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PSYCHIATRIC NEWS

AMERICAN PSYCHIATRIC ASSOCIATION

ISSN 0033-2704

Ted Grudzinski/American Medical Association

APA member Patrice Harris, M.D., was elected chair-elect of the AMA Board of Trustees last month at the AMA's annual policymaking meeting in Chicago. Her election reflects the value of psychiatry's perspective on major issues within the House of Medicine. See story below.

Former APA Board Member Chosen Chair-Elect of AMA Board

The election of psychiatrist Patrice Harris, M.D., by fellow trustees to be chair-elect of the AMA Board is a significant honor from the leaders of American medicine and a testament to the high regard in which she is held throughout the House of Delegates.

BY MARK MORAN

Psychiatrist Patrice Harris, M.D., received back-to-back honors of the highest kind at the meeting of the AMA House of Delegates last month, when she was elected by the 500-plus member House of Delegates to a second term as a member of the Board of Trustees, then the next day was elected by her fellow trustees to be chair-elect of the Board.

The selection by fellow Trustees to have Harris serve as chair-elect is a significant recognition by the leaders of American medicine of her effectiveness as a spokesperson for physicians. APA leaders say it testifies to the trust her fellow board members place in her and to the high regard in which she is held throughout the House of Delegates.

The AMA Board of Trustees is an elected body of 21 physicians who guide the AMA as it sets standards and policy for the medical profession.

"I am thrilled that Dr. Harris was elected chair-elect on the AMA Board," said APA President Renée Binder, M.D. "The APA Board of Trustees is looking forward to working with her as both groups strive to improve and advance the practice of medicine."

Harris, who is the director of Fulton County (Ga.) Health Services and the head of the Fulton County Department of Behavioral Health and Developmental Disabilities, is a past member of the APA

*see **Harris** on page 38*

Mental Health Reform Bill Reintroduced Into House

The bill would strengthen enforcement of the federal mental health parity law, advance early intervention and prevention programs, and create a national strategy for increasing the mental health workforce.

BY MARK MORAN

Reps. Tim Murphy (R-Pa.) and Eddie Bernice Johnson (D-Texas) have reintroduced their bipartisan legislation promising comprehensive reforms to the U.S. mental health care system. The bill, the Helping Families in Mental Health Crisis Act (HR 2646), was first introduced in 2013 in response to the tragic shootings in Newtown, Conn.

A major focus of the bill is on eliminating the fragmentation of mental health resources across federal departments through the establishment of a new position, the assistant secretary for mental health and substance use disorders within the Department of Health and Human Services. The position's duties would emphasize the coordination of those services and the promotion of science-driven and evidence-based approaches to care.

The bill would also substantially improve the enforcement of the Mental Health Parity and Addiction Equity Act by requiring annual reports to Congress on parity compliance investigations from federal departments, tasking the proposed assistant secretary with

*see **MH Bill** on page 35*

PERIODICALS: TIME SENSITIVE MATERIALS

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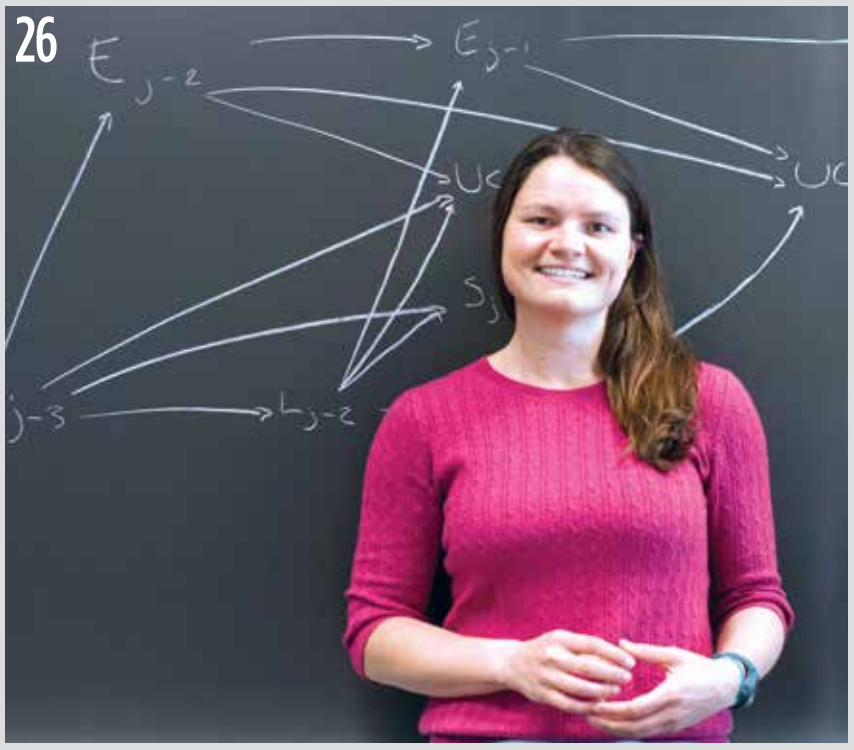

PROFESSIONAL NEWS

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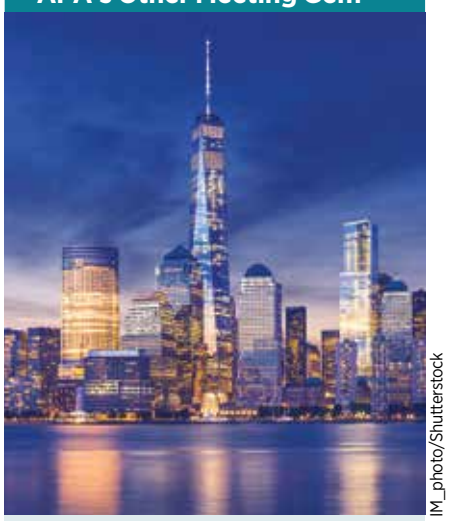
CLINICAL & RESEARCH NEWS

Mark Calendar Now for APA's Other Meeting Gem



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APA's next major meeting is the IPS: The Mental Health Services Conference, which will be held October 8 to 11 at the Sheraton New York Hotel and Towers in New York City. This year's theme is "When Good Care Confronts Red Tape: Navigating the System for Our Patients and Our Practice."

Registration and other information about the meeting can be accessed at http://www.psychiatry.org/ips.

Departments

FROM THE PRESIDENT

Stigma: 'I Need to Tell You Something I've Never Spoken to You About'

BY RENÉE BINDER, M.D.

In her passionate speech at the Convocation of Distinguished Fellows at APA's 2015 annual meeting in May, Nora Volkow, M.D., director of the National Institute on Drug Abuse, disclosed her personal experience with stigma. She emotionally related how she was summoned to her mother's deathbed. Her mother, weak from her fight with cancer, said, "'I need to tell you something I've never spoken to you about.' " It was then, decades after the fact, when Dr. Volkow first learned that her grandfather had been addicted to alcohol and taken his own life. What she was told as a child and believed ever since—that he had died suddenly from cardiovascular disease—wasn't true.

As I heard Dr. Volkow speak, I was reminded of the death of an acquaintance who was at the top of her career when she died suddenly after complications from surgery, according to her obituary. I later learned that she had died from suicide, possibly in response to her struggle with chronic pain and resulting depression.

Stigma serves as a barrier to seeking treatment because of fears of discrimination. A few years ago, a patient requested that I not keep any records and wanted to pay me in cash. He was concerned that if his psychiatric records were ever discovered, his career could be negatively impacted. Were this man's concerns legitimate? I am reminded of Sen. Tom Eagleton, who was forced to withdraw as a candidate for vice president after it was discovered that he had suffered from depression and undergone ECT.

According to the *Merriam-Webster Dictionary,* the definition of stigma is a set of negative and unfair beliefs that a society or group of people has about something; it is a mark of shame or discredit.

How can we begin to address stigma? Here are several ideas: We need courageous spokespersons who are willing to come forward and talk about mental health issues that they or their families are experiencing. Former Rep. Patrick Kennedy is one such champion. He has openly discussed his struggles with mental illness and substance abuse and how treatment has helped him lead a productive and rewarding life.

We can learn from the LGBT community and their struggles with stigma and negative stereotypes. They have taught us that "coming out" by public figures and celebrities can decrease stigma.

Another way of combating stigma is for all of us, as psychiatrists, to take responsibility for closely monitoring the language that is used by the media and others in our society. Words such as "lunatic," "crazy person," or "maniac" convey images of people who are out of control and dangerous rather than people who are suffering from a mental illness and deserve our compassion and support in getting effective treatments. Changes in language and terminology have been an important factor in modifying perceptions about women, LGBT groups, and ethnic and racial groups. Part of our role as psychiatrists should be to write articles for local news sources, letters to the editor, and letters of complaint when the media use stigmatizing language. We can make presentations to local churches, synagogues, schools, and community groups. In addition, we need to hold our entertainment industry accountable for portrayals that reinforce negative stereotypes about people who suffer from mental illness.

As I said at the annual meeting as I was outlining the year ahead as your president, there is no health care without mental health care. Almost everyone will suffer from a mental health problem at some point in his or her lifetime. A host of issues—marital or employment stress, problems related to a loved one, or a medical issue—can result in some psychiatric symptoms. But for people to be willing to access the mental health care they need, we have to continue the fight against stigma.

If we are successful in addressing stigma, and we must be, then not only will we change the conversation, we will also change people's lives and change the culture. We will finally reach the point where all of us can openly talk about someone's death by suicide and encourage people with mental health problems to seek the help they need without fear of judgment or harmful repercussions. PN

PROFESSIONAL NEWS

German Psychiatrists Explore, Acknowledge Nazi-Era Failings

Members of Germany's major psychiatric society have spent years looking honestly at their predecessors' shameful behavior under the Nazi regime.

BY AARON LEVIN

More than half a century passed before the German psychiatric community openly acknowledged the role of its predecessors in the deaths of thousands of people with mental illness during the Nazi era, said Frank Schneider, M.D., Ph.D., at APA's 2015 annual meeting in Toronto.

"Psychiatrists and psychiatry were not victims; they were actors," said Schneider, a professor of psychiatry, psychotherapy, and psychosomatics at Aachen University in Germany. "This was a dark chapter in German psychiatry, but it is still important to learn from it."

Nazi-era psychiatrists took part in identifying Germans with severe mental, neurological, and physical illnesses under a 1933 law for the "Prevention of Hereditarily Diseased Offspring," said Schneider. The individual's "hereditary value" became the prime criterion for who would live or die.

Nearly 360,000 people—including those with schizophrenia, bipolar disorder, epilepsy, Huntington's disease, blindness, deafness, severe physical deformity, and severe alcoholism—were forcibly sterilized in operations that led to more than 6,000 deaths. Ultimately, 200,000 mentally disabled people were murdered by the Nazi regime in a program largely staffed by psychiatrists, called "Aktion T4." Ironically, the few psychiatrists who refused to take part in the program usually escaped without punishment, said Schneider.

Aktion T4 served as preparation for the mass murder that was to follow during World War II. The killing centers used gas chambers and crematoria, and Irmfried Eberl, M.D., the medical director of the Brandenburg and Bernburg killing centers, later became the first commandant of the Treblinka death camp.

David Hathcox

German psychiatrists and the organized psychiatric community is still in the process of acknowledging the criminal betrayal of patients during the Nazi era, says Frank Schneider, M.D., Ph.D., a past president of the country's psychiatric society.

The stigma attached to mental illness and other hereditary defects lingered for decades after the war, leading to suppression of the history of sterilization and murder during the Nazi era, said Schneider.

Many of the physicians who participated returned to civilian life without facing any consequences. Two even became president of the post-war German Association for Psychiatry, Psychotherapy, and Psychosomatics (DGPPN).

One German psychiatrist, Gerhard Schmidt, M.D., wrote a book about the sterilization and killing programs in 1945 but could not find a publisher for another 20 years.

"No one wanted to hear the story," said Schneider. "In the 1960s and 1970s, psychiatrists saw themselves as victims, and only beginning in the 1980s was there an attempt to examine the past."

That attempt was advanced in 1990 when Johannes Meyer-Lindenberg, M.D., then the president of the DGPPN, addressed APA's annual meeting: "Psychiatrists had failed to respond or were indifferent to patients during the Third Reich," Meyer-Lindenberg said. "The majority of psychiatrists did nothing to protect their patients or to stop the action."

The profession's self-scrutiny of its involvement in this dark period has since

see ***Nazi Era*** *on page 34*

PSYCHIATRY & INTEGRATED CARE

What Can Psychiatrists Do for People With SMI?

BY LYDIA CHWASTIAK, M.D., M.P.H., AND BENJAMIN DRUSS, M.D., M.P.H.

In this month's column, Drs. Chwastiak and Druss, two of our nation's leading experts in integrated care, outline timely opportunities for psychiatrists to improve the lives of patients with severe and persistent mental illness using the core principles of collaborative care.

