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PSYCHIATRIC NEWS

AMERICAN PSYCHIATRIC ASSOCIATION

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David Hathcox

APA President Renée Binder, M.D., emphasizes the moral responsibility of the psychiatric profession in her presidential address at APA's 2016 Annual Meeting in Atlanta. Coverage of the meeting begins in this issue.

Hawaii Psychiatrists Help Block Psychologist Prescribing Bill

Years of diligent work and cooperation with other medical organizations helped to stave off legislation in the Island State.

BY AARON LEVIN

A coalition led by the Hawaii Psychiatric Medical Association (HPMA) was able to defeat a bill allowing psychologists to prescribe medications when the Hawaii H Aouse of Representatives sent the bill back to committee on May 3. The move effectively ended prospects of passage this year.

Opponents of the bill—including APA, the HPMA, the AMA, and the Hawaii Medical Society—argued that granting prescriptive authority to psychologists would jeopardize the provision of safe, high-quality care for Hawaii's patients.

"We're relieved that it's over, but we know we have more work ahead of us because the bill will come back and January is right around the corner," said Julienne Aulwes, M.D., of Tripler Army Medical Center and president of the HPMA, referring to the month when the legislature comes back into session.

Teamwork in Hawaii and coordination with APA headquarters were keys to the legislative victory.

"We put together a great team of other medical organizations, consumers, and members of the HPMA to foster relationships with legislators," said

see **Hawaii** on page 3

Binder Highlights Five Areas Where Psychiatrists Must Remain Committed

At APA's 2016 Annual Meeting, APA President Renée Binder, M.D., outlined key areas in which psychiatrists must take the lead to ensure that people with mental illness get the high-quality care they deserve.

BY MARK MORAN

Let's claim our future.

That's the message outgoing APA President Renée Binder, M.D., delivered to APA members last month at the Opening Session of APA's 2016 Annual Meeting.

Binder emphasized the moral obligations of a professional medical association. "We must assume our responsibility to help our neediest patients, decrease stigma, improve diagnoses, advocate for research funding, continue to strengthen parity enforcement, work to improve access to care, continue to educate our members, and be responsible for the quality of care provided by our profession," she said.

She outlined the achievements of a busy presidential year, especially highlighting the inauguration of the American Psychiatric Excellence (APEX) Awards in April. The event focused on drawing national attention to the tragedy of incarcerating people with mental illness, an issue of special concern to Binder, who is a leader in forensic psychiatry. Legislators including Sen. Al Franken (D-Minn.) and Florida State Sen. Miguel Díaz de la Portilla (R-Miami-Dade) were honored at the event, as were the stars of the popular television drama "Orange Is the New Black" (*Psychiatric News*, May 20).

Binder specified five areas of responsibility for psychiatrists:

- **Caring for citizens who are most in need.** "As psychiatrists, we need to apply our knowledge and political clout to help people who suffer from serious mental illness. This includes individuals who are incarcerated and who need mental health care rather than imprisonment," Binder said. "Although our nation's jails are ill suited to treat people with mental illness, in many locales

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PERIODICALS: TIME SENSITIVE MATERIALS

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PSYCHIATRIC NEWS

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AMERICAN PSYCHIATRIC ASSOCIATION

Majority of Americans Say Mental Illness Impacts Overall Health, Economy, But Congress Not Acting on Issues

While those polled said that comprehensive mental health reform is important in addressing societal challenges, only 5 percent of Americans believe Congress has made mental health care a priority.

BY MARK MORAN

Roughly two-thirds of Americans believe that untreated mental illness has a significant impact on the U.S. economy and that comprehensive mental health reform is important in addressing societal challenges, such as high suicide rates and access to care. At the same time, only 5 percent of Americans believe Congress has made mental health a priority.

The findings are from an APA-sponsored poll conducted by Porter Novelli and the GfK Knowledge Panel, a market research firm, and were announced last month at APA's 2016 Annual Meeting.

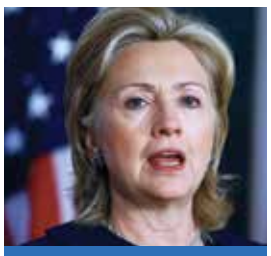
Candidates seeking the White House didn't score high marks either when Americans were asked which candidate would best ensure that the needs of those living with mental health problems are met. Democrat Hillary Clinton came in first at 21 percent, with Vermont Sen. Bernie Sanders a close second at 19 percent. About 10 percent said Republican Donald Trump would be the best in meeting the nation's mental health needs.

