWS.ORG | NEWSPAPER OF THE AMERICAN PSYCHIATRIC ASSOCIATION | VOLUME 49, NUMBER 12, JUNE 20, 2014

PSYCHIATRIC NEWS

The First and Last Word in Psychiatry

ISSN 0033-2704

Stephen Bobb

Patrick Kennedy, a former member of Congress and now a senior advisor to APA, gives the keynote speech at a summit on child mental health care last month at Children's National Medical Center. "We are operating in a 'fail-first model' " with regard to children, he said.

Changes Needed in Mental Health Care Of Children, Experts Agree

Hospital administrators, pediatricians, psychiatrists, advocacy groups, and legislators share strategies for broadly improving mental health care for America's children and adolescents.

BY JUN YAN

Overcoming the barriers and providing better mental health care for children will require a wide range of changes, from public policies to clinical practices and from local hospitals and school districts to federal laws and regulations. The need to change the current way youth are treated for mental health problems was the key message arising from a multidisciplinary summit held in Washington, D.C.

The summit was organized by Children's National Medical Center, one of the largest children's hospitals in the country. The summit, titled Children's National Summit on Improving Children's Mental Health Care, took place on May 7 and was attended by administrators of children's hospitals, directors of pediatric or psychiatric departments, medical association leadersh, state and federal health care regulators, and several members of Congress.

The summit was a response to a 2013 call to action by the White House to effect improvements in childhood mental health care, according to Kurt Newman, M.D., president and CEO of Children's National Medical Center. The call to action was in part spurred by tragic incidents such as the Sandy Hook Elementary School shooting in Newtown, Conn.

Patrick Kennedy, a former member of Congress and now a senior advisor to

see ***Children's MH Care*** *on page 20*

Court Limits Use of IQ Score In Death Penalty Eligibility

The Supreme Court sides with APA on standards for determining intellectual disability in death-penalty cases.

BY AARON LEVIN

"Intellectual disability is a condition, not a number," said Supreme Court Justice Anthony Kennedy, declaring that states cannot use a fixed IQ score to determine eligibility for the death penalty but must also include a more complex evaluation of adaptive functioning when evaluating intellectual disability.

In a 5-to-4 decision May 27, the Court ruled in favor of Freddie Lee Hall, convicted in Florida of the rape and murder of a 21-year-old woman in 1978.

"This Court agrees with the medical experts that when a defendant's IQ test score falls within the test's acknowledged and inherent margin of error, the defendant must be able to present additional evidence of intellectual disability, including testimony regarding adaptive deficits," Kennedy wrote. Justices Stephen Breyer, Ruth Bader Ginsburg, Elena Kagan, and Sonia Sotomayor concurred.

"As the majority opinion indicates, there are areas where professional expertise can inform the legislature and the courts so that the decision makers will have the consensus of the field

see ***Death Penalty*** *on page 9*

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Psychiatric News, ISSN 0033-2704, is published bi-weekly on the first and third Friday of each month by the American Psychiatric Association, 1000 Wilson Boulevard, Arlington, Va. 22209-3901. Periodicals postage paid at Arlington, Va., and additional mailing offices. Postmaster: send address changes to *Psychiatric News,* APA, Suite 1825, 1000 Wilson Boulevard, Arlington, Va. 22209-3901. Online version: ISSN 1559-1255.

SUBSCRIPTIONS
U.S.: individual, $130. International: APA member, $177; nonmember, $195. Single issues: U.S., $24; international, $41. Institutional subscriptions are tier priced. For site licensing and pricing information, call (800) 368-5777 or email institutions@psych.org.

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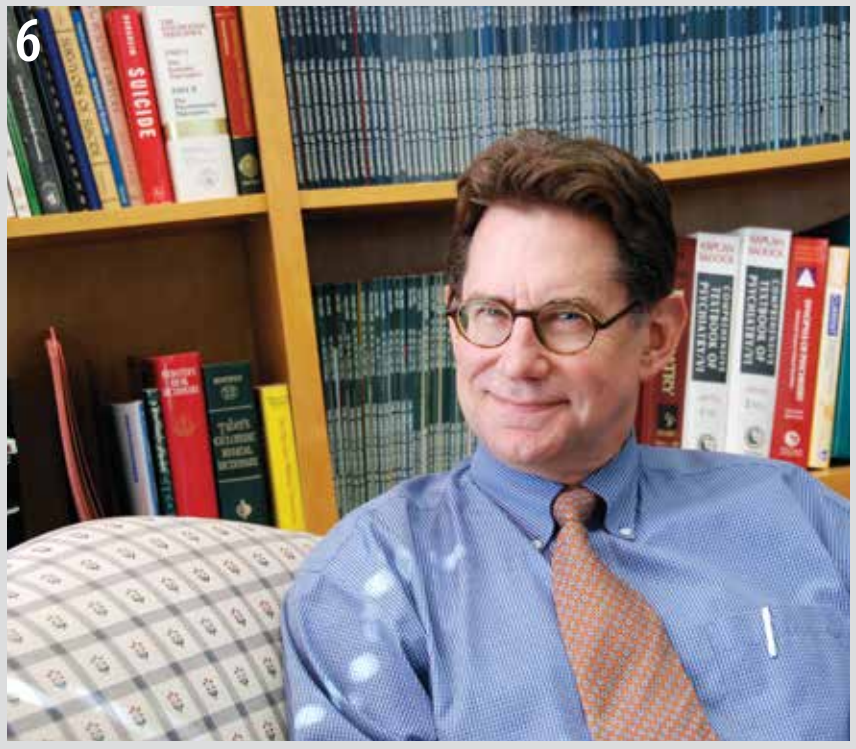

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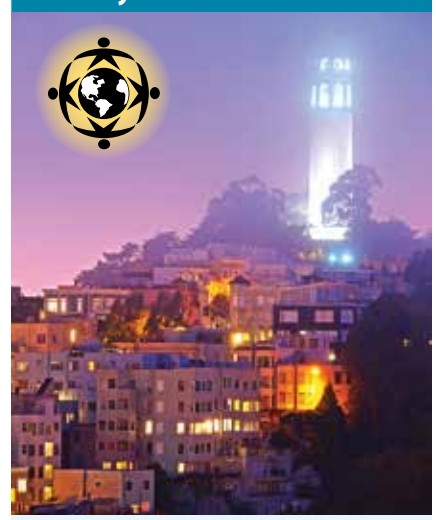

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APA's next major meeting—the Institute on Psychiatric Services—is being held October 30 to November 2 in San Francisco at the San Francisco Marriott Marquis. The meeting is often referred to as APA's "little gem" because of its high quality and intimate size compared with the annual meeting. The theme of this year's institute is "Integrating Science and Care in a New Era of Population Health." Watch this space for more information about advance registration and housing options.

Departments

FROM THE PRESIDENT

APA Poised to Take Advantage of Unique Time in History

BY PAUL SUMMERGRAD, M.D.

I am honored to begin my term as president of APA. First of all, I want to thank Jeffrey Lieberman for the excellent and impassioned job he has done, and I am grateful for his mentorship, example, and support.

We are in a unique period in the history of psychiatry. The recognition and understanding that psychiatric illnesses are the most common disabling and preeminent disorders of young people is now widespread. We are on the cusp of what has been a complex and difficult journey to discover the fundamental mechanisms, underlying genetics, neurobiological substrates, and environmental factors in what have been among the most feared disorders of humankind. This endeavor will not be easy and is testimony to the complexity of the human brain and the unique personal stamp and intimacy of psychiatric disorders. No conditions are closer to our sense of self, and no matter the discoveries about the etiology of these illnesses, their care will always require a respectful attention to the experiences of our patients. It is indeed, as Sigmund Freud reminded us, "not an easy thing to play upon the instrument of the soul."

As we recognize the frequency of these disorders, we also recognize their burden—in human suffering, in wasted lives, in the ravages of the wildfires that race across developing brains, leaving young people stunted and besieged. There is also the cost, both psychological and financial, in years of life lost to disability from both mental and medical illness and in lives languishing in the throes of the judicial and criminal justice systems, instead of a compassionate and caring medical system.

Linked to all of these are stigma, prejudice, and discrimination. Abraham Lincoln, who suffered deeply from depression (or melancholy as it was called in the 19th century) wrote in 1841, "A tendency to melancholy is a misfortune not a fault." Could any of us say this better?

The impact of mental disorders is also not random. Their roots in both neurodevelopment and early-life trauma make them profoundly disruptive over the long course of many lives. This impact is not just regional or national, but global as well, and not just personal, but social and communal in profound ways. These illnesses penetrate everywhere, and so does the shame and stigma that so sadly travel in their wake. Failing to search for the causes of these illnesses with the hope of treating them effectively and humanely is simply, finally, unacceptable.

As psychiatry stands at a cusp, so does APA. We are the oldest medical specialty organization in the United States and the only one that fully bridges the worlds of general medicine and psychiatry. We must lead, not just because it is right for our field, but because it is right for the patients and families we serve. For 170 years, we have been in a position of trust as fiduciaries for our science and profession. We must continue to live up to that trust.

We now have a once-in-a-generation opportunity. We can set a course for our field to allow us to be effective for the next 20 years, or we can miss the possibilities embedded in this moment.

What makes this moment so special? Mental health today is both in the spotlight and under a microscope. Public interest in mental health issues has never been more intense, triggered in part by events that make for tragic headlines and leave us all sick at heart. But despite the polarization in Washington, mental illness is not a partisan affair—as we know all too well, mental disorders have no respect for position, wealth, fame, or political persuasion. The children of Democrats and Republicans, of the rich and poor, can and do fall ill.

But there is a younger generation that has lived with mental illness, who will not stay silent, who will not hide, but will speak out—even sometimes in ways that might discomfort us. They know, as did the early and vocal advocates for gay rights and treatment for AIDS, that "silence equals death."

The very real scientific opportunities before us are unprecedented in human history. We have never before had the capacity to image the brain, to see the impact of genetic abnormalities on neurodevelopment, or begin to understand the complex ways our brains shape our perceptions of the world and in turn are shaped by them. We also live in a world where health care reform is finally being realized and providing opportunities to fully integrate the care of so many of our patients. Who among us would have a child or brother or spouse with mental illness only to watch that loved one die years too soon from a treatable medical condition? These developments are truly once-in-a-lifetime moments that we dare not waste.

So what are the tasks that lie before us?

First, we need to speak on behalf of both our patients and the growing body of science as physician experts on mental health. This means helping others understand what we know so well as physicians—that these illnesses are real, disabling, and strongly associated with medical comorbidity, but also amenable to care, treatment, and the power of contemporary science. To that end, we have a special responsibility to put aside internecine battles, especially those driven by ideology, and go where the science takes us.

Second, we need to advocate for our patients and our profession. Our patients live with stigma, and we do as well. We cannot act in their best interest if we do not speak fully in support of equity and parity. Across this country every day, psychiatrists take excellent care of patients in hospitals, offices, and yes, under bridges and in prisons. Thousands of our colleagues work tirelessly in military and veterans facilities caring for service men and women, and we must lend our energy and support to these critical endeavors as well. With regard to our research and academic mission, it goes without saying that that future is dependent on our creativity and imagination, and we must continue our vigorous support for them.

Third, as we talk about mental health, we need to find simple and direct language to communicate with ourselves, our patients, and the public. We should take advantage of the increased public interest in mental health and partner with allies in the media to amplify our message.

Fourth, we need to embrace our role as international leaders in psychiatry, in a manner that not only reflects the strength of our intellectual and human capital, but is also deeply respectful of the diversity of our own membership and other cultures. Many parts of our world are undergoing enormous social, economic, and political development, and discovering both the importance of mental health in their own countries, in addition to the burden that the stigma of mental illness places on their populations. Colleagues from around the world who are experiencing these cultural upheavals have much to teach us as well.