—Jürgen Unützer, M.D., M.P.H.

There is a growing call for psychiatrists in public mental health settings to assume greater oversight of the general medical care of their patients with serious mental illness. With training in medicine and expertise in health behavior change, psychiatrists are in a unique position to bridge the gap between behavioral health and medicine and to reduce the barriers to high-quality medical care for their patients. The core principles of collaborative care provide a framework for the work that needs to be done.


Management of cardiovascular risk factors should be patient-centered and evidence-based. Psychiatrists must consider the metabolic side effects of psychotropic medications and discuss these with patients so that they can make an informed decision. Schizophrenia treatment guidelines, such as those from the United Kingdom National Institute for Health and Care Excellence (NICE), are clear that psychiatrists are responsible for the adverse metabolic effects of the medications they prescribe and should try to minimize these complications. Here are other guidelines for psychiatrists:

- Avoid off-label use of antipsychotic medications, especially when there are more metabolically neutral options.
- When antipsychotic medications are necessary, choose ones with lower metabolic risk.
- Review ongoing medication requirements and consider lowering doses or switching medications when there is evidence of significant metabolic impact (such as weight gain of 7 percent of body weight or new-onset hyperlipidemia).
- Avoid antipsychotic polypharmacy whenever possible.

Patients should have regular screenings for chronic medical conditions and preventive services, such as cancer screening and immunizations against infectious diseases. Guidelines for metabolic monitoring for patients treated with antipsychotic medications and have

continued on facing page

Lydia Chwastiak, M.D., M.P.H., is an associate professor in the University of Washington Department of Psychiatry and Behavioral Sciences and assists with education and training efforts in its Advancing Integrated Mental Health Solutions (AIMS) Center. Benjamin Druss M.D., M.P.H., is the Rosalynn Carter Chair in Mental Health and the director of the Center for Behavioral Health Policy Studies at the Rollins School of Public Health at Emory University. Jürgen Unützer, M.D., M.P.H., is an internationally recognized psychiatrist and health services researcher. He is a professor and chair of psychiatry and behavioral sciences at the University of Washington School of Medicine, where he directs the Division of Integrated Care and Public Health and the AIMS Center, dedicated to "advancing integrated mental health solutions."

AMA House of Delegates Backs End to Ban On Transgender Individuals Serving in Military

In support of the resolution, the written testimony of an anonymous AMA member and member of the armed forces who is transgender was read, which stated that "delaying adoption of this policy … will only serve to further harm those of us who actively serve our country in silence every day."

BY MARK MORAN

There is no medically valid reason to exclude transgender individuals from service in the U.S. military, and transgender service members should be provided care according to the same medical standards that apply to non-transgender personnel.

So declared the AMA House of Delegates during its 2015 annual policy-making meeting in Chicago last month by approving a resolution introduced by the Section Council on Psychiatry in coordination with several other groups.

The resolution was widely supported during reference committee hearings and passed without debate during the meeting of the House.

"This resolution is about ending the blanket ban that prohibits transgender people from military service and transgender military service members from equal access to care," said Brian Hurley, M.D., a psychiatrist speaking for the section council. "There is a difference between having a transgender identity and having gender dysphoria, and there is no reason that transgender status alone should exclude anyone from military service or equal access to care.

"This resolution asks the AMA to state that there is no medical justification for this blanket ban and, in doing so, empower military physicians and commanders to assess readiness to serve on a case-by-case basis."

Hurley is a delegate to the Section Council on Psychiatry from the Gay and Lesbian Medical Association: Health Professionals Advancing LGBT Equality (formerly known as the Gay and Lesbian Medical Association).

"We don't exclude gay people from military service or treat gay people and straight people according to different standards of care, so there is no justification for a continuing ban that treats transgender people different from cisgender people," Hurley said. "There are over 15,000 transgender service members who remain closeted as a matter of policy, so it is urgent that the AMA weigh in now to affirm that there is no medical justification for this discriminatory policy."

Mark Moran

Brian Hurley, M.D., a delegate to the Section Council on Psychiatry from GLMA: Health Professionals Advancing LGBT Equality, said there are over 15,000 transgender service members who remain closeted as a matter of military policy.

Carl Streed, M.D., an internist at Johns Hopkins Bayview Medical Center, speaking in support of the resolution, reminded House members that at least 18 other countries have allowed transgender individuals to serve in the military. Streed is a member of the Resident Fellow Section (RFS) and is the RFS representative to the Board of Trustees Advisory Committee on LGBT issues.

During his remarks to the House, Streed read the written testimony of an anonymous AMA member and member of the armed forces who is transgender. The anonymous written testimony included the following comments:

*see **Transgender** on page 15*

continued from facing page

been available since 2004, and annual screening for hypertension, diabetes, and dyslipidemia is recommended.

Screening alone, however, is insufficient to improve clinical outcomes—we must intervene to address the medical problems of people with serious mental illness (SMI). Smoking and obesity are the two main causes of preventable mortality in the general population and explain a substantial proportion of the premature mortality of persons with SMI. Pharmacotherapy is effective for smoking cessation, and evidence-based lifestyle interventions that promote weight loss have been adapted for patients with SMI, but these treatments are not widely available in community mental health centers.

We have a tremendous opportunity to translate these important research findings into changes in health care provided in real-world clinical settings and improve clinical outcomes. Psychiatrists should provide counseling on lifestyle modification and smoking cessation, taking into consideration the social determinants that contribute to poor physical health in many patients with SMI. For example, cooking skills can be taught in classes at community mental health organizations, and nutritional information and recipes should consider budgets for food. All patients with SMI should have access to evidence-based lifestyle modification programs, and psychiatrists should advocate for such programs to be implemented in the settings where they work.

Psychiatrists should implement a population-based approach to management of medical problems, including cardiovascular risk factors. Modeling on the chronic-disease management programs of our primary care colleagues, we can start by defining the populations that need targeted proactive treatment for chronic medical conditions. Registries (lists of patients currently involved in treatment along with outcomes being tracked) are critical for monitoring treatment and evaluating outcomes. A registry could be used, for example, to monitor the metabolic screening of a psychiatrist's patient panel or diabetes performance measures among all patients at a community mental health organization who have comorbid diabetes.

Patients with chronic medical conditions need timely medical follow-up, and treatment should be adjusted when disease is poorly controlled. Because patients with SMI typically have frequent contact with psychiatrists, a psychiatrist may be the physician in the best position to monitor medical disease control and quality of care. To ensure that patients are receiving adequate treatment, psychiatrists should maintain knowledge about treatment guidelines and performance measures for chronic medical conditions such as hypertension, hyperlipidemia, and diabetes. Active engagement in management of chronic medical conditions for patients with SMI may require establishing a system of consultation with primary care and specialty colleagues, or retraining psychiatrists in general medical skills learned in medical school. Efforts are under way to address workforce issues, including changes in psychiatry residency curricula and courses such as "Primary Care Skills for Psychiatrists" offered at APA's annual meeting.

Training in medicine provides psychiatrists with a unique skill set to provide health care for the whole person. We need the vision to tackle medical illness proactively and much earlier in the course of illness. To lead models such as behavioral health homes, we will have to develop new competencies and accept accountability for medical outcomes. Our patients face a terrible burden of medical morbidity and premature mortality. This is a time for us to be advocates and agents of change. PN

NICE's guidelines, "Psychosis and Schizophrenia in Adults: Treatment and Management," are posted at https://www.nice.org.uk/guidance/cg178.

ASSOCIATION NEWS

Toronto Meeting Went Beyond Science to Offer Collegiality

With more than 10,000 people in attendance and a scientific program replete with leading lights in clinical practice and research, APA's 2015 annual meeting in Toronto was a rousing success. Many annual meeting events brought people together for fun and networking (additional annual meeting articles and photos appeared in the June 19 issue). APA's next meeting, the IPS: The Mental Health Services Conference, will be held October 8 to 11 at the Sheraton New York Hotel and Towers in New York City.

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1 Residents from Creighton University/University of Nebraska won the 2015 MindGames competition. The members of the winning team were (left to right) Venkata Kolli, M.D., Varun Monga, M.D., and Rohit Madan, M.D.

2 Rahn Kennedy Bailey, M.D., chair of APA's Membership Committee, greets guests from 48 countries at the welcome reception for new international members, fellows, and distinguished fellows.

3 Women psychiatrists take time out from scientific sessions to gather in the Women's Center and network with colleagues.

4 Psychiatry residents Benoit Bergeron, M.D., Ph.D., Alexandre Dow, M.D., and Ariane Piche-Jutras, M.D., gather after checking in at the registration center.

5 Janice Van Kempen, M.D., and Gabriel Attallah get an early start on introducing the next generation of psychiatrists to APA's annual meeting.

6 Former Rep. Patrick Kennedy signs a copy of *Understanding Mental Disorders: Your Guide to DSM-5* for Padraic Carr, M.D., president of the Canadian Psychiatric Association. Kennedy wrote the foreword to the book, which was published by American Psychiatric Publishing just prior to the start of the meeting.

Photos: David Hathcox

ASSOCIATION NEWS

David Hathcox

Posing for a photo after the presentation of the Awards for Advancing Minority Mental Health are (from left) Saul Levin, M.D., M.P.A., chair of the American Psychiatric Association Foundation's Board of Directors and APA CEO and medical director; Marie-Claude Rigaud, M.D., M.P.H., of Rebâti Santé Mentale; Paul Burke, executive director of the Foundation; XinQi Dong, M.D., M.P.H., of Rush University Medical Center; and James Nininger, M.D., a member of the Foundation's Board of Directors

APA Foundation Announces Winners of Advancing Minority MH Awards

The Foundation recognizes the efforts of those who are helping underserved minority populations get access to mental health care.

BY LINDSEY MCCLENATHAN

The American Psychiatric Association Foundation announced the winners of its 2015 Awards for Advancing Minority Mental Health at its annual benefit held in conjunction with APA's 2015 annual meeting in Toronto.

Lindsey McClenathan is the development officer in the American Psychiatric Association Foundation.

These awards, created in 2003, recognize psychiatrists, other health professionals, mental health programs, and other organizations that have undertaken innovative and supportive efforts to raise awareness of mental illness in underserved minority communities, the need for early recognition, the availability of treatment and how to access it, and the cultural barriers to treatment; increase access to quality mental health services for underserved minorities; and improve the quality of care for underserved minorities, particularly those in the public health system or with severe mental illness.

Here are brief descriptions of this year's winners:

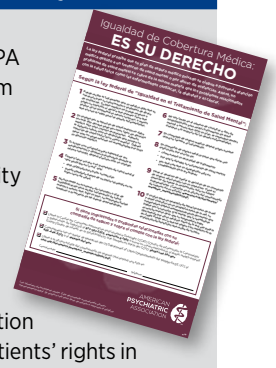
- **XinQi Dong, M.D., M.P.H.,** a professor of geriatric medicine, behavioral sciences, and nursing at Rush University Medical Center, has focused his career on social justice and mental health issues within the aging Chinese population in the Chicago area. Among other mental health outreach and research, Dong has hosted countless workshops and lectures in these Chinese communities to break down barriers and myths associated with mental illness and family violence.

- **Rebâti Santé Mentale** is an organization dedicated to establishing an effective mental health capacity in Haiti. In rural areas outside of Port-au-Prince, mental health services are severely limited. Thus, Rebâti Santé Mentale is establishing collaborative partnerships to create sustainable mental health programs in Haiti. The organization also runs a mental health training program to teach health professionals, teachers, religious leaders, and other community members to recognize the symptoms of psychological distress and raise community awareness about mental health issues.

- **We Hear You—Te Eschuchamos** is a mental health awareness campaign of the Chicago School of Professional Psychology's Center for Latino Mental Health. It is designed for young Latinos/as to reduce the stigma related to mental health issues and increase the likelihood of mental health service use in this population. In addition to community workshops, the campaign includes a bilingual website, social media, workshops, and monthly participation in a local radio broadcast. PN

More information about the Awards for Advancing Minority Mental Health is posted at http://www.americanpsychiatricfoundation.org/what-we-do/awards/awards-for-advancing-minority-mental-health.

Now in Spanish: Patients' Rights Under Parity Law



The poster that APA produced to inform patients of their rights under the Mental Health Parity and Addiction Equity Act is now available in Spanish as well as English. In addition to pointing out patients' rights in clear, easy-to-understand language, the poster notes the steps to take when violations are suspected. Armed with this information, patients are in a stronger position to ensure that they are getting the mental health benefits they are afforded under the law. Psychiatrists are encouraged to download the poster and hang it prominently in their offices or clinics or use it as a handout; also, the link can be forwarded to others in the community, such as employers and members of the clergy. Federal law is clear that insurers can no longer discriminate against patients with mental illness. To download the poster in either English or Spanish, go to http://www.psychiatry.org/practice/parity.