APA has endorsed efforts in Congress to reform the nation's mental health system, voicing its support for the Helping Families in Mental Health Crisis Act, introduced by Reps. Tim Murphy (R-Pa.) and Eddie Bernice Johnson (D-Texas), and the Mental Health Reform Act of 2015, introduced by Sens. Chris Murphy (D-Conn.) and Bill Cassidy (R-La.). Legislation in both the House and the Senate has stalled this year.

"We applaud the lawmakers in Congress who recognize the dire need to improve our nation's mental health system," said APA President Renée Binder, M.D. "But we call upon Congress as a whole to embrace this issue. Our poll findings show that the majority of

*see **Poll** on page 30*

Which presidential candidate do you feel will be best to ensure that the needs of those living with mental health issues are met?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IN THIS ISSUE

Join 'Find a Psychiatrist'

If you haven't joined one of APA's newest member benefits—the Find a Psychiatrist national database—don't put it off any longer. The database enables individuals seeking treatment to easily locate a psychiatrist living in their community. Join at http://psychiatry.org/fapoptin.

Departments

Hawaii

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Area 7 Trustee Jeffrey Akaka, M.D., of Honolulu, the HPMA's legislative representative. "Nobody can do this alone."

Those relationships were cultivated over many years, as members of the HPMA presented lawmakers with carefully researched, published data on which to base their case that medical training is required to properly diagnose, treat, and monitor patients given psychotropic medications.

Mental health consumers also contributed to the outcome, expressing their concerns to legislators about the potential for substandard care.

The first psychologist prescribing bill in the United States was introduced in Hawaii in 1985. Since then, APA and HPMA have repeatedly emphasized to lawmakers that such legislation would result in "unsafe prescribing" because the required training was insufficient compared to years of medical school and postgraduate psychiatric residency.

As of 2014, 28 states and two territories had considered bills that would authorize prescribing by psychologists. New Mexico passed a prescribing law in 2002, and Louisiana did so in 2004. Illinois passed its law in 2014, but regulators there are still working out the details of the training requirements so the law has not been implemented yet.

APA has always opposed prescribing privileges for psychologists, primarily citing safety concerns arising from the complex effects of psychotropic medications on the body.

"These bills would put patients at risk, allowing people with only a crash course in medicine to dispense powerful psychotropic medications," according to an APA document on the issue. Several lawsuits have been filed in Louisiana alleging harm from drugs prescribed by "medical psychologists," as they are termed in that state.

Another concern is that data from New Mexico and Louisiana reveal that some psychologists have gone beyond prescribing for psychiatric disorders and written prescriptions for cardiovascular medications, muscle relaxants, and anticholesterol drugs.

One argument for granting prescribing privileges to psychologists is that it would expand care options in underserved areas, especially rural counties. However, so far, prescribing psychologists in New Mexico are still concentrated in the metropolitan areas around Las Cruces, Albuquerque, and Santa Fe, just like most other medical and mental health professionals. In Louisiana, the largest concentrations are in and around two cities, the state capitol of Baton Rouge and Lafayette, the state's fourth largest city. Fifty of Louisiana's 64 parishes (counties) have no prescribing psychologists.

To address the limited access to mental health care across Hawaii's far-flung islands, the HPMA is backing a number of initiatives in the state, such as expanding the use of telepsychiatry and transforming clinical practice with increased professional training,

The HPMA is also working to share psychiatric expertise with other physicians in Hawaii.

"The ECHO Hawaii Project organizes weekly video teleconferences with rural primary care providers to provide informal case discussions about difficult cases," said Aulwes. She participates in the program and seeks to recruit more of her colleagues to do the same. PN

More information about providing psychiatric care in rural Hawaii can be found in "Psychiatrists Get Creative in Hawaii's Remote Regions" posted at http://psychnews.psychiatryonline.org/doi/full/10.1176/pn.45.2.psychnews_45_2_01.

PROFESSIONAL NEWS

New Quality Reporting Program To Reward Value-Based Care

Merit-Based Incentive Payment System (MIPS) reporting begins in January 2017, with payment adjustments starting in January 2019. How should you prepare?