As we set our course to achieve these

*see **From the President** on facing page*

DSM-5 May Help Educators, Trainees Embrace the 'Whole Child'

A psychiatric educator says the new version of *DSM* is more developmentally oriented than previous editions and provides a clearer expression that most psychiatric illnesses occur across the lifespan.

BY MARK MORAN

The enhanced developmental focus of *DSM-5* can assist in the education of child and adolescent psychiatrists by supporting a renewed emphasis on using diagnostic criteria in conjunction with information on development and context to assess "the whole child."

So says Arden Dingle, M.D., director of child and adolescent psychiatry at Emory University, in an article in the February *Academic Psychiatry* titled, "The *DSM-5*: An Opportunity to Affirm `The Whole Child' Concept in Child and Adolescent Psychiatric Residency Training."

In the article, she says that in conjunction with an evaluation of developmental and environmental characteristics, the *DSM-5* classification provides a framework to describe and conceptualize the emotional and behavioral issues of children and adolescents that can inform and guide treatment. The article was one of six published by the journal to examine the educational implications of the new diagnostic manual for the training of medical students, residents, and fellows.

"The *DSM-5* emphasizes development in the organization of the manual, categorization of the disorders, and the description of diagnostic criteria," Dingle pointed out. "Additionally, the manual's discussion of the dimensional aspects of psychopathology more closely matches how development is conceptualized and understood, making it easier to apply both in clinical situations. Implementing the *DSM-5* provides an opportunity to examine and support strategies to teach and include development as a key element in child and adolescent psychiatry [CAP] education and practice. For example, a true understanding of development and its interface with psychopathology requires exposure to and interaction with typical children and adolescents in their usual environments, such as daycare, schools, and recreational programs to understand individual and group behavior as well as societal and cultural expectations for youth. The *DSM* has the potential to be a strong justification for providing these types of activities in CAP residency training."

Developmental Perspective Is Valuable

In comments to *Psychiatric News*, Dingle said that she believes the developmental perspective of the new manual can help to correct some contemporary tendencies in practice and teaching. "I think as we have learned more about the biology of psychiatric illness in children, had more choices in terms of psychopharmacological treatment, developed more standardized approaches to assessment and treatment, and become more 'doctor-like' in our behavior, we have tended to increasingly emphasize the identification and documentation of symptoms as the main activity of CAP and that other people collect information about other aspects of the child and data about the child's life and environment, if it is collected at all," she said.

"But I don't think we can understand children and their issues if we do not know about their environment, interactions with others, and general psychology," she added. "And I think a number of practitioners have responded to financial and other pressures by trying to diagnose a child in a time-limited session as opposed to spending enough time up front to try and have a reasonable idea or picture of the child and the child's life.

"While the *DSM* diagnostic system is useful and necessary, without knowing the details of a child's life and circumstances, I don't think it is possible to make an adequate diagnosis and treatment plan," she told *Psychiatric News*. "Knowing that a child has ADHD does not tell one enough to develop and implement good treatment."

Arden Dingle, M.D., program director of child and adolescent psychiatry at Emory University School of Medicine, says the new *DSM-5* is a clearer expression that most psychiatric illnesses occur across the lifespan and includes better descriptions of what disorders look like at different ages.

Dingle believes the new version is more developmentally oriented, in terms of the organization of the manual and the information included. "It is a clearer expression that most psychiatric illnesses occur across the lifespan, and it includes better descriptions of what disorders look like at different ages."

Teaching Material Likely to Change

Additionally, she said that any new version forces teachers to revise their presentations and methods of instuction. "So this becomes an opportunity for educators to reincorporate these aspects of the assessment into the expected or standard approach to evaluation," she said.

In the run-up to publication, *DSM-5* attracted much attention and some concern about changes to certain criteria. But Dingle said the publication of the revised manual provide an important opportunity to teach students and trainees about the evolving knowledge base of neuroscience and psychiatry, as well as the limitations of diagnostic criteria.

In the article, Dingle said that "introduction of the *DSM-5* is an opportunity to formally discuss how diagnostic classification systems are conceptualized and developed, their strengths and weaknesses, and how these systems reflect and influence our concepts of psychiatric illnesses and their care. It also can help trainees enhance and refine their knowledge and skills, as well as develop and maintain the ability to be flexible, problem solve, and prioritize in clinical situations."

In comments to *Psychiatric News*, she said it is an opportunity for educators themselves to demonstrate that one can be skilled and competent and still need to learn more about developments in their field.

"I generally teach psychopathology using the approach that it is important to understand what the core deficits and problems are for a disorder, how these problems might be demonstrated in children of various ages, and the strengths and limitations of the diagnostic criteria in describing these core issues," she said. "In this context, it is important to discuss and understand the limitations of diagnostic criteria, especially for high-functioning individuals." PN

"The *DSM-5:* An Opportunity to Endorse the `Whole Child' Concept in Child and Adolescent Psychiatric Residency Training" is posted at http://link.springer.com/article/10.1007/s40596-013-0007-5.

From the President

continued from facing page

goals, we must remember that none of these are the work of one president or one board or one moment in time. These are the ongoing tasks that must animate this great organization and profession for years to come. None of this will come quickly. Indeed we have already been on a long journey for knowledge and justice. In his quest for civil rights, the words of Martin Luther King Jr. ring just as true about our work today and in the future: "The arc of the moral universe is long, but it bends toward justice."

Our patients, their families, and our profession need our counsel, guidance, and selfless efforts, so that when we look back, we can all be proud of our work and accomplishments. I am honored to take on this responsibility—to serve and to work for the benefit of our patients, our profession, and our communities—and to work with you to achieve these ends. PN

MUR Members: Get Ready For Next Year's Election

In APA's 2015 election, the position of minority and underrepresented (MUR) group trustee will appear on the ballot. Only enrolled members of the MUR caucuses may vote for the MUR trustee. Psychiatrists who identify with any of APA's recognized MUR groups and are not enrolled in a caucus are urged to join by **December 1** in order to receive a ballot that permits voting for this position. Members with a valid email address on file with APA will receive an electronic ballot via email; members without a valid email address on file will receive a paper ballot. To join a caucus or check your caucus status, log on to Online Member Profile at www.psych.org; select Section 3: Current Practice and Professional Activities; and then go to question 3Fa APA Minority and Underrepresented Group Caucus Membership. There are seven MUR caucuses: American Indian/Alaska Native/Native Hawaiian, Asian American, Black, Hispanic, Lesbian/Gay/Bisexual, International Medical Graduate, and Women.

PROFESSIONAL NEWS

Task Force Recommends Against Suicide Screening in Primary Care

Experts agree there would be much greater utility in screening for depression and anxiety in primary care rather than for suicide risk.

BY MARK MORAN

Jan Fawcett, M.D.

Jan Fawcett, M.D., says evidence doesn't show that a primary care provider can prevent a suicide or determine which patients scoring high on a scale are "really" suicidal.

Evidence for the effectiveness of screening for suicide risk in primary care practices is insufficient and is not recommended, according to the United States Preventive Services Task Force (USPSTF).

The USPSTF reviewed evidence on the accuracy and reliability of instruments used to screen for increased suicide risk, benefits and harms of screening for increased suicide risk, and benefits and harms of treatments to prevent suicide. The reviewed studies used various screening tools in primary care patients aged 18 to 70.

The sensitivity and specificity of screening tools generally ranged from 52 percent to 100 percent and from 60 percent to 98 percent, respectively. The instruments showed a wide range in accuracy, but data were limited, and no instruments were examined in more than one study.

The USPSTF concluded in a report in the May 20 *Annals of Internal Medicine* that the "evidence is insufficient to assess the balance of benefits and harms of screening for suicide risk in adolescents, adults, and older adults in a primary care setting."

Several clinicians with expertise in suicide issues say that the USPSTF recommendation is wise and not surprising. And all agreed on the greater utility of screening for major depression.

"Screening for suicide, as opposed to suicidal behaviors, has a low specificity and sensitivity rate," said Jan Fawcett, M.D., who was chair of the *DSM-5* Mood Disorder Work Group and Suicide Sub-Work Group. "What should the primary care physician do to prevent the predicted suicide? Send the patient to an emergency department? Try to admit the patient involuntarily for psychiatric care? There is no evidence that the primary care provider can prevent a suicide, much less determine which patients scoring high on the scale are `really' suicidal. Why should the primary care physician want to accumulate high suicide screens if he or she cannot do anything about them and can be held liable for not being successful?

"Perhaps teaching primary care clinicians to evaluate, treat, and refer suicidal depression patients would be more useful than using untested check lists from patients," Fawcett said.

Eric Caine, M.D., co-director of the Center for the Study of Prevention of Suicide at the University of Rochester Medical Center, said he believes the USPSTF recommendation makes a lot of sense. "Having a diagnosis of major depression may increase the risk for suicide 50 fold," he told *Psychiatric News*. "The suicide rate is approximately 12 per 100,000 persons in the general population; it is about 600 per 100,000 persons with major depression. One would find 600 deaths of persons with major depression during the ensuing year, and 99,400 with major depression who won't die," Caine said.

"So, if I were seeing a person with major depression I would be correct more than 99 percent of the time saying that she or he won't die by suicide even without evaluating the person. Screening a general population will not have utility as suicide prevention and will identify many persons 'at risk' who never will die [by suicide], but will be labeled as such with potential consequences.

Likelihood of Detection Extremely Low

"In a general medical setting, the likelihood of detecting a suicidal person is very, very low," Caine said. "At the same time, I very much support assessing the burden of distress and depression in general medical patients—not for the purposes of suicide prevention but for the fact that they are burdened and very much need further evaluation and, very often, treatment."

Yeates Conwell, M.D., director of the geriatric psychiatry program at the University of Rochester Medical Center and an expert on depression and suicide among the elderly, concurred.

Aaron Levin

Yeates Conwell, M.D., says there are costs to screening for suicide risk in false negatives and false positives and points out that questions remain about the most effective way to respond to the true positives.

"The great majority of people who take their own lives have a mental illness, and depression is most common in primary care," Conwell said. "Most of those patients, therefore, will be picked up by regular depression screening in that setting, which this recommendation does not address and is increasingly standard practice in primary care."

Conwell said there are individuals who are at risk but don't have depression, and others with depression who screen positive but deny suicidal ideation. "My take is that the task force recommendations reflect shortcomings in our knowledge about how best to elicit thoughts that indicate risk, and how to interpret and optimally respond," he said. "When are thoughts of death without intent in an older person normal, for example, and when are they signs about which we should be concerned and intervene? There are costs to screening, of course, in false negatives and false positives, and even questions that have still to be answered about what is the most effective way to respond to the true positives."

Suicide Contagion Can Be a Risk

And David Shaffer, M.D., of Columbia University, an expert on epidemiology of adolescent suicide, said the recommendation makes sense for adolescence, a time when suicides are rare despite the fact that suicide ideation is much more common than at any other time in life.

He said the real risk factors for adolescent suicide—alcohol abuse for boys and anxiety coupled with depression for both genders—are under-identified. "They are very much worth identifying and treating, not for the relatively rare outcome of suicide within those groups, but because of their much more common impact on education and early working experience and social development," Shaffer said. "Alcohol abuse is also important as a cause of mortality in road traffic accidents. Anxiety disorders are the diagnoses that are the least likely to have been identified by parents as a problem, with 60 percent of anxiety-disordered teenagers never having been identified, diagnosed, or treated—a situation that calls out for universal screening. The introduction of routine preventive screening for anxiety and for alcohol abuse during adolescence would require further research but would represent a major advance in preventive mental health." PN

"Screening for Suicide Risk in Adolescents, Adults, and Older Adults in Primary Care: U.S. Preventive Services Task Force Recommendation Statement" is posted at http://annals.org/article.aspx?articleid=1872851.