Transgender

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"Delaying adoption of this policy … will only serve to further harm those of us who actively serve our country in silence every day. We simply cannot wait. … The AMA's mission is to promote the art and science of medicine and the betterment of public health. The science on this issue is clear. There is no medical basis for the current ban."

Also speaking in support of the resolution was retired Rear Admiral Alan M. Steinman, who was the director of health and safety for the U. S. Coast Guard from 1993 to 1997. He was coauthor of a 2014 report in the journal *Armed Forces and Society,* which analyzed Defense Department regulations and other medical data to determine whether U.S. military policies that ban transgender service members are based on medically sound rationales.

Steinman and his fellow authors concluded that that there is no compelling medical reason for the ban on service by transgender personnel, that the ban is an unnecessary barrier to health care access for transgender personnel, and that medical care for transgender individuals should be managed using the same standards that apply to all others.

"Simply treating transgender service members in accordance with established medical practices and standards, as it does with the provision of all medical care, is all that's needed to end the unnecessary and harmful policy of discrimination against transgender service," Steinman and colleagues said.

"While no new medical rules are needed, the Defense Department could look to foreign military experiences as it formulates administrative guidance to address fitness testing, records and identification, uniforms, housing, and privacy. … Foreign military regulations that apply to transgender military service are straightforward, sensible, and fair, offering a sound model for U.S. military policy. … [T]aking these steps to reform current military policy governing transgender service would improve care for U.S. service members without burdening the military's pursuit of its vital missions," the authors stated. PN

An abstract of "Medical Aspects of Transgender Military Service" is posted at http://afs.sagepub.com/content/41/2/199.abstract.

ASSOCIATION NEWS

DDHE Director Speaks About the Importance of Diversity in Psychiatry

The mission of APA's Division of Diversity and Health Equity is to meet the professional needs of psychiatrists from minority and underrepresented groups and improve the quality of care for minority and underserved populations.

BY VABREN WATTS

July is APA's Diversity Mental Health Month, a month during which the mental health needs of diverse populations are spotlighted, as well as the importance of continued training in cultural competence by the health care professionals who serve them. Last year APA launched Diversity Mental Health Month, which is spearheaded by the Division of Diversity Health Equity (DDHE), formally known as the Office of Minority and National Affairs. Since July 2014, the division has undergone some change, including the appointment of Ranna Parekh, M.D., M.P.H., as DDHE director. In an interview with *Psychiatric News*, Parekh discusses the purpose of APA Diversity Mental Health Month and the future of DDHE.

Aaron Levin

Ranna Parekh, M.D., M.P.H., believes that as patient demographics continue to change and as more diverse groups access mental health care, the way in which health care professionals approach diversity has to broaden.

PN *What is APA Diversity Mental Health Month?*

RP Diversity Mental Health Month was created two years after Steve Koh, M.D., M.P.H., M.B.A., Barton Blinder, M.D., Ph.D., and Joseph Mawhinney, M.D., wrote an action paper calling for APA to designate a month to spotlight diversity initiatives—looking at patient health care disparities, workforce diversity, and cultural competency issues. They thought it was important to designate a month that really focused on the importance of the diversity of our members, the patients we serve, and the science that informs our work as psychiatrists.

PN *Why do psychiatrists need to be sensitive to diversity issues?*

RP It is important that people recognize that disparities exist in access to mental health care. The U.S. Department of Health and Human Services reports that Hispanics and African Americans are, respectively, 30 percent and 40 percent less likely to receive any mental health care services than whites. Asians are 50 percent less likely to access mental health care than whites. One of the hopes for Diversity Mental Health Month is to provide a platform that makes health care disparities more visible.

Whenever a psychiatrist interfaces with a patient with a background different from his or her own, there is going to be a huge range of differences in how they view the world around them. Psychiatrists need to be aware of how their cultural, racial, and ethnic background differs from those of their patients so they are able to provide their patients with the best care possible.

PN *How do you define "diversity?"*

RP Diversity is a broad term that continues to evolve. Our division was created in 1974 as the Office of Minority and National Affairs. Its purview expanded through the years until it became clear that we needed a new name for the department that reflected the broader mission we have today.

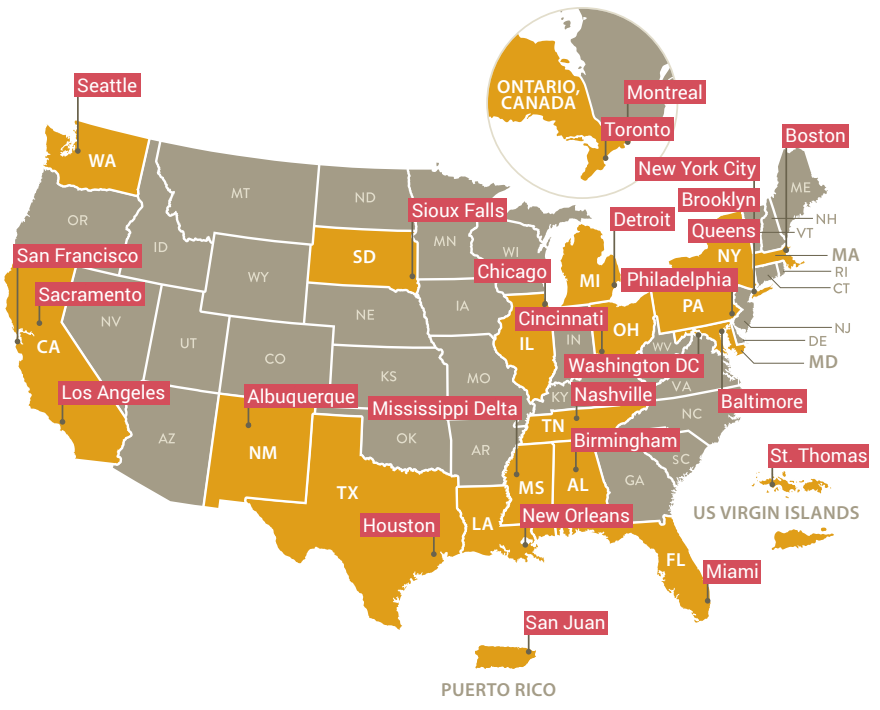
APA has long been committed to racial and ethnic groups who have a long history of health disparities and have been underrepresented in the field of psychiatry, including Asians, American Indian, Hispanics, and African Americans. At the same time, we want to evolve with the definition of diversity to include other groups, such as women; members of the lesbian, gay, bisexual, and transgender (LGBT) community; religious minorities; internationals; and those who are underrepresented geographically.

PN *You've been DDHE director since January. How do you like your position?*

RP I feel really fortunate. I get to think about ways to improve diversity in psychiatry every day—this is a dream job come true. Prior to coming here, I worked as a practicing psychiatrist at Massachusetts General Hospital for 15 years. I loved being a practicing physician, but having the opportunity to work with 36,000 members, seven minority/underrepresented caucus groups, an incredible council on minority mental health and health disparities, and a great DDHE team has been absolutely amazing.

It has also been exciting to be a part of the APA administration and work with our elected leaders who have made diversity issues a top priority for the organization.

[Note: The seven minority/underrepresented caucuses represent American Indian, Alaska Native and Native Hawaiian psychiatrists; Asian-American psychiatrists; black psychiatrists; Hispanic psychiatrists; international medical graduates; lesbian, gay and bisexual psychiatrists; and women psychiatrists.]



Locations of meetings, community outreach, and "On Tour" programs where DDHE has gathered physicians, patients, and advocates of mental health care to address mental health disparities of minority populations.

PN *What is your vision for DDHE?*

RP Part of my goal is to continue to develop the great work that APA is already doing. This work includes continuing to grow the minority fellowship programs, which at their core is about increasing workforce diversity—a platform of one of my predecessors, Jeanne Spurlock, M.D. We are also looking to expand in the areas of education, research, as well as partnerships with APA district branches, governmental agencies, and community and other mental health advocacy organizations.

At this year's annual meeting, we had the first "conversation" in a series on diversity and health equity. Through this candid dialogue with members, DDHE now has a better idea about what programs need to be continued, improved upon, or discontinued and what new programs members would like to see added. The "conversations" event was the first step in APA reimagining what the DDHE can mean for our members and the patients we serve. We plan to make these conversations with members a regular part of future annual meetings and the IPS: The Mental Health Services Conference.

PN *What events does DDHE have planned for later this year?*

RP We will have a "DDHE on Tour" program at this year's IPS: The Mental Health Services Conference in New York City in October on domestic violence (see page 10). This will be a very unifying event where the seven minority caucuses will be able to participate because domestic violence affects all ethnic racial, geographical, cultural, and socioeconomic groups. Psychiatrists should be leaders in mental health issues surrounding domestic violence, especially as it relates to destigmatizing help for victims. We should also be trained to provide better services to this population.

continued on facing page

COMMUNITY NEWS

David Hathcox

Families fleeing violence, repression, and poverty in Central America often travel to the United States in piecemeal fashion. As a result, children following their parents north may experience traumatic journeys, says William Arroyo, M.D. At left is Pedro Ruiz, M.D.

Child Refugees May Have Harrowing Journey North

Trauma experienced in their home countries or during their journey north from Central America may leave unaccompanied children in need of mental health care.

BY AARON LEVIN

Unaccompanied children apprehended at the U.S.-Mexico border nearly tripled between 2012 and 2014—from 24,000 to 69,000—and brought with them a complex mixture of responses.

While the numbers appear to be lower so far this year, these children still represent a highly traumatized population, said Andres Pumeriega, M.D., a professor and chair of psychiatry at Cooper Medical School of Rowan University in Camden, N.J., at APA's 2015 annual meeting in Toronto in May. "They are fleeing little-known conflicts at home and face an uncertain legal quagmire and an often hostile, anti-immigrant political climate in the U.S."

Many of the child refugees travel north to the United States from Honduras, El Salvador, and Guatemala to be reunited with parents who arrived in the United States before them.

Even before the journey begins, many of these children face traumatic experiences. In their home countries, they may have experienced crime and violence or been threatened by or forced into gangs or paramilitary units. As they move north, the children, many of whom are alone, may experience more violence and danger as they traverse Mexico.

If picked up by U.S. Immigration and Customs Enforcement (ICE) agents, these children are held for a hearing within 21 days.

"They have no right to counsel, and it would take a lawyer [hired by the family] four to six weeks to properly prepare their case," said William Arroyo, M.D., a regional medical director of the Los Angeles County Department of Mental Health and clinical assistant professor of psychiatry at the Keck USC School of Medicine.

"About 85 to 90 percent of these minors are then placed in communities, but ICE won't give any information on where the children are released," said Arroyo. ICE provides a minimal level of mental health services while these children are held, but such services are not guaranteed to be available after they leave ICE custody. "We do know that the amount of services they receive diminishes because of their undocumented status."

No federal funds can be used to help these children, but some states such as California provide their own funds, he said.

This is not the first wave of unaccompanied children to reach U.S. soil, noted discussant Pedro Ruiz, M.D., a former APA president and a professor of psychiatry and behavioral sciences at the University of Miami Miller School of Medicine. At the start of the Castro era, more than 14,000 Cuban youth were sent to Florida by their parents (usually Roman Catholics fearing religious repression) in Operation Pedro Pan. They were resettled temporarily around the country by charities, but often haphazardly.

"Many of these children suffered from anxiety and nightmares when exposed to a culture not their own," said Ruiz. "Many were so angry about their separation that they refused to talk with their parents when they were eventually reunited."

Refugees aren't the only ones to have to adjust to the realities of immigration, pointed out Kenneth Thompson, M.D., a clinical associate professor of psychiatry at the Western Psychiatric Institute in Pittsburgh. The people living in the country receiving immigrants may also experience challenges, as the community around them changes.

Such changes may lead some people in the host nation to feel their identity, familiar surroundings, security, or status is threatened, he said.

The response in the host country does not have to be negative, though. He noted that Toronto expected to add one million people to its population between 2005 and 2020, mostly immigrants.

"We must recognize the losses but focus on and foster the gains," he said. "The host country can be accepting if it is ideologically ready and has the needed resources. We must address the concerns of the people who are anti-immigrant."

That balance has to be achieved in helping the influx of child migrants, said Pumariega, who came to the United States from Cuba as a child.

"Children can be more adaptable to cultural change but also more vulnerable, especially when rejected," he said. "The United States can work to integrate the new immigrants. The resiliency of these communities is amazing. People can see these changes through if they have the willingness, the patience, and the perseverance." PN

continued from facing page

PN *What do you want APA members to know about DDHE?*

RP My hope is that APA members know that DDHE represents them. Also, they should be aware that we offer a valuable resource to which they can turn when faced with questions about how best to work with patients of different backgrounds. Our plan is to build a robust website with more resources for our members that will ultimately help them provide better care for all patients seeking mental health services. PN

The DDHE toolkit for APA Diversity Mental Health Month is posted at http://www.psychiatry.org/diversity-month.