This is the second in a continuing series of articles on value-based payment.

CHANGING PRACTICE CHANGING PAYMENT

The American health care system is moving from paying physicians for the volume of services they perform to paying for the value of the care they provide. This movement toward "value-based payment" has greatly accelerated in recent years to address the high level of Medicare spending and is furthered by advances in technology—especially the proliferation of electronic health records (EHRs) and payer-incentive programs to encourage more EHR adoption. The goal of this evolution is summed up in the so-called Triple Aim: improved patient care, better population health, and lower per capita cost of health care.

In the second of a series of articles in "Changing Practice/Changing Payment," *Psychiatric News* focuses on a new quality program, known as the Merit-Based Incentive Payment System (MIPS), which was established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). APA submitted detailed comments on the MACRA proposed rule that the Centers for Medicare and Medicaid Services (CMS) issued on April 27. The final MACRA rule is expected in November.

Q *What is MIPS?*

A MIPS consolidates current Medicare quality programs (Physician Quality Reporting System, EHR Meaningful Use, and Value-Based Payment Modifier) and adds a new category for "clinical practice improvement." MIPS also offers the first substantial rewards for achieving high-quality care.

MIPS reporting begins in January 2017, with payment adjustments starting in January 2019. Each "eligible clinician" or group will receive a "composite performance score" for performance in four categories—quality, resource use, use of certified electronic health records under "Advancing Care Information," and clinical practice improvement activities—compared against the average of all MIPS clinicians. Those scoring above average receive a bonus, while those scoring below average receive a penalty. Scoring is somewhat flexible, but here are some general guidelines:

- Quality counts 30 percent (50 percent in 2019 and 45 percent in 2020), based largely on the Physician Quality Reporting System (PQRS).
- Resource use counts 30 percent (10 percent in 2019 and 15 percent in 2020), replacing the Value-Based Payment Modifier (VM). CMS will calculate this, with no reporting required.
- Advancing care information (ACI), which assesses the use of EHRs and replaces the Meaningful Use program, counts 25 percent.
- Clinical practice improvement activity (CPIA), the new category, counts 15 percent.

MIPS bonuses—and penalties—will be up to 4 percent in 2019, 5 percent in 2020, 7 percent in 2021, and 9 percent starting in 2022. Those payment adjustments are budget neutral. But there is an extra $500 million a year for bonuses of up to 10 percent for "exceptional" performers, from 2019 to 2024.

Q *What else do I need to know before the MIPS adjustments take effect in 2019?*

A In 2017 and 2018, Medicare payments to all psychiatrists (regardless of practice size) will be subject to value-based payment modifier bonuses or penalties. These currently range up to 4 percent.

Starting in 2018, all Medicare claims will include special codes to identify the care episode, patient condition, and physician's relationship to the patient. These codes will link patients to clinicians for measuring resource use. APA is working with member experts to recommend appropriate psychiatric episodes of care.

MACRA sets a goal of achieving interoperability of EHRs by the end of 2018.

Q *What are the key features of the MIPS program for psychiatrists?*

A Psychiatrists are exempt from MIPS reporting and payment adjustments for a particular year if (1) this is their first year of Medicare enrollment; (2) they meet the "low volume threshold" of no more than $10,000 in Medicare billings and 100 Medicare patients; (3) they qualify for the MACRA bonus for "advanced" alternative payment models (APMs); or (4) they meet the definition of a partial qualifying APM participant and choose not to report under MIPS.

Psychiatrists will no longer be required to report nine quality measures across three National Quality Strategy "domains." They will have to report only six quality measures, including one cross-cutting measure and one outcome measure. If no outcome measure is available, they must report one measure related to appropriate use, patient safety, efficiency, patient experience, or care coordination.

APA will post a list of MIPS quality measures relevant to psychiatry after the final rule is issued. The new ACI program offers partial credit for using electronic health records; however, some psychiatrists may find the limited outcome measures in high-priority areas a significant barrier to meeting the scoring criteria.

CPIA options include "Integrated Behavioral and Mental Health" activities such as providing integrated care consistent with the collaborative care model.

Starting in 2018, psychiatrists in small practices (of up to 10 clinicians) may form "virtual groups" for joint MIPS reporting and assessment. The infrastructure is still being developed, and APA will keep members informed as more details become available.