PROFESSIONAL NEWS

Despite Progress on Many Fronts, Gay Community Still Faces Violence

Gay and lesbian individuals have won the right to marry in 18 states, and same-sex married couples are now eligible for federal benefits, but despite this progress, hate crimes directed at them have increased 4.3 percent since 2006.

BY VABREN WATTS

Although federal laws and those in several states have granted some civil rights to individuals who identify as lesbian, gay, bisexual, or transgender (LGBT), violence against people of the LGBT community remains a major concern.

"I gave a lecture on violence among LGBT people in 2006 at the [APA] annual meeting," Philip Bialer, M.D., an attending psychiatrist at Memorial Sloan Kettering Cancer Center, told attendees at a session on violence directed at minorities at last month's APA annual meeting. "It is disconcerting that since 2006, anti-LGBT violence has gotten worse—at least in terms of the numbers."

In 2012, the Federal Bureau of Investigation reported approximately 6,000 hate-crime incidents in the United States, with 19.6 percent of those crimes resulting from sexual-orientation bias—up from the 15.3 percent reported in 2006.

Memorial Sloan Kettering Cancer Center

Philip Bialer, M.D., maintains that to reduce bias and hate crimes directed at LGBT individuals, sexual orientation and gender identity must be included in all federal and state antidiscrimination legislation.

During an interview with *Psychiatric News*, Bialer, who is also an associate professor of clinical psychiatry at Weill Cornell Medical College, explained that until late in the 20th century, most criminal offenses that were reported as hate crimes were based on "perceived race, color, religion, or national origin." Sexual orientation was finally added to the list under the Hate Crime Statics Act of 1990. The act was amended in 2009 to include gender and gender identity.

According to the National Coalition of Anti-Violence Programs (NCAVP), the most common forms of violence reported against LGBT people are verbal harassment, threats and intimidation, and physical violence. LGBT individuals who are white are twice as likely as those who are members of ethnic minorities to report such incidents; however, ethnic minorities and transgender individuals are more likely to suffer more severe attacks.

"People of color and transgender women are at very high risk for severe anti-LGBT violence and even homicide," Bialer said at the meeting. He cited statistics from the NCAVP showing that African Americans accounted for 54 percent of homicide victims of anti-LGBT hate crimes in 2012, compared with 15 percent and 11.5 percent, respectively, reported among Latino and Caucasian populations. Transgender women, regardless of race, accounted for over half of the acts of violence against LGBT individuals that resulted in homicide.

Because ethnic minority and transgender women are at high risk for sexual-orientation bias crimes and less likely to report violence, Bialer emphasized that it is of utmost importance for LGBT support groups to devote more effort to ensuring that these higher-risk populations for anti-LGBT violence feel more comfortable and accepted when seeking support.

Bialer also addressed other issues that impact the health of LGBT individuals, particularly increased hostility against LGBT individuals by some police and first responders, bullying of LGBT youth, and increased rates of suicidality and negative behaviors such as substance use and binge drinking that may be attributed to being victims of discrimination or targets for violent acts.

Bialer told *Psychiatric News* that

see ***Hate Crimes*** *on page 19*

Violence Against Youth Declined Over Last Several Years

Whatever the reasons—for example, school-based programs targeting bullying or interpersonal conflict—violence directed against America's youth appears to be declining.

BY JOAN AREHART-TREICHEL

Even though shootings at schools, theaters, or malls dominate the news, it looks as if violence directed against America's youth is on a downward trajectory.

This is a key finding from a study conducted by David Finkelhor, Ph.D., director of the Crimes Against Children Research Center at the University of New Hampshire, and colleagues. The results were published April 28 in *JAMA Pediatrics.*

The study was based on three national telephone surveys of representative samples of children and adolescents and their caregivers from 2003, 2008, and 2011. Each survey concerned children's victimization by violence.

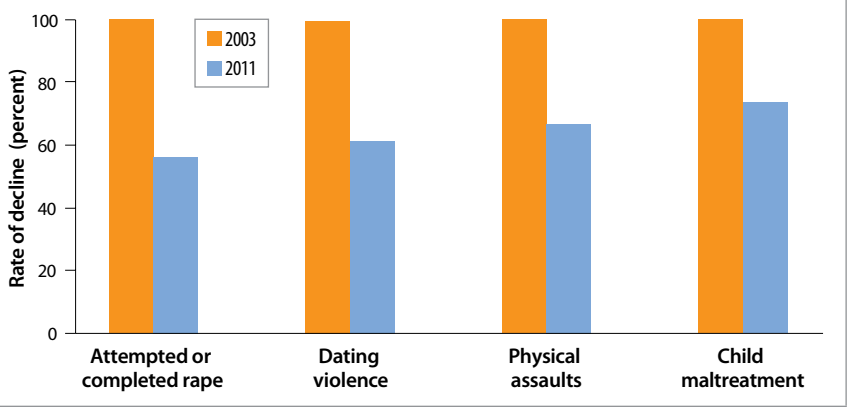
During each of the three surveys, a short interview was conducted with an adult caregiver (usually a parent) to obtain demographic information. The youngster in the household with the most recent birthday was selected for an interview. If the selected child or adolescent was aged 10 to 17, the interview was conducted with the child. If the child was younger than age 10, the interview was conducted with the caregiver.

Survey results from nearly 1,100 youth were analyzed.

The researchers used the survey results to track trends in 50 aspects of youth victimization by violence from 2003 to 2011—for example, a physical assault with no weapon or injury, an assault by a peer or sibling, property victimization, sexual assault by a known adult, attempted or completed rape, bullying, or dating violence. Even when demographic variables were controlled, there were 27 significant declines and no significant increases in these trends during the eight years.

Youth Are Less Likely to Be Violence Victims

Researchers tracked trends in 50 aspects of youth victimization by violence between 2003 and 2011. Even when demographic variables were controlled, there were 27 significant declines and no significant increases in these trends during these eight years. For example, attempted or completed rape declined 43 percent, dating violence declined 39 percent, physical assaults in general declined 33 percent, and child maltreatment declined 26 percent.



For example, attempted or completed rape declined 43 percent, dating violence declined 39 percent, physical assaults in general declined 33 percent, and child maltreatment declined 26 percent.

The major recession that started in 2008 did not appear to reverse the downward trends, although there were fewer significant declines during the 2008 to 2011 period than during the six preceding years. "This suggests that although the recession may have caused much hardship, it did not translate into more violence and crime exposure for children

see ***Violence*** *on page 21*

Coercion and Autonomy Sometimes Collide in Patient-Care Decisions

Involuntary treatment should be invoked carefully and with close attention to the patient's decision-making capacity, caution forensic psychiatry experts.

BY AARON LEVIN

A single standard should apply to decision-making capacity for both physical and mental illnesses, said George Szmukler, M.D., Ph.D., at APA's annual meeting in New York in May.

"In physical disorders, a high value is placed on autonomy, even when there is a high risk of death," said Szmukler, a professor of psychiatry and society in the Institute of Psychiatry at King's College London. "But for mental illness, there is a stereotype that people with mental illness are not capable of making decisions about their care."

Coercion in mental health care has a long but highly variable history in psychiatry, said Paul Appelbaum, M.D., the Dollard Professor of Psychiatry, Medicine, and Law and director of the Division of Law, Ethics, and Psychiatry at Columbia University College of Physicians and Surgeons, speaking at the same session.

In the United States, individuals with mental illness could be committed to a workhouse under the "poor laws" in colonial times, he said. In 1752, people with mental illness were treated at the Pennsylvania Hospital (the nation's first) with other patients, but there was no legal oversight, and the patient's fate was controlled by his or her family, he continued.

In 1833, Worcester State Hospital opened in Massachusetts, ushering in the era of "moral treatment" in big state hospitals. Voluntary admission began in 1881—initially in Massachusetts, but eventually spreading to other states—but most patients in the following decades were still committed involuntarily.

"People with mental illness were presumed to be not competent to make their own decisions, and the burden was placed on the individual to show restoration of competence," Appelbaum pointed out.

Those views lasted until the 1960s and 1970s, when institutional care became seen as inherently worse than community care for the vast majority of psychiatric patients, and the state's power to intervene became limited to a standard of danger to self or others, he said. The dream then was that involuntary hospitalization would "wither away."

"Involuntary approaches are still with us, but the locus has moved into the community," Appelbaum said. "The leveraged approaches used can be formal or informal, legal or extralegal, overt or subtle."

Thus, compliance today may not depend on commitment orders but on the patient's interest in avoiding jail or hospitalization, maintaining parental custody or student status, or other implied or explicit consequences.

"In the end, neither a blanket rejection nor acceptance of coercion is warranted," said Appelbaum. "Many people with mental illnesses can and should make decisions for themselves, but the nature of mental illnesses may justify coercive interventions."

Much hinges on the patient's autonomy, said Arthur Caplan, Ph.D., a professor and head of the Division of Bioethics at New York University Langone Medical Center. "It makes sense ethically to intrude on a person's autonomy in the short run if you can build back autonomy in the long run, even if in the short run you may override someone who is manifestly competent."

Autonomy is the ability to make a choice based on the capacity to reason to a goal or action, using standards in line with accepted conventions of reality, he said.

But it also means having choices. Autonomy requires privacy and time to consider options without pressure. Those options must be authentic and not constricted by real-world considerations such as poverty or addiction. And patients need dignity—a respect for oneself and for the autonomy of others, he said.

Treating people with addictions is complicated by the reality that some addicts are not necessarily incompetent but their compulsions for a substance render them less than fully autonomous. That may permit justifiable intrusion into autonomy, given evidence that treatment works, is safe and can be stopped, and can be reviewed within reasonable time limits, said Caplan.

Szmukler suggested a "fusion proposal." He said, "A single law would apply to all patients for any nonconsensual, involuntary, or facilitated treatment, without reference to mental disorders," he said. "It would cover all illnesses in all settings in which the person has difficulty in decision making."

Patients would be assumed to have decision-making capacity unless otherwise established, he continued. "All practicable steps must first be taken before the person is considered as unable to decide. Any act or decision made on behalf of someone must be done, or made, in his or her best interests."

"Best interests" means the choices the patients would have made had they retained capacity. An advance health care statement is the best way of making those interests clear, he said. Involuntary treatment is indicated in emergencies but with a stepped process of assessment accompanied by independent review and accountability mechanisms.

"If patients retain decision-making capacity and refuse treatment, they should be treated like any other patient," he said. "And all people who are equally risky should be equally subject to detention." PN

Death Penalty

continued from page 1

before them in these very important determinations," said APA President Paul Summergrad, M.D., the Dr. Frances S. Arkin Professor and Chairman of Psychiatry and Professor of Medicine at Tufts University School of Medicine and psychiatrist-in-chief at Tufts Medical Center.

Florida law set an automatic cutoff at an IQ of 70, and Hall had scored at least 71 on several IQ tests. However, Hall's attorneys said that result failed to account for an inherent five-point error of measurement and ignored recent research findings into intellectual disability.

The court agreed, saying that use of an IQ score alone created an unacceptable and unconstitutional risk that a person with intellectual disability would be executed.

"An IQ score is an approximation, not a final and infallible assessment of intellectual functioning," wrote Kennedy. "A State that ignores the inherent imprecision of these tests risks executing a person who suffers from intellectual disability."

The majority's view quoted heavily from the amicus curiae brief submitted by APA and the American Psychological Association. The brief in turn was grounded in the research underlying *DSM-5*'s discussion of intellectual disability.