CLINICAL & RESEARCH NEWS

Benzodiazepines: Experts Urge Balance

Experts counsel a balanced, informed view when deciding whether benzodiazepines are indicated for treatment for anxiety.

BY AARON LEVIN

While the use of benzodiazepines for the treatment of anxiety have come under much scrutiny lately, a more balanced view is needed, said Edward Silberman, M.D., at APA's 2015 annual meeting in Toronto in May.

When used appropriately and carefully, benzodiazepines have their place, said Silberman, a professor of psychiatry at Tufts University School of Medicine in Boston, who chaired the symposium "The Place of Benzodiazepine for Anxiety Disorders: Are We Ignoring the Evidence?"

The roots of the debate lie as much in medical history as they do in symptomatology, said sociologist Allan Horwitz, Ph.D., a professor in the Department of Sociology and the Institute for Health, Health Care Policy, and Aging Research at Rutgers University in New Brunswick, N.J.

In the 1950s and 1960s, anxiety was seen as lying at the core of neurotic disorders in the first two iterations of the *DSM,* said Horwitz. Medications were seen as useful responses to the stresses of life and tranquilizers were the drug of choice, applied to a range of psychosocial problems.

All that changed suddenly around 1975 with the ascendancy of what the late psychiatrist Gerald Klerman, M.D., called "pharmacological Calvinism," the idea that if a drug makes a person feel good, it must be bad.

"Benzodiazepines got caught up in the anti-drug movement as the Food and Drug Administration attacked drug companies for seeking to mitigate the problems of ordinary life rather than curing diseases," said Horwitz.

David Hathcox

In the 1950s and 1960s, medications were used to treat people in response to the stresses they were experiencing in life, and tranquilizers were the drug of choice, says sociologist Allan Horwitz, Ph.D., of Rutgers University.

Publication of *DSM-III* in 1980 was "a truly revolutionary event," he said. It sliced up anxiety into many subspecies while broadening the ways to diagnose depression, making diagnosis of the former more difficult and the latter easier.

A major transformation was under way. In the 1950s, the social context led to stress and then to anxiety. By the 1990s, depression, generated within the individual, became the cause of disorder.

Prescriptions for anxiety were three times more common for anxiolytics in 1962, a proportion completely reversed by 2002. Antidepressants are sometimes prescribed today as benzodiazepines were half a century ago, said Horowitz, "to address underlying, ordinary human psychic, somatic, and interpersonal problems."

Some clinicians and researchers have raised questions about how benzodiazepines are prescribed.

"[U]se of benzodiazepines in the United States is substantially higher among women than men and increases with age," wrote Mark Olfson, M.D., M.P.H., a professor of clinical psychiatry

see ***Anxiety*** *on page 37*

SSRI Use in Late Pregnancy May Slightly Increase Risks of Newborn Respiratory Disease

Overall increased risk of persistent pulmonary hypertension of the newborn in babies born to mothers taking SSRIs was found to be quite modest and much smaller than previous studies have suggested.

BY NICK ZAGORSKI

In 2006, the Food and Drug Administration (FDA) issued a public health advisory on the possible increased risk of persistent pulmonary hypertension of the newborn (PPHN)—a rare but severe and potentially fatal respiratory disease—to babies born to women who took selective serotonin reuptake inhibitors (SSRIs) during late pregnancy.

This warning was based primarily on one large study that suggested SSRI use after 20 weeks resulted in a sixfold increased risk of PPHN. Since then, however, subsequent research has produced conflicting results as to whether this risk is genuine. As a result, the FDA revised their warning in 2011, stating that it was premature to link SSRIs with PPHN.

However, no definitive answer exists yet for this important question, noted Krista Huybrechts, Ph.D., an assistant professor of medicine at Brigham and Women's Hospital and Harvard Medical School.

"While PPHN is quite rare, antidepressants, especially SSRIs, are frequently used during pregnancy, which means there are a lot of women who may be potentially at risk," she said.

To investigate this issue, Huybrechts led a comprehensive analysis of over 3.7 million pregnant women enrolled in Medicaid between 2000 and 2010. (The studies that have not found any connection between SSRIs and PPHN have been in small populations, and thus may not have been able to uncover small changes in risk.)

Within this maternal population, 128,950 women were taking an antidepressant within 90 days of giving birth—and in about 80 percent of these instances (102,179), it was an SSRI.

Huybrechts and colleagues compared the rates of PPHN in the different groups, finding that 7,630 infants not exposed to antidepressants were diagnosed with PPHN (about 20.8 per 10,000 births) compared with 322 infants exposed to SSRIs (about 31.5 per 10,000) and 78 infants exposed to other antidepressants (about 29.1 per 10,000).

While the absolute rates where about 50 percent higher, when the authors adjusted for other differences between the antidepressant and unexposed groups, they found no statistical differences in PPHN rates for any of the groups.

"When we did some secondary analyses with different scenarios, we did find that SSRI use led to a slightly increased risk in PPHN cases that did not have other contributing factors like congenital heart defects or premature birth," Huybrechts said.

"However, given that the changes were so modest, I would be cautious in making any claims that SSRIs do increase PPHN risks in this instance."

And since most of the women were taking SSRIs, Huybrechts noted that her study could not draw any conclusions as to differing risks among various types of antidepressants.

"SSRIs are the most common, and therefore the most intensely studied antidepressants," she said. "However, it would be worthwhile to explore the risks of other types of antidepressants in more detail, as well as other psychotropic medications, which are becoming increasingly used during pregnancy."

Still, based on these findings, Huybrechts told *Psychiatric News* the message for pregnant women remains encouraging. "While we did not rule out a connection between SSRI use and an increased risk of PPHN, the risk—if any—is much smaller than previous studies have suggested," she said.

The study by Huybrechts and colleagues was published June 2 in *JAMA* and was supported by a grant from the Agency for Healthcare Research and Quality. PN

"Antidepressant Use Late in Pregnancy and Risk of Persistent Pulmonary Hypertension of the Newborn" is posted at http://jama.jamanetwork.com/article.aspx?articleid=2300602.

CLINICAL & RESEARCH NEWS

Strategy Slows Down Weight Gain In Youth Taking Antipsychotics

Developing strategies that protect patients from the weight gain, lipid abnormalities, and insulin resistance associated with long-term use of antipsychotics could help improve the overall health of people after psychosis.

BY VABREN WATTS

Although numerous studies have explored the effectiveness of interventions for antipsychotic-induced weight gain in adults after first-episode psychosis (FEP), data on interventions for children dealing with this is lacking. A group of Australian researchers may be able to help fill in the gap.

At APA's 2015 annual meeting in Toronto, Jackie Curtis, M.D., clinical director of Youth Mental Health at South Eastern Sydney Local Health District in Australia, premiered results from an ongoing study showing that a multidisciplinary approach may be able to help reduce antipsychotic-induced weight gain in youth.

"I've been working in early intervention programs since I started doing work in psychiatry 15 years ago," said Curtis, in an interview with *Psychiatric News*. "I have watched young people get better as it pertains to their psychotic symptoms, but they were putting on weight—gaining anywhere from 10 to 30 kilograms."

According to Curtis, previous research has shown that clinically significant weight gain occurs in 23 to 61 percent of FEP patients prescribed antipsychotic medications for 10 to 16 weeks, with rates increasing to an average of 80 percent after one to two years of treatment. Lipid abnormalities can emerge within the first 12 weeks of treatment and insulin resistance can occur in the first year.

Vabren Watts

Jackie Curtis, M.D., says that psychiatrists have a responsibility to help their patients achieve "total health." "It's not just about mental health," she believes.

Curtis said that though awareness of antipsychotic-induced weight gain is greater now than it was 15 years ago, more research is needed to understand ways to overcome this condition, particularly in young people with FEP.

Curtis and her colleagues enrolled 28 youth, aged 15 to 25, with FEP into the Keeping the Body in Mind Program (BMP), a 12-week pilot intervention program that offers weekly individualized dietetic monitoring and education and a prescription for exercise with a trainer, in addition to education in a group setting. Sixteen youth participated in BMP, while the remaining youth served as controls. Weight, blood pressure, and lipid and glucose levels were assessed.

see ***Weight Gain*** *on page 38*

Gene Expression Changes in Summer, Winter

Nearly one quarter of the genome changes in activity over the course of the year, providing biological evidence for why many diseases—including psychiatric disorders—display stronger symptoms during the winter.

BY NICK ZAGORSKI

From falling leaves to shedding fur, nature provides many external signs that the seasons are changing. Seasonality affects humans as well—just ask anyone with arthritis or allergies. Yet, how seasons impact the underlying molecular details of human physiology is not well understood.

This is an important area to consider in terms of mental health, as more and more research studies are finding evidence that, like many other diseases, psychiatric disorders have seasonal patterns of activity.

A new genetic study appearing in *Nature Communications* indicates that such seasonal differences have a strong biological component. Researchers examined over 22,000 genes from a diverse set of individuals—from both Northern and Southern hemispheres—and found that nearly a quarter of them (5,136) showed some seasonal variation.

The genes showed a roughly equal split in their activity, with around 2,300 genes being more active in the summer and 2,800 more active in the winter. Most of these genes contributed to processes that seemed quite logical; for example, the composition of blood and fat cells changed during the winter, in line with the concept of preparing to keep the body warm. Genes related to the immune system were also seasonally dynamic, including many genes that affect vaccination response.

"In some ways, it's obvious," noted study author John Todd, Ph.D., director of the JDRF/Wellcome Trust Diabetes and Inflammation Laboratory at the Cambridge Institute for Medical Research. "It helps explain why so many diseases, from heart disease to mental illness, are much worse in the winter months."

The surprising aspect, Todd noted, was the breadth of seasonal change that this study uncovered. He believes the findings may have implications for how we administer vaccines, treat certain diseases, or even carry out research studies.

One notable gene of interest to psychiatry was the circadian clock gene ARNTL, which showed a 50 percent increase in activity between February (low) and August (high). (Interestingly, while circadian clock genes might be prime candidates for seasonal change, only about half of the clock genes tested changed in activity during the year.)

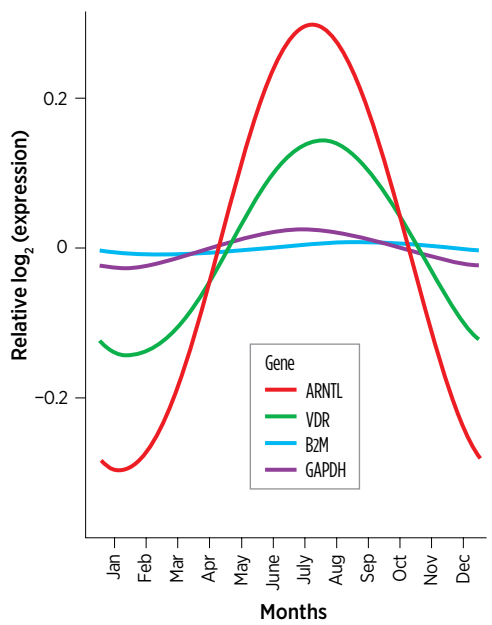
ARNTL has been connected with depressive symptoms, especially those in seasonal affective disorder, but has also emerged as a potential player in other mental disorders including bipolar disorder, schizophrenia, and autism.

How the circadian clock may affect a symptom like psychosis is still being teased out, though Todd and his colleagues did find that several anti-inflammatory genes, such as the receptors that bind the stress hormone cortisol, had expression profiles that mirrored ARNTL. Numerous research studies have hinted at a connection between schizophrenia and the immune system, including a recent analysis carried out by the Psychiatric Genomic Consortium that identified over 80 new schizophrenia risk genes (*Psychiatric News*, September 5, 2014).

The current study used data from over 16,000 volunteers from the United States, United Kingdom, Iceland, Germany, Australia, and The Gambia. The work was supported by the National Institute for Health Research. PN

Gene Expression Varies Over Course of Year

The circadian clock gene ARNTL (red), implicated in several psychiatric disorders, shows tremendous summer-winter differences in expression, even more so than the vitamin D receptor (green), one of the more well-known seasonal genes.



Source: X.C. Dopico, Ph.D., et al., *Nature Communications*, May 12, 2015

"Widespread Seasonal Gene Expression Reveals Annual Differences in Human Immunity and Physiology" is posted at http://www.nature.com/ncomms/2015/150512/ncomms8000/full/ncomms8000.html.

CLINICAL & RESEARCH NEWS

Depression Increases Stroke Risk, Even After Symptoms Remit

Two years after the symptoms of depression subsided, adults over 50 continued to be at a 66 percent increased risk of stroke compared with those with no depression over the same period.

BY NICK ZAGORSKI

The link between a healthy mind and a healthy heart is well established, but new findings published in the *Journal of the American Heart Association* in May have added a new wrinkle to the mind-body connection, finding that long-term depression can elevate the risk of stroke even after the symptoms go away.