MIPS may apply to clinical psychologists and clinical social workers starting with reporting in 2019 and payments in 2021.

MACRA includes $100 million for technical assistance to small and rural practices, plus those in health professional shortage areas, for MIPS reporting and transitioning to new models of care.

MIPS does not apply to Medicare Advantage payments or programs.

Q *Are there advantages for registry reporting?*

A MACRA preserves current reporting methods but also encourages reporting via qualified clinical data registries (QCDRs) by individuals and group practices. In addition to being less burdensome, registry reporting counts toward the ACI and CPIA categories, potentially leading to higher MIPS scores and bonuses. QCDR measures can also be directly approved by CMS, avoiding longer review by the National Quality Forum—the only organization designated by Congress to endorse quality measures. APA is now beginning to develop a mental health clinical quality data registry for use by psychiatrists in quality reporting.

Q *What is new for quality measures?*

A MIPS will continue most valid PQRS quality measures and add measures used by private payers and for different settings. MACRA includes $75 million in development funding of new measures. CMS has issued a final Quality Measure Development Plan to address measure gaps. (Information on the plan is posted at http://APAPsy.ch/pn-mips.) APA submitted comments on the draft plan in February.

Q *How can APA help you prepare for MIPS?*

A We welcome your questions!

- **MIPS Quality and Resource Use:** Samantha Shugarman, sshugarman@psych.org
- **MIPS CPIA:** Nevena Minor, nminor@psych.org
- **MIPS ACI/EHRs:** Nathan Tatro, ntatro@psych.org
- **MACRA APMs:** Eileen Carlson, ecarlson@psych.org
- Coding, reimbursement, and practice management questions: APA Practice Management Helpline, (800) 343-4671 PN

APA's Practice Management HelpLine Wants to Hear From You

If you receive a Medicare Comparative Billing Report (CBR) showing how your claims compare with other psychiatrists, please let us know. The APA's Practice Management HelpLine is tracking how these reports are being distributed so we can determine if any response from the APA is necessary. You can fax us a copy of the CBR to (703) 907-1089, email us at hsf@psych.org, or call us at (800) 343-4671.

ANNUAL MEETING

Oquendo Emphasizes Collaboration Is Key to Preventing Mental Illness

The growing movement toward integrated care offers unique opportunities for prevention through partnerships, says APA's president-elect.

BY MARK MORAN

Prevention is the future of American medicine and of psychiatry, APA President-elect Maria Oquendo, M.D., said last month in her Opening Session address at APA's 2016 Annual Meeting, where she introduced her theme for the coming presidential year, "Prevention Through Partnerships." During the lecture, she emphasized the importance of collaboration with colleagues in primary care and other specialties.

"In the last two decades, medicine has been moving at an accelerated pace toward focusing on prevention," Oquendo said. "The concept is to identify those at risk, before any symptoms emerge through the use of genetic and other molecular markers. For psychiatry, this of course is a very exciting prospect, but one that seems quite out of reach at the moment. I propose to you that we need not wait that long. I submit to you that not only can we work toward prevention, but that the best way to do so will be through partnerships."

She continued, "In thinking about the many ways that APA makes a difference for our members and our patients every single day, it seems to me that we can also leverage our membership and leadership to develop partnerships with other disciplines in medicine and with the community."

Oquendo said the growing movement toward integrated care offers unique opportunities for prevention through partnerships. "One of the salient models for integrated care proposes that the psychiatrist be embedded in the primary care setting, working closely with physicians, nurse practitioners, physician assistants, and case workers. The notion is that the psychiatrist would oversee the care of all the patients in that practice or setting. Straightforward, bread-and-butter cases of depression or anxiety would receive their treatment from the nurse practitioner or physician assistant under the supervision of the psychiatrist, reserving the psychiatrist's direct care for the more complex or treatment-refractory cases. Interestingly, implied in this model is that the number of individuals requiring psychiatric assistance in an ordinary medical practice is simply too large for one person to care for. Rather, an entire team would be needed to address the mental health needs of the population under that practice's care. This model is intended to identify individuals suffering from mental illness. But there is no reason why care could not be extended to those who have subthreshold symptoms."

David Hathcox

APA President-elect Maria Oquendo, M.D., tells Annual Meeting attendees that building partnerships with physicians in other medical specialties is the key to prevention of mental illness.