"The Court's decision in *Hall* recognizes that criteria for diagnosis of mental disorders—here specifically intellectual disability—should be determined by professional standards, not by the arbitrary decisions of state legislatures," said Paul Appelbaum, M.D., the Dollard Professor of Psychiatry, Medicine, and Law and director of the Division of Law, Ethics, and Psychiatry at Columbia University College of Physicians and Surgeons, in an interview. "From a court that is often skeptical of psychiatry, this is a major acknowledgment that courts should turn to psychiatry when issues related to the diagnosis of mental disorders arise."

More specifically, the court accepted the view of intellectual disability as a neurodevelopmental disorder, said neuropsychiatrist James Harris, M.D., a professor of psychiatry and behavioral sciences and pediatrics at Hopkins University, in an interview with *Psychiatric News*.

"IQ alone is insufficient to assess reason and functioning in real-life situations," said Harris. Evaluation now must also include conceptual skills, social reasoning, and practical problem-solving abilities.

The *Hall* case, perhaps inevitably, grew out of gray areas in *Atkins v. Virginia* (2002). The Court said then that the Eighth and 14th amendments to the Constitution forbade execution of persons with intellectual disability, but left it up to the states to define that term.

The dissenting justices, led by Samuel Alito Jr., said the *Hall* decision was based not on precedent and society's "evolving standards of decency" but on the evolving standards of "a small professional elite"—standards that were "likely to result in confusion."

However, Kennedy noted that not one medical professional had supported Florida's position.

"We've finally gotten to the point where the Supreme Court has acknowledged the role of professional organizations," said Harris. "This is a victory for science." PN

APA's amicus curiae brief is posted at http://www.psychiatry.org/File%20Library/Learn/Archives/amicus_2013_Hall.pdf. The text of the U.S. Supreme Court's decision, including the dissent, is posted at http://www.supremecourt.gov/opinions/13pdf/12-10882_36g4.pdf.

LEGAL NEWS

When APA Decides to Go to Court

When the needs of the profession or patients demand it, APA may enter the courtroom in one of several roles.

BY AARON LEVIN

David Hathcox

APA's Committee on Judicial Action makes recommendations to APA leadership on court cases involving mental health, explained former APA president Paul Appelbaum, M.D. (left), and Howard Zonana, M.D., at the APA annual meeting in New York.

In the American justice system, APA's Committee on Judicial Action plays many roles, from a concerned bystander to a full participant, said speakers at APA's annual meeting in New York in May.

In one long-running case, for example, the committee joined with other mental health organizations in an amicus curiae ("friend of the court") brief in *Hall v. Florida*, a case argued in March before the U.S. Supreme Court. The brief opposed Florida's use of a fixed IQ score of 70 to determine a convict's eligibility for the death penalty (see page 1).

Under previous Supreme Court rulings, 18 states had barred executions for people with intellectual disabilities because, it said, "execution doesn't contribute to goals of retribution or deterrence."

DSM-5 uses three criteria to define intellectual disability: an IQ score below 70, deficits in adaptive functioning, and onset during development—although no specific time parameter is cited.

"However, the court did not ask about the *DSM-5* definition of intellectual disability in oral arguments," said former APA President Paul Appelbaum, M.D., the Dollard Professor of Psychiatry, Medicine, and Law at Columbia University College of Physicians and Surgeons. "They were looking for a bright line and focused on the IQ test's standard error of measurement, which has a range of plus or minus 5 points" (*Psychiatric News*, April 1).

The committee also provides APA district branches and state associations with substantive help in cases with important professional implications, said Yale University forensic psychiatrist Howard Zonana, M.D. In the New York state case, *N.Y. v. Rivera*, for example, it provided funds and a review of appellate briefs by a Washington, D.C., attorney specializing in appeals work. That case attempts to clarify whether the mandatory duty to report child abuse overrides confidentiality and attorney-client privilege when the examining psychiatrist or psychologist is hired by the defendant's attorney.

As a practical matter, most attorneys know about the reporting law, but the status of those employed by them is at issue in the *Rivera* case, said Zonana.

"I tell a defendant that I will report if he reveals child abuse," he said. "But most states have not answered the question about mandated reporting when working for a lawyer."

In a third case, APA and others filed suit against Connecticut's Anthem Health Plans regarding certain nonquantitative treatment limitations, which APA and the other amici say violates the Mental Health Parity and Addiction Equity Act, said Marvin Swartz, M.D., a professor of psychiatry and behavioral sciences at Duke University.

Quantitative limits include terms such as annual maximum payments or time limits. Nonquantitative limits include utilization reviews or requiring a visit on a different day to a second provider in order for a patient to receive psychotherapy treatment.

Anthem thus imposes "double copayments on psychiatric patients, reduces reimbursement rates for psychiatrists, creates disparities in rates between mental health and medical/surgical services, and fails to pay for psychotherapy by psychiatric physicians," according to APA's complaint. This case is still in the Connecticut courts (*Psychiatric News*, April 5, 2013).

Such active roles have to be carefully chosen for their wider impact on the profession and patients. "Being a party to a case is very expensive and thus limits the number of cases APA can pursue," Swartz explained. But the ability to have APA's voice heard "is important for patients." PN

Applications Invited for Congressional Fellowship

The American Psychiatric Foundation is inviting nominations for the Jeanne Spurlock, M.D., Congressional Fellowship. This fellowship provides psychiatry residents, fellows, and early career psychiatrists a unique opportunity to work on Capitol Hill in a congressional office on federal health policy, particularly policy related to child and/or minority issues. The fellowship was established in honor of the late Jeanne Spurlock, M.D., who was deputy medical director and head of APA's Office of Minority/National Affairs and an advocate for child and minority issues.

The fellowship is open to all psychiatry residents, fellows, and early career psychiatrists. Applicants must be APA members and U.S. citizens or permanent residents. Applications, in the form of a letter, three letters of recommendation, and a CV, should be sent by July 10 to Marilyn King, APA Division of Diversity and Health Equity, 1000 Wilson Boulevard, Suite 1825, Arlington, Va. 22209.

ANNUAL MEETING

Photos Help Tell Story of APA's Annual Meeting

With more than 16,000 people in attendance, a speech by Vice President Joe Biden, and a scientific program replete with leading lights in clinical practice and research, last month's annual meeting in New York was a rousing success. Here is just a sampling of the many highlights (additional annual meeting articles and photos appeared in the June 6 issue). APA's next meeting, the Institute on Psychiatric Services, will be held in San Francisco October 30 to November 2.

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1 Otto Kernberg, M.D., John Gunderson, M.D., and Paul Links, M.D., chat with meeting attendees at an author-signing event by American Psychiatric Publishing.

2 APA members enjoy a moment of rest in the Exhibit Hall.

3 Outgoing APA President Jeffrey Lieberman, M.D., presents a check to Nancy Olecki, director of development of the Doe Fund, for $20,000. The Doe Fund was chosen as the recipient of this year's "APA Gives Back" program, which was created as a way to give thanks to the annual meeting's host city. Donations continued throughout the meeting, reaching a final total of $23,786.

4 Gopinath Gorthy, M.D., discusses his new-research poster with Sharvari Shivanekar, M.D.

5 Mary Giliberti, J.D., the executive director of NAMI, presents its Exemplary Psychiatrist Award to R. Murali Krishna, M.D., at the APA-NAMI breakfast held during the annual meeting.

6 Ericka Goodwin, M.D., Patty Ordorica, M.D., Ruby Lekwauwa M.D., Silvia Olarte, M.D., Catherine Roberts, M.D., and Amy Poon, M.D., gather in the APA Women's Center. The center was created to give women psychiatrists a place to connect with friends and colleagues, dialogue about women's issues, and exchange career advice.

Photos: David Hathcox (1,3-6) and Ellen Dallager (2)

RESIDENTS' FORUM

Annual Meeting Activities Put Residents in Spotlight

BY LARA COX, M.D.

I am always excited when I anticipate going to the APA annual meeting, and I was even more thrilled than usual this year since the meeting was in my adopted hometown of New York City. With the largest turnout of any annual meeting in recent memory, it seems I was not alone!

The highlights included talks by luminaries including Alan Alda, Eric Kandel, and Joe Biden, along with sessions by our colleagues on a multitude of important topics. For the first time, this year there was an official resident track, with sessions designed especially for (and often by) resident-fellow members (RFMs)— and there were also many fantastic opportunities for us to network with our peers, more-senior colleagues, and APA leadership.

One key venue for this was the Resident Resource Center (RRC), a designated place for RFMs to relax and get information about the meeting and the city. This is the second year that we've had an RRC, thanks to the hard work of our outgoing RFM trustee Erik Vanderlip. This year, it was a space free from scientific programming. There were daily brown-bag lunches for informal advice and mentoring by leaders from a number of the subspecialty organizations, and several of them also passed along additional leadership opportunities for RFMs within their groups. The RFM Caucus also met in the RRC on both Monday and Tuesday afternoons. On Monday, we were joined by Dr. Renée Binder, APA's president-elect, for a wonderful, intimate brainstorming session on how best to recruit, engage, and retain young members.

We also had the chance to talk with experienced psychiatrists at the early-morning Meet the Experts breakfast, the Women's Mentoring Breakfast, and the Early Career Research breakfast. Outside of the meeting itself, we explored the city and got to know other RFMs as well as early career psychiatrists and medical students from the PsychSIGN group at a series of stellar social events organized by incoming RFM Trustee-Elect Ravi Shah, who is a PGY-2 at Columbia. We kept up with the real-time info on these events via the Annual Meeting Resident Edition Facebook page, which had more than 450 members! Ravi said, "I had the opportunity to meet residents and fellows from all over the country and even the world, all with their own unique backgrounds, experience, and plans for the future. Many expressed interest in participating in APA leadership and opportunities, and I realized so many people want to be involved. I must say after my first annual meeting, I have never been more excited about our field's future."

I couldn't agree more! Every year that I've been to the annual meeting, I leave exhausted from the whirlwind pace and at the same time energized by meeting so many other psychiatrists who are passionate about improving conditions for our patients and our colleagues and by getting more exposure to APA's amazing work. For example, Uyen-Khanh Quang-Dang, who is a PGY-4 at the University of California, San Francisco, and the outgoing president of the APA Leadership Fellowship, not only presented at a workshop on mentoring but chaired both a workshop on media appearances and a symposium on issues of patient suicide during residency. She put it beautifully in saying, "APA has worked hard to build meaningful relationships so that mental health awareness is brought to Capitol Hill and the national stage. It's one of the many reasons why I wholeheartedly believe that every single psychiatrist should be a member of APA. The Association's tireless advocacy benefits all of us. We wouldn't be at the policymaking table without APA."

This year's meeting was a resounding success, and a great kickoff to what I'm sure will be an incredibly rewarding year as the RFM trustee. I'm looking forward to working with you, and I want to encourage you to take advantage of the many opportunities APA has to offer! Jon Fanning, who is APA's new chief membership and RFM-ECP officer, put together a handbook listing all of the ways to get involved. You can find it on the resident page at http://www.psychiatry.org/residents. One of my goals this year is to help connect RFMs to the wealth of information and resources that APA has to offer—and to help integrate the many talented and motivated RFMs who want to make a difference in their local and national communities into APA as a whole. So please feel free to email me any time at larajcox.apa@gmail.com. I can't wait to hear from you! PN

Lara Cox, M.D., is the resident-fellow member trustee on the APA Board and a fourth-year resident at New York University.

MEMBERS IN THE NEWS

Psychiatrist/Marathon Runner Shows She Is 'Boston Strong'

Psychiatrists and mental health clinicians helped Bostonians navigate the devastating aftermath of the 2013 Boston Marathon bombing.