These results came from a study that assessed over 16,000 adults (aged 50 and up), who participated in the Health and Retirement Study between 1998 and 2010. As part of the study, participants were interviewed every two years about symptoms of depression, history of stroke, and stroke risk factors.

Similar to previous findings, the authors found that sustained depression increased the risk of stroke; compared with people who showed low or no depressive symptoms at two consecutive interviews, people with high depressive symptoms were more than twice as likely to have a first stroke during the subsequent two years.

Surprisingly, however, participants who had symptoms of depression at the first interview but not at the second still had a 66 percent greater risk of stroke compared with people with no depression. In contrast, people who reported symptoms of depression only during their second interview (the recent-onset group) did not show an elevated stroke risk.

"We were surprised to see that the onset or remission of depressive symptoms takes more than two years to influence stroke risk," lead study author Paola Gilsanz, Sc.D., told *Psychiatric News*. "But it's an important finding, as depression is not static, and both clinicians and patients want to know how changes in depressive symptoms affect overall health."

Study coauthor Maria Glymour, Sc.D., an associate professor in epidemiology and biostatistics at the University of California, San Francisco, pointed out that understanding how changes in depression may affect stroke risk also provides clues as to which pathways are responsible for this risk.

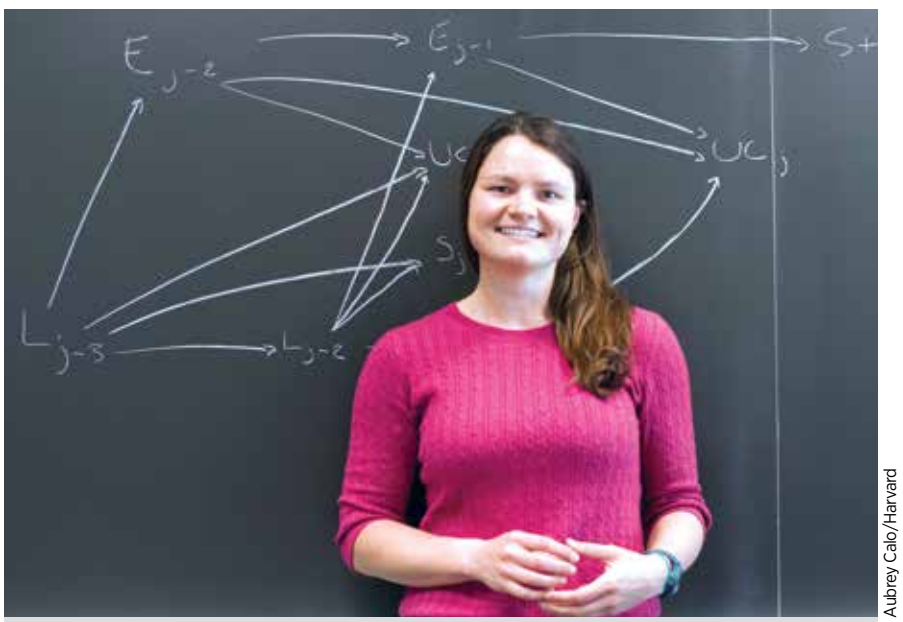
"It has been speculated, for example, that depression may increase the incidence of atrial fibrillation (irregular heartbeats), which would increase short-term stroke risks, but our data do not support this mechanism, at least in older adults," she said.

The two-year lag suggests rather that depression influences vascular health via long-term mechanisms brought on by biological and/or behavioral changes in depressed individuals.

Jesse Stewart, Ph.D., an associate professor of psychology at Indiana University-Purdue University Indianapolis (IUPUI), told *Psychiatric News*, "These findings reaffirm that people with depression should not lower their guard once their symptoms go away."

Marco Sanchez/UCSF Documents & Media

Study co-author Maria Glymour, Sc.D., believes that the observed lag between a change in depression status and stroke risk indicates that depression influences vascular health via long-term biological and/or behavioral mechanisms.



Aubrey Calo/Harvard

Paola Gilsanz, Sc.D., says many unanswered questions remain regarding the relationship between depression and stroke, including whether younger people whose symptoms of depression have subsided are also at greater risk.

But he also cautioned that this study assessed people only two years after a change in depression status, and that in the longer term, symptom remission may have more pronounced cardiovascular benefits.

Stewart noted one of his own studies that compared the effects of providing either collaborative or usual care to depressed people over an eight-year period (*Psychiatric News*, March 15, 2014). "In our study, we found few dif-

see ***Depression*** *on page 31*

Risk of PTSD Symptoms Among Police May Be Predictable Years Ahead

Several factors measured when officers enter the police academy strongly suggest how the officers will react to stressful incidents years later.

BY AARON LEVIN

Big-city police officers experience three life-threatening events a year on average, yet the normative response to traumatic stress is resilience, reported Charles Marmar, M.D., a professor and chair of psychiatry at New York University's Langone Medical Center, at APA's 2015 annual meeting in Toronto in May.

Predicting who will and who won't develop symptoms of stress could help police forces improve training for all and lessen vulnerability.

David Hathcox

Risk and resilience in the face of life-threatening events in police work may be predictable—and planned for—well in advance, said Charles Marmar, M.D., at APA's annual meeting in Toronto.

Thirteen years ago, Marmar and colleagues began studying 400 candidates for police forces in San Francisco, Oakland, Calif., and New York City. They sought to find ways to help police, first responders, or soldiers prepare for and respond to stress, he said. "The idea was not to screen people out but to help them adapt better to the stress of these professions and provide early interventions to protect their resilience."

The researchers gathered an array of data on demographic factors, family history, and stress biomarkers and administered a three-hour psychiatric evaluation.

Marmar and colleagues also measured cortisol levels, eye-blink responses, skin conduc-

see ***Police*** *on page 36*

CLINICAL & RESEARCH NEWS

Study Suggests ADHD in Adults May Be Distinct Disorder

An analysis of over 1,000 New Zealanders finds only a fraction of adults with ADHD symptoms were diagnosed as children. ADHD adults also performed relatively normal on neuropsychological tests.

BY NICK ZAGORSKI

A study published May 22 in *AJP in Advance* suggests that adults presenting with ADHD symptoms may not have a childhood-onset neurodevelopmental disorder.

The study followed a cohort of 1,037 people who were born in Dunedin, New Zealand, in 1972 and 1973 and were followed for nearly four decades with comprehensive interviews and health evaluations—including psychiatric and neuropsychiatric tests—at periodic intervals.

In line with other prevalence data, childhood ADHD was diagnosed in 61 study participants (about 6 percent), mostly in boys. Adult ADHD was diagnosed in 31 individuals (3 percent), with equal gender distribution.

Those 31 people were not simply children who failed to manage their symptoms; only three of the 31 ADHD adults had a childhood ADHD diagnosis.

"What's more, the adults diagnosed with ADHD showed almost none of the neuropsychological deficiencies that are a hallmark of childhood ADHD," said lead study author Terrie Moffitt, Ph.D., the Knut Schmidt Nielsen Professor of psychology and neuroscience at Duke University. "Their brains seemed to work just fine when taking IQ or working memory tests."

In comparison with test scores, however, those adults with ADHD did report cognitive problems, such as forgetting why they went to a store or having trouble finding words when speaking.

Another difference was that the adult ADHD cases had much higher rates of substance abuse (around 48 percent) than those diagnosed as children.

These are interesting discrepancies that Moffitt thinks will be subject to interpretation. "Hard-nosed types who view ADHD as an overdiagnosed condition might see the normal neuropsychological profiles and elevated substance use as evidence that adult ADHD is not a genuine disorder," she told *Psychiatric News*.

"Others would argue that since over half of the cases had no diagnosed disorder, it serves as evidence that adult ADHD is a real and distinct problem. And while we don't fully understand it yet, the people who have it deserve mental health care."

No matter one's interpretation of the findings, Moffitt hopes this study can fuel further research that may help clarify the matter in either direction. There are other longitudinal studies examining ADHD in different populations, so more population evidence should be available in the near future.

And if these current findings are replicated, Moffitt believes changes should be made to the *DSM-5* to categorize ADHD as a distinct, non-neurodevelopmental disorder.

To help determine where this condition might fit, Moffitt's team is moving forward and analyzing the genetic data collected from the Dunedin cohort. Their current study found that unlike childhood ADHD cases, people with adult-onset ADHD did not have a genetic profile associated with an elevated risk of ADHD, which suggests the two disorders are biologically distinct. She hopes to study this in more detail to see what genetic influences may contribute to an adult-onset ADHD and if these differences are shared among any other disorders.

This study was funded by the National Institute on Aging, UK Medical Research Council, and Jacobs Foundation. The study participants were members of the Dunedin Multidisciplinary Health and Development Study. PN

"Is Adult ADHD a Childhood-Onset Neurodevelopmental Disorder? Evidence From a Four-Decade Longitudinal Cohort Study" is posted at http://ajp.psychiatryonline.org/doi/full/10.1176/appi.ajp.2015.14101266.

Antidepressants May Inhibit D-Cycloserine From Improving Symptoms in People With OCD

While D-cycloserine (DCS) improved the response of antidepressant-naïve OCD patients to cognitive-behavioral therapy, a similar benefit from taking the medication was not seen in patients taking antidepressants.

BY NICK ZAGORSKI

Cognitive-behavioral therapy (CBT) is a proven approach to help people overcome obsessive-compulsive disorder (OCD), though not everyone will respond quickly or fully. Researchers have been looking for pharmacological agents that might help augment CBT, and one promising agent that has emerged is D-cycloserine (DCS), an antibiotic that can also interact with some receptors in the brain.

"DCS has been one of the truly exciting recent innovations in psychiatry," said Eric Storch, Ph.D., a professor of clinical psychology at the University of South Florida and clinical director of OCD services at Rogers Behavioral Health-Tampa Bay. "However, the early promise has given way to mixed results in early clinical trials, which shows we still don't know enough about how DCS works or whom it works best for."

New research from the Karolinska Institute in Sweden may have provided a significant answer: antidepressants can interact with DCS and block its ability to help people with OCD extinguish the anxieties and fears that trigger their compulsions.

These findings, published May 13 in *JAMA Psychiatry*, arose from a clinical study of 128 adults with OCD who received CBT with either DCS or placebo for 12 weeks. Previous DCS trials had involved 20 to 30 participants, making this the largest trial conducted by far.

In this new trial, led by Christian Ruck, M.D., Ph.D. of Karolinska's Osher Center for Integrative Medicine, DCS supplementation did not improve CBT effectiveness among patients as a whole, either at the end of the 12-week treatment regimen or at follow-up three months later.

However, when patients were classified based on their medications status, big discrepancies in response appeared; 60 percent of the antidepressant-free patients on the DCS + CBT therapy achieved a remission of their symptoms at follow-up, compared with only 24 percent of patients on antidepressants. In comparison, the remission rate in the CBT-only group was 50 percent for patients taking antidepressants and those who were not.

"Given the good safety profile for DCS, these findings provide a basis to include DCS pharmacotherapy as part of a CBT strategy for some patients," Michael Jenike, M.D., a professor of psychiatry at Harvard Medical School and founder of the OCD Program at Massachusetts Gen-

continued on facing page

Key Points

128 adult outpatients with OCD were randomized to receive 12 weeks of Internet-based CBT along with 50 mg of either D-cycloserine (DCS) or placebo.

- Among all participants, there were no differences in the changes of either clinician-rated or self-rated OCD scores between the two groups at week 12 and at three-month follow-up.
- However, there were significant differences in treatment response between the DCS and placebo groups among patients not taking an antidepressant (n=91).
- Three months after CBT ended, 60 percent of the antidepressant-free patients receiving DCS achieved a remission of their symptoms, compared with 24 percent of patients on antidepressants.

Bottom Line: Antidepressants may interact with DCS to block its ability to augment fear-extinction therapies. In antidepressant-free OCD patients, DCS may be a viable CBT supplement.

Understanding Epigenetics May Offer Insights for Treatment of Mental Illness

Genomic methylation patterns influence gene expression in the brain and elsewhere and may open windows to treatment.

BY AARON LEVIN

David Hathcox

A deeper understanding of how epigenetics influences the brain could lead to more individualized approaches for psychiatric treatment, Moshe Szyf, Ph.D., tells attendees at APA's annual meeting in Toronto.

Life is more than DNA, said Moshe Szyf, Ph.D., a professor of pharmacology and therapeutics at McGill University in Montreal.

"The genome is the book of life, but it is a static book and life is dynamic," said Szyf at APA's 2015 annual meeting in Toronto in May.

Part of that dynamism is attributable to epigenetics, the pattern of methylation found on the gene. Call it *coding*—the organism's basic DNA—and *coating*—the attachment of a methyl group onto the surface of DNA that shuts down the expression of the gene.

"Genes come with a sequence and a methylation pattern defined by evolution," he said. "Methylation defines which gene works, in which cell, at what time."

In the brain, a constantly changing combination of chemical, biological, and social inputs interactively affects signaling pathways that influence methylation and demethylation and thus can influence behavior, mental health, and mental illness.