Partnerships with physicians in pediatrics and obstetrics-gynecology can be especially fruitful for psychiatrists and their women patients. She noted that 1 in 4 women will suffer from depression either during or after pregnancy and that maternal mental health impacts the child's mental health and development.

"Most do not present for psychiatric care, yet intervention for this population is an essential task. … It is now crystal clear that maternal mental health has a tremendous impact on outcomes for her child. It has impact on that child's nutrition. It has impact on that child's vaccination schedule. It has impact on that child's home environment. It has impact on that child's early education. But more strikingly, it has a direct impact on that child's mental health. In fact, we know from studies that if a mother is depressed, her children are more likely to exhibit behavioral symptoms."

Oquendo concluded her remarks saying that the future is bright for psychiatry and for the prevention of mental illness. "We know more about the brain than ever, and new treatments are being developed that range from pharmacology to behavioral interventions and from brain stimulation to psychological treatments. We are poised to join our sister disciplines in medicine to develop preventive strategies. These will be the centerpiece of 21st Century medicine and 21st Century psychiatry." PN

Clinicians Should to Talk to Patients About End-of-Life Goals

People have goals in life other than living longer, and they should be prompted to talk about them, advises noted surgeon and author Atul Gawande, M.D., M.P.H.

BY MARK MORAN

"Well-being is more than health," noted surgeon and author Atul Gawande, M.D., M.P.H., at the Opening Session of APA's 2016 Annual Meeting last month. Gawande, whose latest book is *Being Mortal: Medicine and What Matters in the End*, discussed the problematic relationship that American medicine has tended to have with death and dying.

Gawande said patients, their families, and clinicians usually come to late-life and end-of-life care decisions utterly unprepared to answer the important questions: What do patients want and don't want as they near the end of their lives? How much care is too much? What is the minimal quality of life patients are willing to endure in exchange for a longer life?

"When it comes to these kinds of conversations, it is always too early until it is too late," he told psychiatrists at the meeting. "Our difficulty with these issues is directly related to our own anxiety about our mortality."

David Hathcox

Atul Gawande, M.D., M.P.H., tells psychiatrists that people value a feeling of positive well-being more than they do health.

Speaking in an impromptu fashion, Gawande described the research he did for writing *Being Mortal*—talking to geriatricians, palliative care physicians, psychiatrists, and other clinicians as well as patients and their families.

A first lesson, he said, is that human beings' experience of their own life tends to get better as they age, even as their health declines in medical terms. "Our standard image of growing old is that it's a total drag," Gawande said. "But the reality is that our well-being is larger and means more than our health."

A second and related lesson is that people have goals and priorities as they age other than living longer. The way to learn what these goals and priorities are, he said, is to use "that highly technical skill that you as psychiatrists use every day—ask patients and listen to them."

Gawande said a body of research is emerging showing that certain interventions can improve palliative and end-of-life care and focus medical treatment around patients' goals and priorities. He said reforms in medical treatment and deliv-

see ***Gawande*** *on page 13*

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Binder

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they have become the de facto mental health facilities. There are solutions. We need to advocate for better training of police officers; for better community treatment; for diversion programs including mental health courts, drug courts, and veterans courts; and for better treatment and follow-up for people with mental illness who do wind up in jails and prisons."

- **Decreasing stigma.** Binder said people who live with mental illness and substance use disorders still experience discrimination in housing, employment, and relationships. "As psychiatrists, we must lead the fight to decrease stigma. Mental illness is ubiquitous. Most families are affected. We need to talk about it and normalize it so that people feel freer to seek treatment."

She highlighted APA's campaign last year to remove a billboard posted by the fashion icon Kenneth Cole over the Westside Highway in New York that said, "Over 40 million Americans suffer from mental illness. Some can access care…All can access guns." Binder reminded psychiatrists at the meeting that the implication of the billboard was that people with mental illness are violent and should not possess guns.

"Of course, most people with most types of psychiatric diagnoses are not violent, and the billboard contributed greatly to the fear of anyone

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with a mental illness, including anxiety, depression, adjustment disorders, obsessive-compulsive disorders, or neurocognitive disorders," she said. "APA brought together two dozen other professional and advocacy groups to demand that Kenneth Cole remove the billboard. This is an example of what APA has done and must continue to do to fight stigma."