BY LYNNE LAMBERG

At mile 20 of this year's Boston Marathon, just before Heartbreak Hill, psychiatrist Nancy Rappaport, M.D., paused to ask a spectator to repin her nametag higher on her chest.

"I wanted my name to be easy to see," Rappaport told *Psychiatric News*. "Hearing 'Go, Nancy,' and other cheering helped me keep moving."

An associate professor of psychiatry at Harvard Medical School, Rappaport, 54, completed the 26.2 mile run—her 11th Boston Marathon—in 4 hours, 52 minutes, 53 seconds.

She was among 31,931 runners and 53 wheelchair participants who finished this year's race. An estimated 1 million people lined Boston's streets to watch it, double the usual turnout.

"This year's marathon was all about endurance," Rappaport said. "It reflected the community's determination not to be defined by last year's tragedy."

Three people were killed, and 264 were injured, including 16 who lost limbs, when two bombs were detonated near the finish line of last year's race.

Nancy Rappaport, M.D.

Psychiatrist Nancy Rappaport, M.D., celebrates completion of the 2014 Boston Marathon on Boylston Street, near the site of last year's bombings. Rappaport raised nearly $16,000 with her run for Samaritans, a Boston-area suicide prevention group.

While Rappaport did not run last year—she was at home studying for her recertification exam in child psychiatry—her daughter Lila was among spectators near the finish line.

"When a friend called to tell me about the bombs, I was frantic," she recalled. "At first, I couldn't remember my daughter's cell phone number. Then cell phones weren't working. I finally reached one of her friends and learned Lila was safe."

Rappaport also soon learned the alleged bombers, Tamerlan Tsarnaev, who was killed in a shootout with police, and Dzhokhar Tsarnaev, whose trial is scheduled for November, were recent graduates of Cambridge Rindge and Latin High School, where she has worked for more than 20 years as an attending child psychiatrist. She also directs school-based mental health programs at Cambridge Health Alliance.

Rappaport met with the Cambridge Public Schools' superintendent, principal, and director of safety and security before the first school day after the bombings, and later met with school social workers, teachers, students, and parents. The son and daughter-in-law of retired school staff members lost limbs in the bombings. Over the past year, "one of my most professionally challenging times," she said, has been coordinating clinician support for the schools.

Lawrence Abrams, Ph.D., a staff psychologist and director of psychology training at the Brookline Community Mental Health Center (CMHC), had an experience at last year's marathon similar to Rappaport's. His son Jake was among the runners.

Watching the race at mile 23, the Brookline CMHC's location, Abrams and his wife learned about the bombs when their daughter called from Philadelphia to ask if Jake was OK. "We couldn't reach him on his cell phone," Abrams recalled. After an anxiety-filled 45 minutes, they learned Jake had crossed the finish line before the bombs went off and left the area.

This year, Abrams, a runner himself, served as mental health coach for the 42-member Brookline running team, whose members raised funds for four Brookline nonprofits, including the CMHC.

Ten team members ran in last year's marathon, but because of the bombings, eight had to stop before reaching the finish line. None was physically injured.

Some voiced feelings of anxiety, Abrams said, not typical pre-race jitters, but concerns about safety. Some wondered if it was all right to have positive feelings about participating.

I told them the anniversary of a trauma often stirs up event-related feelings, images, and bodily sensations, he said, and that such experiences are both normal

see ***Marathon Runner*** *on page 19*

Promoting Resilience

In the weeks before this year's Boston Marathon, the Boston Public Health Commission (BPHC) expanded its community mental health outreach services, Donna Ruscavage, M.S.W., interim director of BPHC's Family Assistance Center, told *Psychiatric News*.

BPHC held community forums, offered free drop-in consultations with mental health clinicians, staffed the mayor's telephone helpline with mental health clinicians, and developed and distributed marathon anniversary coping guides via community mental health centers, hospitals, schools, and other organizations.

Starting within hours of last year's bombings, Ruscavage said, BPHC, first-responder teams, and organizations such as the Massachusetts Office for Victim Assistance (MOVA), Red Cross, and Salvation Army coordinated their efforts, providing crisis intervention services to thousands of people in the past year.

BPHC also has provided individual counseling, referrals, and a support group for physically injured survivors, family members, and friends, Ruscavage said. It helped develop a moderated online forum for survivors and families, with three-year support from Microsoft. MOVA's new resilience forums will provide additional services to survivors, families, first responders, and others.

Cornell Residents Win MindGames Competition

Do you know the name of the American physician who wrote *Observations Upon the Diseases of the Mind* in 1812? Can you name the disability assessment tool recommended in Section III of *DSM-5*? And who was the rock star who wrote "Nevermind" and who suffered from depression and substance abuse and died by suicide?

Those were just a few of the questions psychiatry residents from three training programs answered during the 2014 MindGames competition at APA's annual meeting last month. (The answers: 1. Benjamin Rush 2. The World Health Organization Disability Assessment Schedule 2.0 [WHODAS 2.0] 3. Kurt Cobain.)

New York-Presbyterian/Weill Cornell Medical Center emerged victorious in the "Jeopardy"-like competition, beating the University of California, San Diego, and the University of Texas at Houston. Pictured are (from left) Cornell residents Seth Kleinerman, M.D., Adam Demner, M.D., and Akshay Lohitsa, M.D., with MindGames host Glen Gabbard, M.D., who presented the trophy.

David Hathcox

This year's competition had an added dose of excitement when Cornell and UC San Diego tied after the "Final Jeopardy" round, necessitating an additional round.

Judges for the competition were past APA President Michelle Riba, M.D., Charles Nemeroff, M.D., and Richard Balon, M.D. MindGames is open to all psychiatry residency programs in the United States and Canada. The preliminary online competition begins in February, when teams of three residents take a 60-minute online test together consisting of 100 multiple-choice questions. The questions follow the ABPN Part I content outline, covering both psychiatry and neurology, with a few difficult history-of-psychiatry questions to make it interesting. The finalists are announced in April at the annual meeting of the American Association of Directors of Psychiatric Residency Training.

Insel Looks to Transformation of Diagnostics, Therapeutics

NIMH Director Thomas Insel, M.D., says that more people are getting more treatment, but outcomes are not getting better, so many of today's treatments may not be sufficient to "bend the curve."

BY MARK MORAN

The field of psychiatry and neuroscience is haunted by four "inconvenient truths" about the diagnosis and treatment of mental illness, said National Institute of Mental Health (NIMH) Director Thomas Insel, M.D., in a lecture titled "From Psychiatry to Clinical Neuroscience" at APA's 2014 annual meeting in New York in May.

These are his four inconvenient truths: the field has failed to "bend the curve" in the prevalence and cost of mental illness; more people are getting more treatment, but outcomes are not getting better; the current knowledge base is insufficient to ensure prevention, recovery, or cure for too many people with serious mental illness; and a transformation of diagnostics and therapeutics is necessary to make significant progress in treating mental illness.

Insel contrasted the remarkable progress of the last several decades in reducing morbidity and mortality associated with major medical conditions such as stroke, heart disease, pediatric cancers, and AIDS with the stubbornly high rates for mental illness. He noted, as an example, that the suicide rate in the United States is as high as it has ever been.

"I can't tell you a success story as I can for pediatric cancer or AIDS when we talk about suicide," he said. "It's rather remarkable that over the last two decades the suicide rate hasn't budged at all. With about 38,000 suicides a year, we are as high in absolute numbers as we have ever been."

David Hathcox

HIMH Director Thomas Insel, M.D., says research is revealing how chemical imbalances can lead to circuit dysfunction, and in turn to behavioral symptoms.

Depression Blamed for High Mortality

Insel added that statistics for morbidity and disability indicate that nearly 20 percent of all medical disability can be attributed to neuropsychiatric disease—more than are associated with cancer, heart disease, or stroke. "These numbers should give us real concern," he emphasized. And he noted that when looking at the metric for "disability adjusted life years"—DALY, or the years lost to premature mortality and disability—the big driver is depression.

"This is partly because of prevalence and because it is so disabling, but also because it starts early," Insel said. "Nearly 75 percent of adults with mental illness describe onset before age 25—that's very different from cancer or heart disease. Up until the fifth or sixth decade, these [neuropsychiatric] disorders are the story."

Insel outlined some of the problems that have hindered efforts "to bend the curve." These include that diagnosis is limited to observable symptoms, and detection is almost invariably late; etiology of most mental illness is unknown; and prevention is not well developed for most disorders. And treatment is trial and error, without cures or vaccines.

Moreover, what is known as the mental health "system" is a poorly integrated maze of nonspecific pathways of care, with some people entering through the emergency department, criminal justice system, primary care system, or nonprofessional services. Diagnosis and treatment vary from provider to provider and from patient to patient, he noted.

Brain Remains 'Unknown Territory'

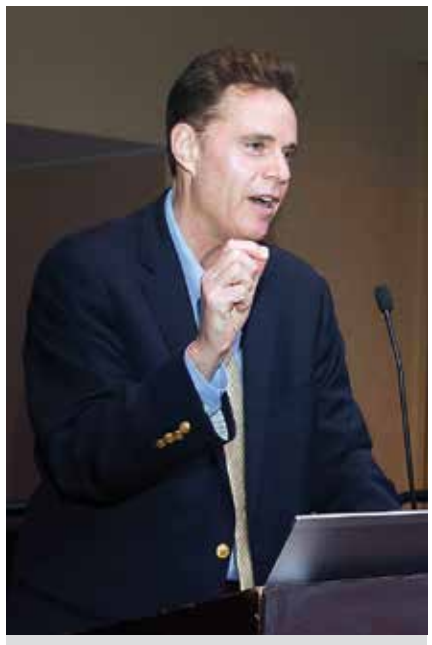
Knowledge of the brain, despite enormous advances in recent years, is still in its infancy, Insel pointed out. "The brain is a world consisting of a number of unexplored continents and great stretches of unknown territory," he said.

But he also described a promising future in which mental illness is reenvisioned as a disorder of brain circuitry that will be greatly advanced by President Obama's BRAIN Initiative, announced in April 2013.

Research is revealing how chemical imbalances can lead to circuit dysfunction, and in turn to behavioral symptoms, and Insel said the connections that are emerging can be used in the development of diagnostic tests for brain disorders that are today diagnosed late through observation of symptoms. "We can now study the mind with the tools of neuroscience," he said.

For instance, he presented evidence that is revealing attention-deficit/hyperactivity disorder to be a disorder of delayed cortical maturation. He also presented evidence of schizophrenia as a neurodevelopmental disorder with distinct risk and prodromal stages that allow for early intervention.

Finally, he described the NIMH Research Domain Criteria (RDoC) project, which he said will work in tandem with *DSM*. "*DSM/ICD* will continue to be the basis of clinical care," he said. "RDoC is a framework for research in which NIMH will support researchers to deconstruct current diagnostic categories or identify dimensions that extend across categories. RDoC will develop through an information commons that integrates data from many sources, transforming the way we diagnose mental disorders in the future." PN



David Hathcox

Inflammatory cytokines may play a role in depression, but not the only role, says psychiatric oncologist Andrew Miller, M.D.

Cytokine Antagonists May Help Some Depression Patients

Studying the relationship of inflammatory cytokines to depression may open doors to the origins of the disorder and possible treatments.

BY AARON LEVIN

A few years ago, some researchers were hypothesizing that inflammatory cytokines were a cause of depression.

The evidence seemed initially persuasive, said Andrew Miller, M.D., at APA's 2014 annual meeting in New York in May.