Animal studies, including those by Michael Meaney, Ph.D., a professor of psychiatry, neurology, and neurosuregery at McGill University, have shown that high and low levels of maternal care by mother rats are associated with different methylation patterns in their pups. The offspring of mothers who spent more time licking and grooming their pups grew up to exhibit less anxiety and a more resilient stress response as adults. Cross-fostering experiments show that care counts more than heritability, and those positive effects are carried by the pups to their own offspring.

The biochemical train of events that connects the social environment around the organism to its genome begins once the senses perceive an event and the brain appraises it, said Szyf. The response may trigger production of glucocorticoids or other hormones, which are then carried throughout the body.

The glucocorticoids usually act indirectly, through intermediary genes that Szyf calls "master regulators." Those are methylated or demethylated and then produce proteins that change methylation states in other genes downstream.

Epigenetic therapies may not be ready for the clinic yet, but it is important that psychiatrists know about the field, said Szyf.

For one thing, epigenetics can provide a way to understand how early life events relate to mental health later on.

"Epigenetics is a form of genomic memory," he said. "It memorizes and interprets events and embeds them in the genome."

Also, experts may one day be able to use these objective genetic markers to assess a patient's vulnerability and resiliency instead of relying solely on methods currently used by psychiatrists to assess patients, he said.

Finally, once epigenetic processes and patterns are better understood, researchers may begin to design drugs to turn methylation events on and off.

"The problem now is specificity," he said. "If you change methylases, it's not just one gene that is affected. How do we get the methylation that we want?"

But that's the wrong question, he said. "Who says we need a magic bullet? There are thousands of genes all over the system, and one gene can have thousands of methylation consequences. So we need to change the system as a whole from a pathological state to a less pathological state. We want to manipulate states systemwide, knowing full well that it will not be perfect."

Such interventions might take several forms. Medications that promote or block methylation could be tried. DNA methylation inhibitors are already known from cancer research, for example.

Behavioral approaches are also possible, Szyf said. "If experience caused these effects, experience should be able to change them." PN

An abstract of "Prospects for the Development of Epigenetic Drugs for CNS Conditions" is posted at: http://www.nature.com/nrd/journal/vaop/ncurrent/full/nrd4580.html.

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eral Hospital, told *Psychiatric News*.

"DCS also has similar properties to drugs like Rapastinel that are used as adjuncts to boost the effectiveness of antidepressants," he continued. "These adjuncts are typically not used alone, but some of them might also be able to augment behavioral therapy, which potentially opens up many new clinical windows."

Jenike had conducted one of the earlier DCS trials back in 2008. His study did not identify any long-term benefits related to OCD symptoms—perhaps because 16 of his 25 patients were taking antidepressants—but it did find evidence that DCS can improve depressive symptoms. According to Jenike, such findings suggest that if a patient receives a diagnosis of OCD with associated depression, DCS plus CBT may be able to serve as a first-line strategy, and an antidepressant can be added later, if needed.

One challenge to this treatment strategy is that many patients are not medication-naïve when they seek help for OCD, as this condition frequently associates with anxiety and depression. "In these cases, it's not as simple as telling someone to stop taking their antidepressant for a few weeks while they try CBT," Storch said. "For one, we don't yet know whether a recent medication user would respond the same as someone who never took an antidepressant. Second, we're still not sure how to best take someone off of antidepressant therapy."

Storch believes these two areas should be targets for more research, as well as looking into how different types of CBT benefit from DCS; this particular study employed a therapist-supported Internet CBT approach (which is useful from a research standpoint, as it can be standardized and has slightly higher retention), but in-person therapies might be more or less sensitive to DCS.

The study was funded by the Swedish Research Council. PN

An abstract of "D-Cycloserine vs Placebo as Adjunct to Cognitive-Behavioral Therapy for Obsessive-Compulsive Disorder and Interaction With Antidepressants" is posted at http://archpsyc.jamanetwork.com/article.aspx?articleid=2293087.

Depression

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ferences between collaborative or usual care in terms of stroke risk over the first two years, but after eight years, collaborative care for depression significantly lowered stroke risk."

Gilsanz agreed that there are plenty of questions left to answer regarding the relationship between depression and stroke, including whether younger people whose symptoms of depression have subsided also are at a greater risk of stroke, and the factors mediating the association.

"If we find that the patterns of hypertension risk mirror stroke risk in people with remitted depression, it might point to high blood pressure as the key mediator in this process," she said.

Gilsanz said she is also interested in how depression remission due to medication, psychotherapy, or spontaneous remission influences stroke risk.

This work was supported by multiple grants from the National Institutes of Health, the American Heart Association, and the Initiative for Maximizing Student Development. PN

"Changes in Depressive Symptoms and Incidence of First Stroke Among Middle-Aged and Older U.S. Adults" is posted at http://jaha.ahajournals.org/content/4/5/e001923.full.

CLINICAL & RESEARCH NEWS

Lithium Remains a Viable Option for People With Bipolar Disorder

Despite studies demonstrating the effectiveness of lithium for the treatment of bipolar disorder, its use in clinical practice in the United States is declining, experts say.

BY VABREN WATTS

"Who here has heard of lithium?" asked Michael Ostacher, M.D., an associate professor of psychiatry at Stanford University School of Medicine, during a session at APA's 2015 annual meeting in May on treating bipolar disorder.

Ostacher deemed the question—which was followed by a light chuckle from the audience—as relevant because though the drug has been a well-established treatment for bipolar disorder for 45 years, its use, at least in the United States, is declining.

"This decline [in lithium prescribing] is understandable," said Ostacher, who explained to session attendees that the underutilization of the drug may be partly attributed to the marketing surge for other FDA-approved drugs for the treatment of bipolar disorder.

According to Ostacher, previous research from insurance databases in the United States suggests antidepressants—initiated at diagnosis and continually used one year after diagnosis—are the most commonly prescribed therapy for bipolar disorder. This research shows that 70 percent of individuals diagnosed with bipolar disorder have been prescribed antidepressants compared with roughly 12 percent who have been prescribed lithium.

During his talk, Ostacher presented data from his recent work comparing the effectiveness of lithium with that of other medications in the treatment of bipolar disorder, including the results of BALANCE (Bipolar Affective disorder Lithium/Anticonvulsant Evaluation)—a multisite, randomized, open-labeled comparison study with lithium and the anticonvulsive divalproex.

The study, which included 330 adults with bipolar I disorder, showed that the risk of symptom relapse was reduced by 41 percent in patients who took a combined daily dosage of lithium (0.4 mmol) and divalproex (1,250 mg) over a two-year period. The risk of symptom relapse was reduced by 29 percent in patients who took lithium alone and 18 percent in patients who took divalproex alone.

"This primarily said that lithium or lithium in combination with divalproex was more effective than divalproex alone," said Ostacher. "This totally contradicts the way we initiate treatment for bipolar disorder in our patients in the U.S."

Ostacher mentioned that one of the limitations of the study was that most of the sample population was on a monotherapy prior to the study, whereas a significant number of people, particularly in the United States, take multiple medications at once.

A study by Andrew Nierenberg, M.D., and colleagues compared the effectiveness of lithium with the antipsychotic quetiapine in 482 patients with bipolar I or bipolar II disorder and at least one comorbid mental health condition. The patients were given a mean dose of 1,008 mg of lithium or a mean dose of 345 mg of quetiapine daily for six months while continuing to take medications for their other mental health conditions.

David Hathcox

Michael Ostacher, M.D., believes that it's important to continue research on all treatments for bipolar disorder, even treatments that are less utilized such as lithium.

The researchers tracked changes in the severity of bipolar disorder–related symptoms reported by patients—as measured by the scale of Clinical Global Impression for Bipolar Disorder Efficacy Index (CGI-BP EI)—and how frequently providers altered dosages of the medications due to side effects or lack of efficacy, known as necessary clinical adjustments (NCAs).

The analysis found both lithium and quetiapine to be equally effective in reducing symptom severity related to bipolar I and II disorder in patients at the study end point. However, the lithium group had significantly fewer NCAs per month than the quetiapine group.

After the session, Ostacher told *Psychiatric News* that "if we learn how to use it properly and safely in patients, lithium can be a mainstay medication for some patients." He emphasized that it is important for experts in the field to conduct more reliable studies that will provide confident enough results that would increase lithium use in clinical practice.

"There are multiple treatment options available to treat bipolar disorder. We just need to have enough information—on all options—to be able to determine which option is best for our patients," Ostacher concluded. PN

Large Population Study Does Not Link Varenicline With Suicide, Psychosis, or Traffic Incidents

Results using Swedish health registry data are in line with several previous controlled clinical studies, suggesting FDA black-box warnings may be misplaced.

BY NICK ZAGORSKI

Varenicline is emerging as a promising smoking cessation agent. This medication has been found to be more effective than nicotine replacement strategies like the patch, and it even works well for people who want to quit smoking gradually instead of abruptly (*Psychiatric News*, March 20). Research highlighted at APA's 2015 annual meeting even suggests that varenicline may be used to treat alcohol use disorder (*Psychiatric News*, June 19).

Despite the results of these trials, there continue to be concerns that varenicline increases the risk of depression, suicide, or psychosis—factors that in 2009 led the Food and Drug Administration (FDA) to issue a black-box warning for the drug. Additionally, varenicline use has been reported to increase the risk of traffic accidents. As a result, several transportation-industry professions have restricted or prohibited its use.

While the psychiatric side effects and increased risk of traffic accidents were

continued on facing page

Oxford University

Using a within-person study design, Seena Fazel, M.D., and colleagues found no evidence for increased risk of neuropsychiatric side effects with varenicline.

MED CHECK

BY VABREN WATTS

FDA Approves Antipsychotic Lasting Three Months

The FDA has approved ***Invega Trinza (paliperidone palmitate***), a long-acting atypical antipsychotic intended to treat schizophrenia, from Janssen Pharmaceuticals Inc.

The approval of the injectable antipsychotic, which remains active in the body for three months, was based on results from a two-year maintenance trial with 506 patients diagnosed with schizophrenia. The analysis, published March 29 in *JAMA Psychiatry*, showed that patients who were administered Invega Trinza were statistically less likely to relapse than those who were administered placebo. The most common adverse effects of the medication included injection-site reactions, weight gain, upper respiratory tract infections, and extrapyramidal symptoms.

The newly approved antipsychotic will come with a boxed warning stating that it is not approved for patients with dementia-related psychosis and that use of the drug may increase the risk for death in elderly patients with dementia.

Before patients can begin taking Invega Trinza, they must first show tolerability to Janssen's Invega Sustenna, a one-month form of paliperidone palmitate, for at least four months.

Invega Trinza was approved under the FDA's priority review process, a fast track for drugs thought to represent a significant advance in medical care. It is being marketed by Janssen.

Otsuka Denied Exclusive Rights To Market Abilify

In May, the U.S. District Court for the District of Maryland denied Otsuka Pharmaceutical's motion for a preliminary order blocking generic versions of Abilify after the company filed suit against the Food and Drug Administration for denying Otsuka exclusive rights to make Abilify until 2021.

Otsuka argued that Abilify was designated an orphan drug—a drug that treats rare conditions—when it was approved for pediatric Tourette's syndrome. The FDA gives several extra years of exclusivity to an orphan drug due to the drug's high cost of development, which may make the product less profitable than other drugs used to treat less rare conditions.

U.S. District Judge George Hazel said that since Abilify has nonpediatric uses, which are not protected by the orphan-drug status, development of generic versions of the drug can proceed.

Abilify is approved to treat schizophrenia and bipolar disorder and lost its patent protection for those uses in April.

Combined Therapy Announced For Treatment of Alzheimer's

Actavis announced that its new therapy, ***Namzaric***, is being marketed to treat moderate to severe Alzheimer's disease.

Namzaric is a once daily, fixed-dose of ***memantine hydrochloride extended-release*** (an NMDA receptor agonist) and ***donepezil hydrochloride*** (an acetylcholinesterase inhibitor). The newly marketed product is available in two strengths 28/10 mg (memantine HCl ER/donepezil HCl) and 14/10 mg for patients with severe renal impairment. The most common adverse reactions reported by patients taking the medication include headache, dizziness, and diarrhea.

Both memantine hydrochloride extended-release, marketed as ***Namenda,*** and donezepil hydrochloride, marketed as ***Aricept,*** are approved for the treatment of moderate to severe dementia associated with Alzheimer's disease. Namzaric is a joint effort between Actavis and Adamas Pharmaceuticals.

California Senate Looks to Reduce Psychotropic Use in Foster Care

Last month, the California state Senate unanimously approved four bills aiming to curb the use of psychotropic medications for youth in the foster system. The bills seek to improve how the state's juvenile courts approve psychotropic prescriptions, require periodic reporting of how often foster children are being medicated, and create new training programs for those providing medical treatment to foster children.