- **Increasing funding for research and delineating diagnoses and treatment.** "We must continue to advocate for more research funding for NIMH and other NIH institutes so that we can explore the underlying causes of mental illness and develop better strategies for prevention, early intervention, and treatment," Binder said. "We also need to play our part in evaluating our current treatments, and we have made some headway in this direction. In March 2016, the Board of Trustees voted to develop an APA registry so that de-identified information about our patients, in the real world, can be collected to better determine what treatments work and for which patients."

- **Advocating for our leadership role in new models of care and increasing access to mental health care.** "We must advocate for seeing that mental health services are available to everyone," Binder said. "There is no health care without mental health care. Mental health care is a right and not a privilege. Providing access to mental health care is also fiscally wise. There is solid

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evidence that mental health care brings down the costs of general health care."

• **Assuming responsibility for measures of quality, competence, and advocacy.** "We are being constantly regulated by various outside groups," Binder said. "For example, third-party payers, including Medicare, are telling us that payment for services will be linked to value and quality. State medical boards and the American Board of Medical Specialties are telling us that there needs to be evidence that we are continuing to practice competently after we are no longer residents and are many years into our practice and that this will need to be demonstrated as a condition of licensure and certification. I don't think that anyone disputes that physicians need to keep up with new treatments and with advances in our fields of practice. Many of the facts that we learned in medical school and residency training are no longer thought to be true. The issue is that we must regulate ourselves and not have others do it for us."

Binder concluded, "We must never forget our role in serving the needs of our patients and our society. We are members of a principled and great profession—psychiatry—and we have ethical and moral obligations to see that our neediest patients get the care that they need and deserve. … We must look forward and claim our future for ourselves and our patients." PN

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Gawande

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ery are helping American physicians to rediscover the skills of talking to patients about their goals as they age. He described a recent study at Massachusetts General Hospital in which cancer patients were given expert palliative-care consultation early in their treatment. The patients were happier with their care, experienced less anxiety and depression, and were less likely to get aggressive medical care. They also lived longer than patients who received only standard cancer care.

He also described work at the Dana Farber Cancer Institute in which physicians were given a checklist of questions to discuss with their patients regardless of the stage of cancer treatment they were in—the same questions that physicians have traditionally been reluctant to pose to their patients: What is your own understanding of your health? What are you willing to go through to gain more time to live? What are your goals and priorities?

Results showed that patients who underwent this intervention experience significantly less anxiety and depression, Gawande said.

Ultimately, he said, talking with patients about death is about talking with them about life—and what it means to them.

"When our technology and procedures are divorced from meaning, we actually reduce well-being," he said. "The skills that you as psychiatrists use every day—talking to patients about meaning in their lives and listening to them—are being rediscovered." PN

ETHICS CORNER

Tips for Maintaining Your Professionalism on Facebook

BY CLAIRE ZILBER, M.D.

Advances in communication technology in the last two decades are stunning. Twenty years ago we were just learning about email and the Internet, and now we can Tweet with friends and celebrities, Skype with family members who are overseas, see just about anything we want on YouTube, and navigate the Internet to access information on topics as diverse as the Human Genome Project, the latest CDC epidemiological data about Zika, and the 10 best recipes for flourless chocolate cake.

With these advances comes more time in front of a screen instead of face-to-face interaction, more accessibility to our medical records database with accompanying expectations that we

Claire Zilber, M.D., is chair of the Ethics Committee of the Colorado Psychiatric Society, a former member of the APA Ethics Committee, and a private practitioner in Denver.

will continue working via computer at any time of day or night, and a continuous acceleration of the pace of work. We adapt to each new technological advance, but sometimes the adaptation process is hindered by the fact that we can't possibly anticipate all the implications associated with the new technology.

This article is the first in a series designed to facilitate our adaptation to modern digital media by helping us maintain our professionalism and boundaries as we venture into these new social territories. Specifically, this article addresses ethical concerns when using Facebook, a social networking site launched in 2004 with over a billion daily active users as of April.

There is a generational difference in approaches to online social media. Medical students, residents, and early career psychiatrists grew up in the digital age and may have different expectations about privacy than those of us who were already in practice a dozen or more years ago. There may be no reasonable expectation of privacy when using online sites such as Facebook, and that may bother some of us more than others. Posting something online is like using a can of shaving cream: easy to get it out there, really difficult to get it back in. Regardless of our comfort with sharing elements of our lives online, we must be mindful of preserving an appearance of professionalism.