Levels of IL-6, tumor necrosis factor-α (TNF-α), and c-reactive protein (CRP) are indeed often elevated in patients with depression and are associated with treatment resistance, said Miller, a professor of psychiatry and behavioral sciences and director of psychiatric oncology at the Winship Cancer Institute at Emory University School of Medicine.

Experimentally, inflammatory cytokines induce depressive symptoms in healthy volunteers, as does therapeutic use of interferon in hepatitis-C patients, he said. Furthermore, inhibition of inflammatory cytokines reduces depressive symptoms in patients with cancer, depression, or psoriasis, among other illnesses.

"It all adds up to a good case, but one size does not fit all," cautioned Miller.

see ***Cytokines*** *on page 20*

CLINICAL & RESEARCH NEWS

Body Perception, Eating Disorders Can Differ Among Races

African-American women are more likely to be affected by binge eating disorder than anorexia or bulimia, indicating that race may affect the incidence of eating and other psychiatric disorders.

BY VABREN WATTS

While many studies of eating disorders have primarily focused on psychiatric and other factors in Caucasian women, little research has investigated these illnesses in African-American women.

To remedy that lack of data, researchers from the Department of Psychiatry at Mount Sinai Beth Israel Medical Center lead a comparative study on the ideals of beauty, as it relates to body weight, and binge-eating disorder among young black women and their white counterparts.

"Much, though not all, of the literature suggests that eating disorders per se are more prevalent in Caucasian women than in African-American women," commented Simone Lauderdale, M.D., a psychiatry fellow and lead investigator of the study. Lauderdale explained to *Psychiatric News* that many studies have limited eating disorders to anorexia nervosa and bulimia nervosa, which have been reported to be up to six times more prevalent in white women than black women. However, Lauderdale added, "the literature shows that if African-American women do present a particular eating disorder, it is most likely to be binge-eating disorder rather than anorexia nervosa or bulimia nervosa."

Diego Cervo/Shutterstock

The current study, led by Lauderdale and her colleague Lisa Cohen, Ph.D., was presented at this year's APA annual meeting in May. The study included 57 white women and 21 black women who were matched on age, weight, height, and education. The participants were assessed on their eating behaviors by the Questionnaire on Eating and Weight Patterns–Revised and their perception of body image and body satisfaction by the Body Shape Questionnaire and Beauty Ideals and Body Image Questionnaire (BIQ).

"The BIQ was designed specifically for this study," said Lauderdale. As part of the BIQ, study participants viewed side-by-side images of famous female celebrities—with one celebrity considered "heavier" and the other considered "thinner"—in various types of clothing. The participants were asked to select the celebrity that they would prefer their body to resemble most among each pair of images.

The results showed that white women were more likely to rate thinner figures as more attractive, whereas black women were more likely to rate heavier figures as more attractive. As it relates to eating patterns, white women were almost twice as likely to say they engaged in binge eating as were black women—52 percent versus 29 percent. It was also observed that being overweight as an adult or child was more likely to be reported by black women than white women (57.7 percent versus 27.9 percent). There was no significant difference in body dissatisfaction among the two groups.

"While both Caucasian and African-American women [presented with] some difficulties in regards to food and eating patterns, it seems that the nature of these difficulties is quite different across ethnic groups," Lauderdale explained. "Caucasians having a greater value for a thinner image may be related to the reporting of more eating disorders in this population, whereas African Americans value a heavier body type and report fewer eating disorders."

Lauderdale and colleagues concluded that the current findings can be of benefit to clinicians when assessing cultural differences and the effects of these differences on weight disparities when treating patients of diverse racial backgrounds.

Lauderdale told *Psychiatric News* that she plans to expand the current findings by investigating how factors such as geography and the male preference for particular female body types contribute to eating disorders and body-image perception among women of different cultures. PN

Exercise Said to Benefit Patients With Depression

Though an APA practice guideline includes exercise as an adjunct treatment for depression, many physicians are unfamiliar with the prescription of exercise for this disorder.

BY VABREN WATTS

Exercise may do more than keep people physically fit; it may serve as an adjunct treatment to medication for relieving symptoms associated with certain mental illnesses, and researchers from the University of Texas Southwestern are making mental health professionals aware of the benefits of prescribing exercise for patients with major depressive disorder (MDD).

"Exercise is really important in treating depression," Chad Rethorst, Ph.D., an associate professor of psychiatry, said at the APA annual meeting session titled "Exercise Prescription for Major Depressive Disorder" in New York in May. In a follow-up interview with *Psychiatric News*, Rethorst stated that given the challenges in treating depression, it is important to have as many treatment options as possible, alongside antidepressants, that can aid in reducing symptoms associated with MDD.

According to Rethorst, the use of exercise as an adjunct treatment for MDD has gained support, as suggested by the inclusion of exercise as an intervention option in APA's "Practice Guideline for the Treatment of Patients With Major Depressive Disorder" that was published in 2010, but many physicians are still unfamiliar with the "prescription" of exercise.

David Hathcox

At APA's annual meeting, Madhukar Trivedi, M.D. (above), and Chad Rethorst, Ph.D., discussed the benefits of exercise in treating major depressive disorder and summarized results from the Treatment with Exercise Augmentation for Depression (TREAD) study.

The goal of the annual meeting session was to provide an overview of the literature supporting exercise as a treatment adjunct for MDD and practical advice on the prescription of exercise to patients. Rethorst co-chaired the workshop with Madhukar Trivedi, M.D., the Betty Jo Hay Distinguished Chair in Mental Health at UT Southwestern.

Research highlighted during the workshop included results from the Treatment with Exercise Augmentation for Depression (TREAD) study, which was at conducted at UT Southwestern.

"We recruited [122] patients who had a partial response to a selective serotonin reuptake inhibitor . . . and randomized them to two exercise groups," Rethorst explained. The groups included a "low-dose" group, in which participants engaged in 40 to 60 minutes of aerobic exercise a week, and a "high-dose" group, in which participants engaged in approximately 150 minutes of aerobic exercise a week.

see ***Exercise*** *on page 21*

CLINICAL & RESEARCH NEWS

Same Brain Circuits Linked With Psychosis in Two Disorders

The brains of schizophrenia patients and of those with bipolar disorder who experience psychotic episodes show similar connectivity patterns, which points to a common mechanism that may be associated with psychotic symptoms in the two disorders.

BY JOAN AREHART-TREICHEL

Why is it that some individuals with bipolar disorder experience psychotic episodes, whereas others do not? It could be because the former have certain brain abnormalities in common with individuals who have schizophrenia, a new study suggests.

The abnormalities concern the ventral anterior cingulate cortex (vAAC), a region in the prefrontal cortex thought to regulate emotional behavior through nerve connections with other areas of the brain—notably the orbitofrontal cortex, insula, amygdala, and hypothalamus.

The lead researcher was Alan Anticevic, Ph.D., an assistant professor of psychiatry and psychology at Yale University. The results were published April 29 in *Schizophrenia Bulletin.*

Many individuals with bipolar disorder also experience psychotic episodes. Functional disturbances in prefrontal cortex regions of the brain involved in affect and mood regulation—especially the vAAC—have been implicated in several bipolar disorder studies. Thus Anticevic and his team wanted to determine whether the vAAC might play a role in bipolar-related psychosis.

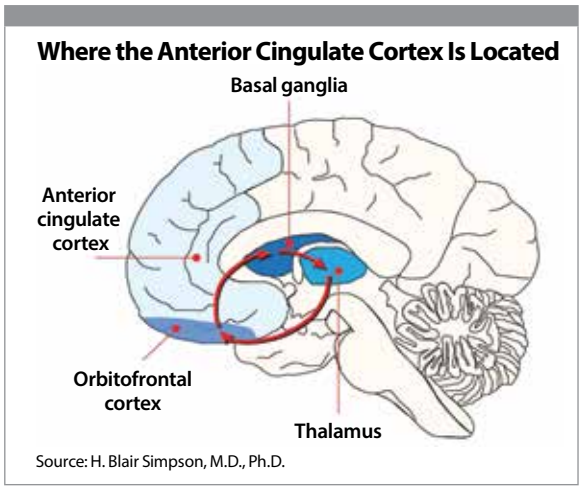
Their cohort included 202 subjects—40 with bipolar disorder who were currently experiencing neither depression nor mania and who had never experienced psychotic episodes; 33 with bipolar disorder who were currently experiencing neither depression nor mania but who had experienced psychotic episodes; 56 demographically matched healthy controls, and 73 demographically matched subjects with schizophrenia. The researchers used brain imaging to compare the functional connectivity of the vAAC among the four subject groups.

Compared with the control subjects, the bipolar-without-psychosis group showed significantly increased coupling of the vAAC to other brain regions, whereas the bipolar-with-psychosis subjects showed significantly decreased coupling of the vAAC to other brain regions. Moreover, the vAAC connectivity observed in schizophrenia subjects was significantly different from that found in the bipolar-without-psychosis subjects, but similar to that found in the bipolar-with-psychosis subjects. The findings remained the same even when the medications that subjects were using were taken into consideration.

"The similarities in vAAC connectivity patterns in schizophrenia and psychotic bipolar disorder patients may suggest the existence of common mechanisms underlying psychotic symptoms in the two disorders," Anticevic and his colleagues concluded.

And these findings may have research implications, they noted, suggesting that researchers should "study neural circuit alterations across neuropsychiatric diagnoses, rather than studying narrowly predefined diagnostic categories."

"The findings reported here are striking and may be very important," J. Raymond DePaulo Jr., M.D., a professor of psychiatry at Johns Hopkins University and a bipolar disorder expert said in an interview with *Psychiatric News*. "The findings are a step toward making functional sense of some of psychiatry's diagnostic groupings and, if confirmed and extended, would contribute to the scientific substrate from which laboratory methods could be introduced into the psychiatric assessments of the future."



The research was funded by the National Institutes of Health, the Fulbright Foundation, and the Brain and Behavior Research Foundation. PN

An abstract of "Ventral Anterior Cingulate Connectivity Distinguished Nonpsychotic Bipolar Illness From Psychotic Bipolar Disorder and Schizophrenia" is posted at http://schizophreniabulletin.oxfordjournals.org/content/early/2014/04/28/schbul.sbu051.abstract.

Negative Life Experiences May Contribute to Bipolar Disorder

If adverse life experiences contribute to bipolar disorder, as a large new study suggests, then patients with the illness might profit from psychotherapy to help cope with such experiences.

BY JOAN AREHART-TREICHEL

Both childhood adversity and recent stressors predict risk of developing bipolar disorder as well as the recurrence of bipolar episodes, a large study published April 22 in *Molecular Psychiatry* has found.

The research team was headed by Stephen Gilman, Sc.D., of the Harvard School of Public Health, and Roy Perlis, M.D., an associate professor of psychiatry at Harvard Medical School and medical director of the Bipolar Clinic and Research Program at Massachusetts General Hospital.

The study was based on a nationally representative sample of 33,375 Americans of whom 1,219 already had been diagnosed with bipolar disorder at the start of the study. All of the subjects were evaluated for childhood adversities and stresses during the previous year and followed up for a three-year period to see whether they experienced any bipolar episodes. During the follow-up period, 631 subjects had their first onset of bipolar disorder, while 180 of the 1,219 subjects who already had bipolar disorder experienced recurrent episodes.

The researchers then assessed whether there was a link between experiencing childhood adversities and the onset of bipolar disorder during the follow-up period. The study found that individuals who had incurred physical abuse, sexual abuse, or economic deprivation during childhood were two to three times more likely to develop bipolar disorder during the follow-up period than were individuals who had not encountered such negative experiences.

After that, the researchers focused on the subjects who already had bipolar disorder at the start of the study to see whether experiencing childhood adversities predicted recurrent bipolar episodes during the follow-up period. They found that study subjects who had been physically or sexually abused in childhood were twice as likely to have recurrent bipolar episodes as subjects who had not been abused.