According to a series of investigative reports published in the *San Jose Mercury News*, almost one in four California teens in foster care has been given psychotropic drugs over the past decade, the vast majority receiving antipsychotics.

Under the proposed laws, social workers would be alerted when youth receive multiple medications or high dosages and when psychiatric drugs are prescribed to very young children.

Mercury News reports that though the legislation has no formal opposition, some child psychiatrists have expressed concerns that too many new rules could hinder care when access to medication is vital.

Combined Use of Antidiabetic, Antidepressant Medications Increases Risk for MI

Scientists from Sweden and Australia analyzed health records of four million Swedish residents aged 45 to 84 to assess the gender-specific risks of developing a first myocardial infarction in people being treated with antidiabetic and/or antidepressant drugs.

The results, published in the journal *Diabetic Medicine*, showed that women aged 45 to 64 who were taking both antidiabetic and antidepressant medications were more than seven times more likely to experience a myocardial infarction than women who were taking neither medication, and two and six times more likely, respectively, to experience such an event than women taking an antidiabetic and antipsychotic alone. Men taking both medications were more than three times more likely to have had a myocardial infarction than men who took neither medication, and twice as likely to experience such an event as those taking an antidiabetic drug or antipsychotic alone.

The analysis also showed that women taking the combined medications were more than two times more likely to experience a myocardial infarction than their male counterparts.

"About 10 to 30 percent of patients with diabetes have a comorbid depres-

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first identified during postmarketing surveillance of varenicline users, several clinical studies since have found no association between varenicline and these problems, except possibly in people with pre-existing mental health conditions.

"Such controlled clinical trials are a gold standard in identifying reactions or effects of a medication," said Robert Gibbons, Ph.D., director of the Center for Health Statistics at the University of Chicago and an expert in pharmacological epidemiology. "However, they typically involve smaller groups so they may not be generalizable to the broad population or catch rare events."

Seena Fazel, M.D., a professor of forensic psychiatry at the University of Oxford, along with colleagues at Sweden's Karolinska Institute, has now published a large, population-level study using Swedish registry data, providing more evidence that the psychiatric concerns linked with varenicline may be unfounded.

The study, which was published last month in the *British Medical Journal*, also offered a new twist in methodology.

"In a traditional comparison study, you would look at people on varenicline versus people not on varenicline," Fazel told *Psychiatric News*. "In this study, we compared the same person at times when they were taking the medication or not taking the medication; so everyone was basically his or her own control."

One advantage of this method, known as within-person analysis, is that several factors that can influence a study—such as genetics or childhood experiences—are constant, which reduces the amount of statistical adjustments that need to be made to account for the natural variability of a large group.

Indeed, when Fazel and his team compared the roughly 70,000 people in Sweden who took varenicline between 2006 and 2009 with the country's population at large, they found that the varenicline users had higher rates of seven adverse outcomes: diagnosis of a new psychiatric condition, suicidal behavior, suspected or convicted of a crime, suspected or convicted of a traffic offense, and transportation accidents. However, such an analysis did not factor in that people on varenicline are all smokers and have inherently different behaviors and health risks than nonsmokers.

When the team carried out a within-person analysis of these same 70,000 people, they found no differences in the rates of these events in relation to varenicline use, except that individuals taking varenicline had a slight increase in depression and anxiety; as in other studies, these risks were confined to people with an existing psychiatric disorder.

However, the researchers found that smokers on the cessation drug buproprion also had slightly elevated risks of mood and anxiety disorders. "So this phenomenon may be a general consequence of nicotine withdrawal and not related to the medication," Fazel said.

"With any drug safety issue, you want multiple lines of evidence pointing in the same direction," Gibbons said. "Varenicline is becoming an important drug, and while patient safety is paramount, we do not want to deny people treatment based on consequences that are not valid."

Gibbons noted that Pfizer, the manufacturer of varenicline, is currently carrying out its own large clinical study assessing neuropsychiatric side effects, and the FDA estimates the results will be available by the end of 2015.

This study was funded by the Wellcome Trust, the Swedish Research Council, and the Swedish Research Council for Health, Working Life, and Welfare. PN

"Varenicline and Risk of Psychiatric Conditions, Suicidal Behaviour, Criminal Offending, and Transport Accidents and Offences: Population Based Cohort Study" is posted at http://www.bmj.com/content/350/bmj.h2388.

JOURNAL DIGEST

BY NICK ZAGORSKI

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Hospice Care Linked To Reduced Depression In Some Surviving Spouses

Not only can hospice care improve the quality of life of patients with terminal diseases, but it also benefits patients' spouses by reducing depressive symptoms, according to a study in *JAMA Internal Medicine*.

Some earlier work had shown that hospice care could improve depression in spouses of cancer patients, but this new national study expands on that to include people receiving hospice care for a range of serious diseases.

Researchers at the Icahn School of Medicine at Mount Sinai looked at data from over 1,000 deceased patients and their surviving spouses; the spouses were followed for two years after their partner's death.

About 30 percent of the families had used hospice services for at least three days, and the researchers found that improvements in depressive symptoms were slightly more common in this group compared with nonhospice users (28 percent compared with 21 percent). Hospice use resulted in about 1.6 increased odds of improved depressive symptoms.

The authors cautioned, however, that over half of the bereaved spouses showed worsening depressive symptoms following their partner's death and that providing additional support to families and caregivers throughout the long course of serious illness is needed.

Ornstein K, Aldridge M, Garrido M, et al. Association between hospice use and depressive symptoms in surviving spouses. JAMA Intern Med. May 26, 2015 [Epub ahead of print] http://archinte.jamanetwork.com/article.aspx?articleid=2296014

Sebastian Kaulitzki/Shutterstock

Hippocampus Holds Two Sets of Neuronal Stem Cells

The hippocampus is one of the few brain regions that generate new neurons during adulthood, producing them from a reservoir of neural stem cells (NSCs). As the hippocampus contributes to both mood and memory, researchers want to understand how one population of stem cells develops into two distinct adult neurons.

Research published in the *Journal of Neuroscience* has shown that the NSCs exist in two distinct subpopulations, in effect primed to mature into memory or mood neurons as needed.

The researchers treated mouse NSCs with two stimulating agents: potassium chloride and norepinephrine. They observed that each individual agent could induce a small percentage of NSCs to proliferate (29 percent for KCL and 48 percent for norepinephrine), while adding both together resulted in an additive effect (about 77 percent NSCs proliferated).

The team also identified that these different NSCs were clustered in different parts of the hippocampus, with more KCL-activated stem cells located in the temporal region and the norepinephrine-activated cells predominantly in the septal region.

With this discovery in hand, the next steps will be a more detailed characterization of these two NSC types, as well as what types of neurons the adult cells will become.

Jhaveri D, O'Keeffe I, Robinson G, et al. Purification of neural precursor cells reveals the presence of distinct, stimulus-specific subpopulations of quiescent precursors in the adult mouse hippocampus. J Neurosci. May 27, 2015; 35(21):8132-44. http://www.jneurosci.org/content/35/21/8132.short

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Lack of Restful Sleep May Add To Alzheimer's Damage

A research team at the University of California, Berkeley, has found evidence that a lack of deep, restful sleep may be the mechanism through which beta amyloid deposits in the brain—which are associated with Alzheimer's disease—destroy memory and bring on dementia.

The researchers used a variety of brain scanning techniques—PET, EEG, and MRI—to visualize the brains of 26 healthy adults (aged 65 and up) during both wake and sleep periods. The volunteers were tasked to remember a series of word pairs, and they were tested both shortly afterward and following a night of sleep.

The researchers saw that the volunteers with the highest amounts of beta amyloid accumulation in a brain region called the medial frontal cortex (a key area for storing long-term memories) tended to have poorer quality sleep and perform worse on the morning memory tests.

As sleep is the critical time during which the brain can flush out toxic compounds like beta amyloid, this lack of sleep can lead to a vicious cycle of memory problems and amyloid buildup.

"But we don't yet know which of these two factors—the bad sleep or the bad protein—initially begins this cycle," senior author Matthew Walker, Ph.D., noted in a press release. "Which one is the finger that flicks the first domino, triggering the cascade?"

This study was published in *Nature Neuroscience*.

Mander B, Marks S, Vogel J, et al. Beta-amyloid disrupts human NREM slow waves and related hippocampus-dependent memory consolidation. Nat Neurosci. June 1, 2015 [Epub ahead of print]. http://www.nature.com/neuro/journal/vaop/ncurrent/full/nn.4035.html

trekandshoot/Shutterstock

Methadone Therapy in Prison Helps Maintain Post-Release Usage

Inmates who stop taking methadone upon incarceration were much less likely to return to this therapy once they were released from prison.

These findings, appearing in *The Lancet*, could have implications for U.S. prison policy, as most people undergoing methadone maintenance treatment (MMT) for opioid addictions will be forced off once they are incarcerated.

The study involved 223 people incarcerated in Rhode Island for six months or less; 114 were allowed to continue their MMT, while the remaining 109 were phased off, per state requirements. Upon release, all the participants were offered assistance in resuming MMT.

Ninety-seven percent of those who had MMT in prison came to a methadone clinic within a month after their release, compared with 71 percent of people who had been weaned off MMT.

The authors noted that because the study participants had short sentences, many of them were being released before their medication was completely phased out; when they looked at those inmates who were fully withdrawn, only 48 percent resumed MMT upon release.

In addition, the prisoners who had been weaned off of MMT reported a higher rate of resuming opioid use (18 percent) within a month of release than those remaining on MMT in prison (8 percent).

Rich J, McKenzie M, Larney S, et al. Methadone continuation versus forced withdrawal on incarceration in a combined U.S. prison and jail: a randomised, open-label trial. Lancet. May 28, 2015 [Epub ahead of print] http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(14)62338-2/abstract

Nazi Era

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grown, Schneider explained. In 2009, the DGPPN acknowledged a "special responsibility to protect the dignity and rights of people suffering from mental illness." The organization also commissioned an international group of researchers to study the Nazi period.

Out of this study came an exhibition called "Registered, Persecuted, Annihilated: The Sick and the Disabled Under National Socialism" that was displayed in the German parliament and is now traveling to numerous cities around the country.

In 2010, Schneider, then president of the DGPPN, formally asked the victims of the Nazi era and their families for "forgiveness for the pain and injustice [they] suffered in the name of German psychiatry and at the hands of German psychiatrists under National Socialism, and for the silence, trivialization, and denial that for far too long characterized psychiatry in post-war Germany." PN

An English translation of Frank Schneider's 2010 speech to the DGPPN acknowledging the failures of German psychiatry during and after the Nazi era is posted at https://www.dgppn.de/de/english-version/history/psychiatry-under-national-socialism/speech-professor-schneider.html. More information on psychiatry under National Socialism is posted at https://www.dgppn.de/de/english-version/history/psychiatry-under-national-socialism.html. A 1946 statement by Gerhard Schmidt, M.D., on the Aktion T4 killing program is posted at http://www.va-holocaust.com/documents/SchmidtTestimony.pdf.

altanaka/Shutterstock

Older Parental Age, Wide Age Gaps Linked to Autism Risk

While a connection between older parental age and an elevated risk of autism has been established, many questions remain. For example, it's still unclear whether the mother's and father's ages have any combined effects.

To answer that question, a study published in *Molecular Psychiatry* combined health records from five countries (Denmark, Israel, Norway, Sweden, and Australia) to amass a cohort of over 5.7 million children—including more than 30,000 with autism. The researchers found that maternal and paternal ages do have an additive effect on autism risk, though of the two, paternal age was a greater risk factor.

However, older parents were not the only ones at heightened risk; pairs of parents in which one was much older than the other also had a heightened risk. (Thus, parents who are both 40 would have a higher risk than parents who are 30, but actually less risk than a pair of parents consisting of a 40-year-old and a 20-year-old.)

The higher risk associated with advanced paternal age is consistent with the idea that accumulated mutations in sperm increase autism risks as men age. However, the reasons behind the other trends, such as the risks associated with a wide gap between a mother's and father's ages, still need to be teased out, though the results suggest that multiple mechanisms contribute to these findings.

Sandin S, Schendel D, Magnusson P, et al. Autism risk associated with parental age and with increasing difference in age between the parents. Mol Psychiatry. June 9, 2015 [Epub ahead of print] http://www.nature.com/mp/journal/vaop/ncurrent/full/mp201570a.html

herjua/Shutterstock

Anesthesia Poses Risk to Language Comprehension, IQ In Young Children

According to a new study in *Pediatrics*, children who receive general anesthesia at an early age have lower language comprehension and IQ than their peers.

Researchers at Cincinnati Children's Hospital Medical Center compared the language development scores of 53 healthy children with 53 children who had undergone surgery before age 4.

They found that those children who received anesthesia during surgery scored significantly lower in listening comprehension and IQ portions of the test; these children also had decreased gray matter density in some brain regions. None of the children had any head trauma or other neurological problems that might contribute to lower performance.