Professionalism is the combination of technical skill, good judgment, and polite behavior that helps to maintain

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the public's trust in a particular occupational group. Doctors are held to a higher standard of professionalism than most other groups, with the possible exception of Supreme Court justices. What we do in our free time reflects on our personal reputation and our profession's reputation.

Facebook may blur the line between personal and professional personas and may erode an appearance of professionalism. Images of doctors imbibing at parties don't improve patients' confidence in our skills. Family photos or descriptions of recent vacations offer up more personal information than psychiatrists usually share with patients. These disclosures can be mitigated by choosing the most stringent privacy settings on your Facebook page, but keep in mind that those settings automatically revert to the lowest privacy settings each time you load Facebook onto a new device.

Beyond compromising our privacy and professional image, having a Facebook page introduces the ethical dilemma of how to respond if you receive a friend request from a patient. If you accept the friend request, you may help to strengthen the alliance with the patient, but you also risk blurring boundaries about the nature of your relationship with the patient and the extent of your clinical availability. Is this person a patient or a friend? If the individual asks you a clinical question in a Facebook message, have you inadvertently extended your clinical space to social media? Accepting a friend request also places you at risk for a breach of confidentiality if the patient discloses on your page that you are his or her doctor. If you ignore or delete the friend request, you may hurt the patient's feelings, harming the alliance, but you also protect your professionalism and confirm your commitment to maintaining appropriate professional boundaries.

In addition to being mindful of the effect of our online profiles on our patients, we must remain vigilant to the image we are projecting to other entities that are interested in our professionalism. Online profiles have been used to vet applicants for residencies and jobs, suspend trainees, and fire employees. These consequences may arise from disclosing patient information in a Facebook post; griping about a clinical encounter, institution, or supervisor; or posting inappropriate images.

If you want to use Facebook, here are a few tips for maintaining your professionalism on the site:

- Maximize your privacy settings and check often that they remain maximized.

- Be vigilant about what you post on your profile and about how others tag you on their pages. (It is possible to adjust your settings so that you have to approve every post before it is displayed on your page, as well as anything that tags you on someone else's page.)

- Periodically review your Facebook profile and ask yourself if you would be happy for everything on your page to be seen by your training director, your employer, your most fragile patient, and that patient's attorney.

- Develop a policy for yourself about how to manage friend requests from patients or family members of patients and how to address the request in the next clinical encounter.

- Facebook and other social media are not off limits to psychiatrists, but it is best if your limits in this medium are clear before you dive in. PN

COMMUNITY NEWS

Gaza Mental Health Organization Carries On Despite Obstacles

A history of conflict and a shortage of resources have not stopped a mental health program in the Gaza Strip from providing care.

BY AARON LEVIN

Aaron Levin

Better connections with the rest of the world would mark a major boost in the capabilities of mental health professionals in the Gaza Strip, said Yasser Abu Jamei, M.D., director of the Gaza Community Mental Health Programme.

The head of the only independent mental health system in one of the most troubled corners of the world came to Washington, D.C., this winter to tell Americans about providing care under difficult circumstances.

Mental health care in the Gaza Strip is continually burdened by ongoing conflict, political tensions, poor access to the outside world, and far too little in the way of medical resources, said Yasser Abu Jamei, M.D., director of the Gaza Community Mental Health Programme (GCMHP). He spoke to Congressional staffers and later in an interview with *Psychiatric News*.

The GCMHP began in the late 1980s, in response to the traumas engendered by the First Intifada, the uprising against Israel's occupation of Gaza and the West Bank. At the time, Gaza's psychiatric hospital served only serious mentally ill inpatients. A Gazan psychiatrist, the late Eyad El-Sarraj, M.D., sought to create a community setting for less acute cases, especially for children. Referrals first came from other medical professionals, including neurologists, internists, and emergency room physicians.

The GCMHP today enrolls a total panel of 50,000 patients and normally sees 750 to 900 new cases annually at three clinics—in Gaza City, Deir el-Balah, and Khan Yunis—and two smaller outlying clinics. About 70 percent of the clinic visitors are children, and each site is equipped with rooms for play and art therapy.