The researchers then determined whether subjects who had bipolar disorder at the start of the study and who had encountered stresses during the previous year experienced significantly more recurrent bipolar episodes than bipolar subjects who had not encountered such stresses. Their data showed that subjects who had experienced personal losses, interpersonal problems, or financial difficulties during the previous year were two to three times more likely to have recurrent bipolar episodes during the follow-up period.

Finally, they assessed whether past-year stresses significantly predicted a first onset of bipolar disorder among subjects who had not been previously diagnosed with the illness. When compared with subjects who had experienced few stresses, those who had were two to three times more likely to develop the illness.

Thus, both negative childhood events and recent negative life events seem to contribute to bipolar illness, Gilman, Perlis, and colleagues concluded, and "add to our understanding of the nongenetic component of the etiology of bipolar disorder, which according to family studies accounts for approximately 20 percent of population variance."

The findings also have clinical implications, Perlis said in an interview with *Psychiatric News*. It is important "to redouble our efforts to do psychotherapy with people with bipolar disorder" in order to help them deal with adverse life experiences that may be contributing to their illness.

The research was funded by the National Institutes of Health. PN

An abstract of "Contributions of the Social Environment to First-Onset and Recurrent Mania" is posted at www.nature.com/mp/journal/vaop/ncurrent/abs/mp201436a.html.

JOURNAL DIGEST

BY VABREN WATTS

High Initial Antidepressant Dosages in Youth May Raise Self-Harm Risk

High initial dosages of antidepressants appear to increase risk of deliberate self-harm in children and young adults, according to data from a study published in *JAMA Internal Medicine*. Researchers from the Harvard School of Public Health examined the relationship between suicidal behavior and antidepressant dosage, and whether such a relationship, if it exists, is dependent on a patient's age. The study assessed data from 162,625 people—aged 10 to 64—with depression who initiated antidepressant therapy with a selective serotonin reuptake inhibitor at "modal" (most prescribed dosage on average) or higher than modal dosages.

The analysis showed that participants aged 24 and younger who initiated antidepressant therapy at high doses were twice as likely to exhibit suicidal behaviors than were their age-matched counterparts who received modal doses—corresponding to one additional event of deliberate self-harm for every 150 patients treated with high-dose antidepressant therapy. The authors found no dose-dependent risk for suicidal behavior among adults aged 25 to 64.

In a commentary, David Brent, M.D., a professor of psychiatry, pediatrics, and epidemiology at the University of Pittsburgh who was not involved in the study, noted that "while initiation at higher than modal doses of antidepressants may be deleterious, this study does not address the effect of dose escalation. . . . Studies on the impact of dose escalation in the face of nonresponse remain to be done—there are promising studies that suggest in certain subgroups that dose escalation can be of benefit." Brent concluded that these findings "add further support to current clinical recommendations to begin treatment with lower antidepressant doses."

Miller M, Swanson S, Azrael D, et al. "Antidepressant Dose, Age, and Risk of Deliberate Self-Harm." 2014. *JAMA Intern Med.* Apr 28. [Epub ahead of print] http://archinte.jamanetwork.com/article.aspx?articleid=1863925

Study Identifies Genetic Biomarker That May Contribute to OCD

Researchers from Johns Hopkins University School of Medicine provided some insight into factors that may underlie obsessive-compulsive disorder (OCD), which affects about 2 percent of the U.S. population, according to the National Institute of Mental Health.

Gerald Nestadt, M.D., Ph.D., director of the OCD program at Johns Hopkins, and colleagues reported in *Molecular Psychiatry* that they conducted a genomewide association study to identify genetic biomarkers associated with OCD. The researchers scanned the genomes of more than 1,400 individuals with OCD and approximately 1,000 close relatives of other people with OCD (as a control group). The study results showed that patients with OCD expressed a particular biomarker located near the protein tyrosine phosphokinase gene—a genetic region that previous research suggested is important in the pathology of OCD.

"OCD research has lagged behind other psychiatric disorders in terms of genetics," stated Nestadt. "We hope this interesting finding brings us closer to making better sense of it."

"If this finding is confirmed," he said, "we might ultimately be able to identify new drugs that could help people with this often disabling disorder, [for whom] current medications work only 60 percent to 70 percent of the time."

Mattheisen M, Samuels J, Wang Y, et al. "Genome-wide Association Study in Obsessive-Compulsive Disorder: Results From the OCGAS." 2014. *Mol Psychiatry.* May 13 [Epub ahead of print] http://www.nature.com/mp/journal/vaop/ncurrent/full/mp201443a.html

Lower Hippocampus Volume Seen in Patients With Psychosis

The Bipolar-Schizophrenia Network on Intermediate Phenotypes—consisting of institutions that include Harvard University, Wayne State University, and the University of Texas Southwestern—conducted a neuroimaging study in 549 patients with schizophrenia, schizoaffective disorder, or bipolar disorder with psychosis to evaluate hippocampal volume in individuals with psychosis and the consequences of hippocampal volume as it relates to the severity of the psychosis. The participants were compared with 337 healthy volunteers.

The results, published in *JAMA Psychiatry*, showed that volume in the hippocampus was significantly reduced in all three groups of patients with psychotic disorders when compared with that of controls. Reduced hippocampal volumes were correlated with worsened psychosis severity, declarative memory, and overall cognitive performance.

"The causal mechanisms underlying psychotic symptoms are not well known," Matcheri Keshavan, M.D., a professor of psychiatry at Harvard Medical School, told *Psychiatric News* in an interview. "The findings in this study point to the hippocampus . . . as a critical node on the network of brain regions that underlie the generation of psychotic symptoms such as delusions and hallucinations. Such understanding can help clinicians explain the nature of psychotic illnesses to patients and [their] families." Keshavan concluded that more studies investigating the consequences of physiological and biochemical alterations in the hippocampus "are critically needed."

Mathew I, Gardin TM, Tandon N, et al. "Medial Temporal Lobe Structures and Hippocampal Subfields in Psychotic Disorders: Findings From the Bipolar-Schizophrenia Network on Intermediate Phenotypes (B-SNIP) Study." 2014. *JAMA Psychiatry.* May 14 [Epub ahead of print] http://archpsyc.jamanetwork.com/article.aspx?articleid=1870670Z

Awareness of E-Cigarettes' Potential Harm Increases

A recent study in the *American Journal of Preventive Medicine* reports that as awareness of e-cigarettes increases, so does skepticism about these products.

A national survey of 3,630 adults found that 77 percent have heard of e-cigarettes—far from the 16 percent that was reported five years ago. Not only was an increase in e-cigarette awareness noticed, but the survey found that there was a 19 percent drop—from 84 percent to 65 percent—in the perception of e-cigarettes being less harmful than regular cigarettes among current smokers.

The authors noted that "the rise in awareness of e-cigarettes could reflect sharp increases in advertising expenditures by manufacturers . . . and [the] presence in popular media." They urged health care and public health professionals to continue to "scrutinize the nature of marketing activities and media coverage of e-cigarettes . . . and how these factors may influence e-cigarette use and smoking prevalence in the U.S. population."

Tan A, Bigman C. "E-Cigarette Awareness and Perceived Harmfulness: Prevalence and Associations With Smoking-Cessation Outcomes." 2014. *Am J Prev Med.* Apr 28 [Epub ahead of print] http://www.ajpmonline.org/article/S0749-3797(14)00107-X/abstract

Naltrexone and Acamprosate More Effective in Treating Alcohol Addiction

Several medications are available to help people with alcohol use disorder (AUD) maintain abstinence or reduce drinking, but the amount of information available on the efficacy of such medications for AUD may be too cumbersome for providers to digest, according to researchers from the University of North Carolina at Chapel Hill (UNC).

Scientists at the Evidence-based Practice Center and Bowles Center of Alcohol Studies at UNC conducted a systematic review of 122 randomized, controlled trials to assess the benefits and harms of medications—approved and unapproved by the Food and Drug Administration—for adults with AUD. The results, published in *JAMA*, showed acamprosate and naltrexone to have the best evidence for maintaining abstinence from drinking and reducing days of heavy drinking. As for medications used off-label for AUD, there were moderate improvements in some drinking outcomes for topiramate and nalmefene.

James Garbutt, M.D., senior author of the study and a professor of psychiatry at UNC, commented, "This work expands upon the growing evidence that medications can play a valuable role in the treatment of alcohol use disorders. We are hopeful that this information will encourage clinicians to strongly consider these medications and that those individuals will gain awareness that there are medications that can help them to stop or significantly reduce their alcohol use." PN

librakv/Shutterstock

Jonas D, Amick H, Feltner C, et al. "Pharmacotherapy for Adults With Alcohol Use Disorders in Outpatient Settings: A Systematic Review and Meta-analysis." 2014. *JAMA*. 311(18):1889-900. http://jama.jamanetwork.com/article.aspx?doi=10.1001/jama.2014.3628

LETTERS TO THE EDITOR

Treatment at Chestnut Lodge

Since I was a staff psychiatrist at Chestnut Lodge from 1957 to 1967—and worked with some Lodge patients for many years after that—I especially appreciated the article in the May 2 issue, "Recalling Chestnut Lodge: Seeking the Person Behind the Psychosis."

I want to emphasize that psychoanalytically informed therapy of psychotic patients always differed profoundly from classical psychoanalysis. Taken in isolation, a comment in the article about the patient's silence not necessarily being a sign of "resistance" could mislead readers to believe that the treatment was a caricature of psychoanalysis. A description of what the psychiatrists did during their usual five sessions a week, highly individualized treatment would also include elements of what is now labeled cognitive-behavioral therapy, dialectical behavior therapy, and a host of rehabilitative activities. During different phases of the treatment, these elements could coexist with dynamic and psychoanalytic approaches.

During my time at Chestnut Lodge, there was also Stanton and Schwartz's therapeutic community approach, Marian Chase's pioneering movement and dance therapy, innovative art therapy, occupational therapy (which included patients running their own shop), various levels of group therapy, weekly all-hospital meetings in which patients raised questions of self-determination and suggested programs and activities, and a program in which families stayed for a week in the Frieda Fromm-Reichmann cottage. When modern psychopharmacology became available, the interactions of medication and intensive therapy were beginning to be studied.

Concerning McGlashan's follow-up study showing that roughly two-thirds of the schizophrenia patients were functioning marginally or worse, it should be kept in mind that Chestnut Lodge offered treatment as the last resort. For most patients, all other treatment options had been exhausted and had failed. For such a patient population, a one-third positive outcome may even be remarkable. PN

JOHN S. KAFKA, M.D, M.S.
BETHESDA, MD.

Letters Invited

Readers are invited to submit letters up to 500 words long for possible publication. *Psychiatric News* reserves the right to edit letters and to publish them in all editions, print, electronic, or other media. Receipt of letters is not acknowledged. Letters should be sent by mail to *Psychiatric News*, APA, Suite 1825, 1000 Wilson Boulevard, Arlington, Va. 22209 or by e-mail to cbrown@psych.org. Clinical opinions in letters are not peer reviewed and thus should be independently verified.

Hate Crimes

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because of the prevalence of anti-LGBT violence and the significant psychiatric sequelae, it is essential for psychiatrists who treat LGBT individuals to inquire about the patients' history of discrimination, harassment, or overt violence and to ask how they are coping with such situations. In addition, he emphasized the need for more training and education for police, EMS workers, and other first responders to increase their knowledge and cultural competency about LGBT people, which could lead to more compassion when interacting with the LGBT community.