The authors noted that these results pose a conundrum, as surgical procedures on young children are typically done to resolve serious or even life-threatening health complications. However, the potential IQ problems should be a factor when discussing the risks and benefits of a surgery.

The study also points to a need to identify new techniques that can lower the strength and/or duration of anesthesia required, or even new drugs that may prove safer in children.

Backeljauw B, Holland S, Altaye M, Loepke A. Cognition and brain structure following early childhood surgery with anesthesia. Pediatrics. June 8, 2015 [Epub ahead of print] http://pediatrics.aappublications.org/content/early/2015/06/03/peds.2014-3526.short

MH Bill

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coordinating all programs and activities related to parity in health insurance benefits, and requiring the Government Accountability Office to investigate compliance with the parity law.

"It's not just a new bill, but marks a new dawn for mental health care in America," Murphy said in a statement. "We are moving mental health care from crisis response to recovery, and from tragedy to triumph. I am tremendously proud of the work we've accomplished and so encouraged about our nationwide grassroots support involved in advancing our legislative vision to help families in mental health crisis."

APA leaders hailed the bill as a critical step toward mental health reform. "The nation's mental health system needs reform and investment—especially on behalf of patients and families living with serious mental illness. We applaud Reps. Murphy and Johnson," said APA President Renée Binder, M.D. In addition to strengthening enforcement of the parity law, she noted that other important provisions of the bill include "enhancing the psychiatric workforce, ensuring better coordination of federal resources, and improving research and treatment for persons with mental illness, including substance use disorders."

Added APA CEO and Medical Director Saul Levin, M.D., M.P.A., "We look forward to working with Congress to pass this bill this year."

According to a summary of the bill prepared by Murphy's office, the bill seeks to address, among other issues, the following:

- **Innovation:** Establishes the National Mental Health Policy Laboratory to drive innovative models of care and develop evidence-based and peer-review standards for grant programs and dedicates funding for the Brain Research through Advancing Innovative Neurotechnologies (BRAIN) Initiative.

- **Improving transition from one level of care to another:** Requires psychiatric hospitals to establish clear and effective discharge planning to ensure a timely and smooth transition from the hospital to appropriate post-hospital care and services.

- **Shortage of crisis mental health beds:** Provides additional psychiatric hospital beds for those experiencing an acute mental health crisis and in need of short-term (fewer than 30 days) immediate inpatient care for patient stabilization.

- **Mental health workforce:** Requires the assistant secretary for mental health and substance use disorders to study and recommend a national strategy for increasing the number of psychiatrists, child and adolescent psychiatrists, and other mental health professionals; includes child and adolescent psychiatrists in the National Health Service Corps; and authorizes the Minority Fellowship Program.

- **Early intervention and prevention programs:** Authorizes, for the first time in federal law, the Recovery After Initial Schizophrenia Episode (RAISE), an evidence-based early intervention program, and launches a new early childhood grant program to provide intensive services for children with serious emotional disturbances in an educational setting.

- **Alternatives to institutionalization:** Incentivizes states to provide community-based alternatives to institutionalization for those with serious mental illness, such as assisted outpatient treatment (AOT) and other assertive community treatment approaches.

In a letter to the authors of the bill, Binder and Levin wrote, "Every day throughout our country, individuals and their families are struggling with mental health crises, many of which could be prevented if our nation enacted comprehensive mental health reform. The statistics are startling: 14 million Americans suffer from serious mental illness, yet almost 40 percent of these individuals receive no treatment at all. The epidemic of preventable hospitalizations and incarceration costs our nation billions and displays widespread systemic failure. Moreover, despite recent progress, pervasive discrimination and stigma continue to harm our patients and impede efforts of the treatment community.

"Your bipartisan Helping Families in Mental Health Crisis Act will address these challenges by promoting evidence-based psychiatric care and research activities, ensuring better coordination of federal mental health resources, addressing the critical psychiatric workforce shortage, and improving enforcement of mental health parity, among other notable provisions," Binder and Levin continued. "This bipartisan legislation is a much-needed remedy for our nation's broken mental health system."

At least one important modification over the previous version of the bill is that HR 2646 provides more flexible requirements for proposed state AOT requirements, a 2 percent block grant bonus for states that have an AOT law, and an additional 2 percent block grant bonus if a state amends its inpatient commitment provision to a "need for treatment" standard. PN

APA's letter to Reps. Murphy and Johnson is posted at http://www.psychiatry.org/File%20Library/Advocacy%20and%20Newsroom/DGR_Letter_MurphyJohnson_HR2646_2015.pdf. A summary of the bill is posted at http://murphy.house.gov/uploads/Latest_Summary_The%20Helping%20Families%20in%20Mental%20Health%20Crisis%20Act.pdf.

Police

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tance, heart rate, and startle reactivity, among other data.

The prospective officers' evaluation revealed they were remarkably healthy. No one was diagnosed with an Axis I disorder, their average IQ was 116, and 26 percent had been exposed to childhood trauma—roughly the same proportion as in the general population.

One test of stress reactions included showing recruits several videos, first a pleasant travelogue followed by a graphic film of a real police officer being blown up by a bomb he was trying to defuse. Marmar's team measured stress hormone levels before and after the videos and asked the candidates how disturbed they felt.

Officers who had the highest cortisol response to the traumatic video were more likely to show resilience six years later after experiencing a stressor in their own lives. "A high cortisol response brakes the stress response," he said.

Over six years they collected more than 2,000 data points on each officer. Managing the information gathered was a challenge that demanded innovative statistical tools to understand the interaction of so many variables.

Although the study is still under way, Marmar and his colleagues have reached some important preliminary observations at the end of six years.

For a start, some hypothesized risk factors proved to be wrong, he said. Gender did not predict outcome—women were as resilient as men. IQ was not a factor, either.

Catecholamine and acoustic startle responses to stress, peritraumatic panic or dissociation, and a family history of mood, anxiety, and substance use disorders were associated with PTSD symptoms at six years. Routine work stresses, such as scheduling issues or poor leadership, also were highly correlated with PTSD symptoms.

"Genetics has complex effects throughout this whole model," said Marmar. "Genes contribute to risk-taking and risk-aversive behavior and thus how often police and soldiers get into life-threatening situations."

The NFKBIA gene—a single variant inflammatory regulatory gene, which is involved in the regulation of the stress response—is associated with high resilience in policing.

Genes are just part of the story, said Marmar's colleague, Isaac Galatzer-Levy, Ph.D., an assistant professor of psychiatry at the NYU School of Medicine.

"They produce indirect effects via intermediaries which can be modified," he said. "It's not a deterministic world."

One major factor surprised Marmar and colleagues: the number of hours of sleep recorded while in the academy and at the end of the first year of service inversely predicted PTSD symptoms at six years.

"If you were sleeping well at the end of one year of police service, you were sleeping well at the end of six years of police service," he said. Other factors like gene variants and cortisol levels complexly interact with sleep.

The presence of risk factors should not automatically be used to screen candidates out of the force, Marmar noted. Risk factors can be modified, and early interventions can lower risk over time. Officers with sleep problems can be assigned less shift work and given sleep hygiene training, for instance. The inflammatory response to stressors can be mitigated, and even gene expression can be modified with medications like dexamethasone given after traumatic events, Marmar said.

"People are not doomed to vulnerability or resilience," Marmar noted. PN

Anxiety

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at Columbia University, and colleagues in the February *JAMA Psychiatry*. Insomnia (42 percent) and anxiety (36 percent) were the most common indications for new benzodiazepine prescriptions among older patients in primary care, where 90 percent of such prescriptions are written.

"Benzodiazepines are drugs that should be used at most for a few days or weeks in selected patients, carefully monitored, and stopped as soon as possible," wrote Nicholas Moore, M.D., Ph.D., of the Department of Pharmacology at the University of Bordeaux, and colleagues in an editorial in the same issue.

At the APA meeting, Silberman suggested that the medications have their place but are not very useful for insomnia. "Benzos don't make people very sleepy," he said. "They are a good sleep medication only if their insomnia is secondary to their anxiety."

Appropriately used as anxiolytics, benzodiazepines are rapid acting, well tolerated, and have low toxicity, he said. They work well for patients with panic, social anxiety, and mixed anxiety diagnoses, but less so for those with generalized anxiety disorder (GAD).

"With GAD you have to be more careful because there is no clear endpoint," he said. "You are trying to keep it under control long enough to allow nonpharmacological approaches to go to work."

At the same time, clinicians should be aware of the potential for some cognitive impairment or coordination problems among elderly patients, contraindicating them for this population, in his view. Abuse of the medication is generally limited to patients with a prior history of substance abuse.

"Benzodiazepines are rarely taken alone for recreational purposes," added Richard Balon, M.D., a clinical professor of psychiatry and anesthesiology at Wayne State University School of Medicine. "They are more often used by users of other drugs like alcohol or cocaine. Long-term treatment is not deleterious and does not necessarily lead to abuse."

The session at the APA annual meeting was well attended, but even a glance at the positions of each side of the controversy suggests that it will continue for some time. PN

"Benzodiazepine Use in the United States" by Mark Olfson, M.D., M.P.H., and colleagues is posted at http://archpsyc.jamanetwork.com/article.aspx?articleid=2019955. A reply, "Need for a Realistic Appraisal of Benzodiazepines" by Richard Balon, M.D., and colleagues, is posted at http://onlinelibrary.wiley.com/enhanced/doi/10.1002/wps.20219/.

Med Check

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sive disorder, which is double the estimated prevalence of depression in individuals without diabetes," said lead author Karin Rådholm, M.D., Ph.D., in an interview with MedicalResearch.com. Based on the current findings, Rådholm emphasized that all patients, especially women with comorbid diabetes and depression, should be aware of any risk associated with taking both medications. PN

K. Rådhol K, Wiréhn AB, Chalmers J, et al. Use of antidiabetic and antidepressant drugs is associated with increased risk of myocardial infarction: a nationwide register study. Diabet Med. Jun 2, 2015. [Epub ahead of print] http://www.ncbi.nlm.nih.gov/pubmed/?term=Use+of+antidiabetic+and+antidepressant+drugs+is+associated+with+increased+risk+of+myocardial+infarction%3A+a+nationwide+register+study

Harris

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Board of Trustees. APA CEO and Medical Director Saul Levin, M.D., M.P.A., noted: "It's an honor to have one of our former Board of Trustees members re-elected to the AMA Board of Trustees and become chair-elect of the board. Dr. Harris will continue to carry the integration of psychiatry and mental health within the house of medicine."

Harris has taken on several leadership roles at the AMA, including a term as chair of the AMA Council on Legislation.

"It's a great honor to be elected chair-elect to our AMA Board of Trustees," Harris said. "I am proud to be in this role and to have a strong voice for the patients we serve. My success in the AMA is in no small part due to the hard work of the members of the Section Council on Psychiatry."

Harris also thanked Carolyn Robinowitz, M.D., chair of the Section Council on Psychiatry; Ken Certa, M.D., of Thomas Jefferson University; APA CEO and Medical Director Saul Levin, M.D., M.P.A.; the delegation; and the Medical Association of Georgia for all of the support they have given her over the years.

As director of health services for Fulton County, which includes Atlanta, Harris directs all county health services, including health partnerships that deliver a wide range of treatment and prevention services. She is a past president of the Georgia Psychiatric Physicians Association and served as a member of the AMA Women Physicians Congress. Harris also maintains a private psychiatric practice.

In an address to the House of Delegates prior to the election, Harris recalled the words of Kent Brantly, M.D., the American physician who contracted Ebola while treating patients in Liberia: "When the going gets tough, the tough return to their calling."

"What an apt description of those of us who are called to medicine!" Harris said. "Our challenges are many—electronic health records, maintenance of certification, alternative payment models. But when we remember our mission and our calling, the challenges are not insurmountable.

"The AMA must continue to protect the practice of medicine and support physicians in choosing their own path," Harris told the House of Delegates. "The challenges are real, the issues are complex, there is work to be done, and it will take all of us to do it. While I cannot promise an outcome, I can promise you the fight." PN

Weight Gain

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The results showed that those enrolled in BMP had an average weight gain of 1.8 kilograms compared with 7.8 kilograms in the control group. Change in waist circumference was on average seven times greater in the control group than in the intervention group. Blood pressure, lipids, and glucose levels did not differ among the groups.

"We know that lifestyle interventions are effective, and these results show that such interventions may serve as important means of maintaining or achieving physical health in patients with psychosis," Curtis said.

Curtis told *Psychiatric News* she plans to continue her research into the effectiveness of interventions for this patient population thanks in part to funding from the National Health and Medical Research Counci of Australia.

"We must consider that our patients are concerned about their physical health and make sure that we address these issues," emphasized Curtis. "It's a part of our job as psychiatrists. It's not just about mental health, it's about total health. I really feel optimistic that total health can be achieved in our patients," she concluded. PN