"There is still much work to be done on federal and state levels," stated Bialer. "My hope is that increased acceptance of LGBT people and continued progress with issues such as marriage equality will have a beneficial effect on attitudes toward LGBT people and eventually result in fewer anti-LGBT hate crimes." PN

Marathon Runner

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and different for each person. To reduce media retraumatization, he encouraged runners to turn off TVs and radios.

Running can help burn off anxiety, he noted. Conversely, he said, runners tend to be resilient, counterdependent, and used to running through pain.

"Plowing through is useful if you're running a marathon," Abrams noted. "But people process trauma better by sharing it with people they trust, those from whom they are most likely to get a validating and comforting response."

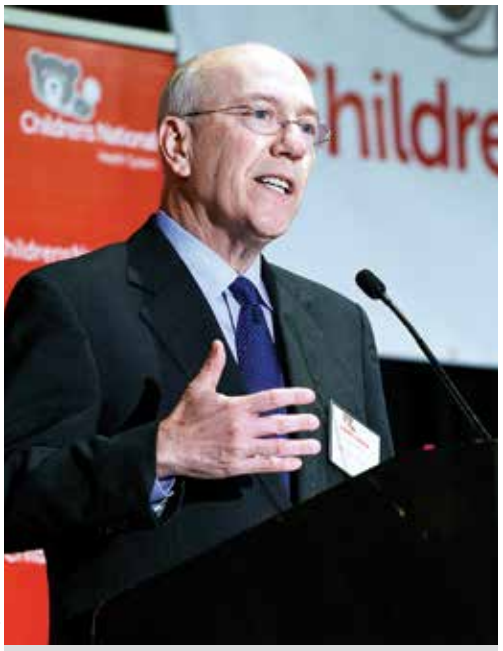
Returning to routines helps people process trauma, Rappaport agreed. "We can never forget those who were killed or injured," she said, "but this year's marathon helped Bostonians regain their balance. It's a spring day, Patriot's Day, and participating in the marathon is what Bostonians do.

"This is our race again," she said. "We took it back." PN

Children's MH Care

continued from page 1

APA, gave the keynote speech. He discussed his personal struggle with bipolar disorder and addictions, noting that there is inadequate screening and intervention for early mental and behavioral disorders in primary care settings. "We are operating in a 'fail-first model,' " he said, as he compared patients' access to mental health care with treating patients with diabetes only when their illness is so severe that they require amputation of a limb.



Stephen Bobb

Kurt Newman, M.D., CEO of Children's National Medical Center, says the center's mental health summit is a response to the 2013 call to action by President Obama to improve childhood mental health.

During his tenure in Congress, Kennedy was the lead sponsor of the Mental Health Parity and Addiction Equity Act, which passed in 2008. In his speech, Kennedy railed against what he saw as lagging accountability for and enforcement of the implementation of the mental health parity law. He partially blamed the stigma against mental illness for the resistance among government officials and lawmakers to enforcing parity reimbursement and coverage by private insurance companies, which has allowed some insurance plans to continue to underfund mental health care. Other attendees at the summit, including children's hospital administrators from across the country, also cited inadequate funding and reimbursements as major barriers to implementing and expanding mental health services that have been proven to be beneficial for patients, families, and communities.

The lack of financial incentives is one contributing factor to the shortage of qualified mental health professionals to meet the overwhelming needs from children and families. In addition to the lack of funding, "we don't have the specialists, especially for child and adolescent mental health, to provide the services needed," Virginia's Secretary of Health and Human Services, William Hazel, M.D., acknowledged.

Pediatricians and primary care physicians need better education and training to assume responsibility for screening and treating mental illness at an early age, Newman commented.

Paramjit Joshi, M.D., the president of the American Academy of Child and Adolescent Psychiatry, emphasized the critical importance of early identification and prevention, because half of all the serious psychiatric disorders occur by age 14, and three-quarters by age 24. Early intervention can significantly reduce long-term severity and disability, she said. Joshi is director of psychiatry and psychology programs at Children's National Medical Center and a member of the *Psychiatric News* Editorial Advisory Board.

Stephen Bobb

Rep. Tim Murphy (R-Pa.) discusses policies and regulations that raise barriers to providing mental health care for children and adolescents.

Several speakers emphasized that the fragmentation of mental health screening and treatment services is another major barrier. The need is great for more community-based, integrated mental health collaborations between hospitals and clinics with families and schools, they pointed out.

Sen. Chris Murphy (D-Conn.) discussed the challenge of "rampant criminalization of youths with mental illness" in his state. And Hazel noted a similar burden of caring for youth with mental illness in the Virginia juvenile-justice system. The sad reality, they pointed out, is that prison is often the first or only place many young people with psychiatric disorders can access treatment.

Rep. Tim Murphy (R-Pa.), who is also a clinical psychologist, outlined several policies and regulations that hinder mental health care for children and adolescents. In December 2013, he introduced a bill in the House, the Helping Families in Mental Health Crisis Act, which proposes to increase the flexibility in current privacy rules for families and physicians of youth with mental illness to facilitate integrated care. The bill also calls for adding an assistant secretary position to the Department of Health and Human Services, as a way to ensure that federal dollars are spent on effective, evidence-based models of treatment and program effectiveness (*Psychiatric News*, May 2).

"I'm very optimistic that once we develop a critical mass of awareness of pediatric mental health issues, we will make positive changes on all levels," Newman told *Psychiatric News* after the summit. "This summit could play a role in sparking the exchange [of ideas] among mental health and pediatric providers, academics, government agencies, legislators, and advocates . . . [and could] stimulate conversation and open people's minds."

Having this summit in Washington, D.C., and bringing together the mental health community and federal and local legislators can also promote political advocacy and promote broad policy reforms that will have greater impact on mental health care, Newman suggested. PN

The text of Murphy's bill, HR 3717, is posted at http://murphy.house.gov/uploads/HR3717%20Bill%20Text.pdf.

Cytokines

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Only subgroups of depressed patients have elevated levels of cytokines, and cytokines are also higher in patients with other psychiatric disorders (such as bipolar disorder, schizophrenia, and anxiety) and in general medical conditions (such as cancer or heart disease).

"Cytokines are not about disorders but about the symptoms and the circuits that are related to those symptoms within those disorders," he said.

Studies in humans and in nonhuman primates suggest that interferon-α (an antiviral/antiproliferative cytokine used to treat viral infections or cancers) taps into pathways known to be involved in depression, said Miller.

"Interferon-α alters glucose metabolism in the basal ganglia and leads to reduced prefrontal cortical metabolic activity," he said. At the same time, there is increased activity in the globus pallidus and putamen, mimicking a pattern seen in Parkinson's disease. "Neurons fire at a high rate because they are not being inhibited by dopamine."

fMRI studies of patients taking interferon-α for hepatitis-C showed that in the ventral striatum, being on the drug correlated highly with reduced motivation and anhedonia. Other studies showed similar effects with a variety of inflammatory stimuli.

Miller then tested the effects of a TNF-α antagonist (infliximab) in patients with treatment-resistant depression. This was not a clinical trial, he emphasized, but a way to better understand the cytokine hypothesis of depression.

Even getting to that point wasn't simple, he said. "It took us a tremendously long time to convince the drug companies to even test the drugs in a depressed population, because the FDA automatically issues a black-box warning that treatment with a potential new drug could precipitate suicide."

Ultimately, they found that use of the drug reduced HAM-D scores overall equal to those found with placebo. However, the subset of patients with higher baseline CRP (>5 mg/L) levels demonstrated a greater treatment response, 62 percent among treated patients compared with 33 percent of those on placebo.

This information might ultimately guide diagnosis or measurement of treatment effects. Plasma CRP has a readily available test and correlates well with CRP in cerebrospinal fluid, he said.

"There are cells in the brain producing CRP, so we're getting a sense of what's going on in the brain in terms of neuroinflammation."

Within six hours of an infliximab infusion, gene expression arrays reflected down-regulation of the TNF-α and NF-κB pathways and predicted who would respond and who would not, he said. "Also, symptoms like motivation, psychomotor retardation, suicidality, and anxiety all got better," as did the brain regions he anticipated would get better after blocking cytokines.

Miller again cautioned that cytokine antagonists are not a panacea for depression and about the need to stratify patients: "Using cytokine antagonists in patients who have low inflammation actually causes them to do worse." PN

Exercise

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The analysis showed that patients who burned at least 16 kilocalories per kilogram of body weight each week (the high-dose group) were more likely to have fewer and less-severe symptoms associated with MDD, have higher recovery rates, and maintain longer remission than those who burned 4 kilocalories per kilogram of body weight per week (the low-dose group). In addition, the researchers observed that aerobic exercise, regardless of dose, was associated with reducing blood levels of pro-inflammatory cytokines such as interleukin-1β (IL-1β) and tumor necrosis factor-α (TNF-α), which have been shown to elevated in some patients with MDD.

"According to this study, energy expenditure seems to be the answer," Rethorst stated.

Some psychiatrists and mental health professionals, including those in the audience, questioned whether patients with MDD will be willing to participate in an exercise program. Both Rethorst and Trivedi emphasized that multiple studies, other than their own, have shown dropout rates of 15 percent—on par with rates in studies assessing the efficacy of medications and psychotherapies, so exercise regimens are possible with a substantial percentage of patients with the disorder.

"Time is the number-one barrier that keeps people from exercising—whether a person has a diagnosis for mental illness or not," said Rethorst. "Having the conversation of 'time' with the patient and helping patients realize that there is some window of time throughout their schedule to fit in exercise is really important."

Rethorst also emphasized the importance of using electronic and mechanical devices such as pedometers, Fitbit, and cellular phone apps that can aid in increasing patients' adherence to physical activity regimens.

Rethorst and Trivedi concluded the workshop with a presentation of a modified version of their "5 A's plus 2" counseling program, which recommends the following:

- **ASSESS** the patient's overall health and ability to participate in regular exercise.

- **ADVISE** patients on the benefits of exercise as it relates to remedying depression.

- **AGREE** with the patient on exercises that best suits them in regard to achieving their personal goals.

- **ASSIST** patients to overcome personal barriers by providing strategies, problem-solving techniques, and creating an atmosphere of support.

- **ARRANGE** follow-ups through office visits, phone calls, or electronic messages such as text and emails.

- **ASSESS** again.

- **ASK** patients about their adherence and then ask again.

The TREAD study was funded by the National Institute of Mental Health. PN

A video interview with Chad Rethorst, Ph.D., can be accessed by scanning the QR code or going to https://www.youtube.com/watch?v=g2flnXsa0ro&index=18&list=PLQ5eP2xWhCQEAsxGrPKsxdfgN97eah9lG.

Violence

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and youth," the researchers said.

The researchers suggested several factors that may account for the decline in violence. One might be the growth and dissemination of prevention and intervention strategies aimed at reducing violence against youth—for instance, school-based prevention programs targeting bullying, interpersonal conflict, and sexual and dating violence, some of which have been found effective in rigorous evaluation studies.

"There is no single more preventable and important cause of psychiatric harm to children than exposure to violence," Andrew Gerber, M.D., Ph.D., an assistant professor of psychiatry at Columbia University and a child and adolescent psychiatrist, told *Psychiatric News*. "It is enormously encouraging to learn that the concerted effort over the past two decades to minimize this exposure appears to be paying off in the form of reduced exposure to violence in our nation's children. While no study can ever demonstrate conclusively that national policies are responsible for this effect, this study suggests strongly that exposure is decreasing and that informed policies are at least partially responsible for this improvement."

The research was funded by multiple sources, including the Centers for Disease Control and Prevention and the Office of Juvenile Justice and Delinquency Prevention. PN

An abstract of "Trends in Children's Exposure to Violence, 2003 to 2011" is posted at http://archpedi.jamanetwork.com/article.aspx?articleid=1863909.