In addition to providing clinical services, El-Sarraj and his colleagues also began a public education campaign to help reduce the cultural stigma associated with mental illness.

Today, there are few sources of mental health care in the Gaza Strip aside from the GCMHP, said Abu Jamei. The Ministry of Health offers some services through community health centers.

The United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) supports community mental health counselors in all of the 252 schools it operates, said Abby Smardon, M.A., executive director of American Friends of UNRWA, in Washington, D.C.

"The counselors also make home visits to evaluate family settings and can provide counseling to parents, who are less likely to seek help," she said.

However, beyond those options, GCMHP can provide more specialized mental health services to both adults and children, said Abu Jamei.

Since the 2014 fighting between Israel and Hamas-controlled regime in Gaza, working with UNICEF's Child Protective Cluster, care for children has included social or family responses, community supports, and focused treatment of people with diagnosed mental illness. The latter is provided by the GCMHP and is the equivalent of tertiary care in a general medical setting, said Abu Jamei.

One year after the similar escalation in 2012, the GCMHP recorded symp-

see ***Gaza*** *on page 39*

Investing in Global Mental Health Care Could Save Billions

According to the World Health Organization, most low- and middle-income countries spend less than $2 per year per person on the treatment and prevention of mental disorders compared with an average of $50 in high-income countries.

BY VABREN WATTS

Scaling up treatment for people living with depression and anxiety disorders around the world can lead to billions of dollars in savings, according to a study published by the World Health Organization (WHO). The report appeared in the May issue of *Lancet Psychiatry*.

"This study suggests that if mental health care was to be increased even to a moderate level of accessibility throughout the world, then not only would this increase be beneficial to the quality of [mental health] care, but it would have great returns on investments in terms of improved health, workforce productivity, and the economy in general," former APA President Paul Summergrad, M.D., chair of the Department of Psychiatry at Tufts University School of Medicine, told *Psychiatric News*.

According to the World Economic Forum, an estimated $2.5 to $8.5 trillion in lost output was attributed to mental, neurological, and substance use disorders worldwide in 2010.

While previous international economic studies of mental health have examined the economic effects of these disorders, including the cost-effectiveness of different intervention strategies and the cost of scaling up care, these studies did not evaluate the value of both economic and health benefits of intervention scale up.

To estimate the global return on an investment in a scaled-up response to depression and anxiety disorders worldwide, Dan Chisholm, Ph.D., a health economist at WHO, and a team of international researchers calculated treatment costs and health outcomes in 36 countries between 2016 and 2030, assuming a linear increase in depression and anxiety treatment coverage. The analysis showed that the estimated cost for a modest increase in mental health care for depression and anxiety would amount to $147 billion ($91 billion for depression and $56 billion for anxiety disorders), a value of $399 billion in economic benefits and health returns.

Paul Summergrad, M.D., believes that achievement of significant and sustainable improvements in global mental health care requires major international organizations, governments, and foundations to be engaged.

"Notwithstanding the general limitations of any projection-modeling study, the analysis suggests that the investment needed to substantially scale up effective treatment coverage for depression and anxiety disorders in the 36 countries included in this analysis is substantial. Extending the scope to the 20 percent of the world's population not living in the 36 countries represented in the study would increase the cost by about 25 percent to $184 billion," the authors wrote. "However, the returns to this investment are also substantial, with benefit to cost ratios of 2.3 to 3.0 when economic benefits only are considered, and 3.3 to 5.7 when the value of health returns is also included."

In an accompanying editorial in *Lancet Psychiatry*, Summergrad wrote, "the Chisholm study brings rigor to the economic case, but there are many other important reasons to consider enhanced investment in global mental health, not least of which are justice, equity, human rights, and the reduction of suffering."

In his published comments, Summer-

see ***Global*** *on page 39*

PSYCHIATRY & INTEGRATED CARE

Addressing Mental Illness Biases Should Start Early in Training

BY HEIDI COMBS, M.D., M.S.

Heidi Combs, M.D., M.S., a highly accomplished medical educator, points out that psychiatric training of medical students who go into primary care and other medical specialties can be a powerful tool to addressing the stigma associated with mental illness.

—Jürgen Unützer, M.D., M.P.H.

For just a moment, I want you to pretend that you have been diagnosed with cancer. Would you tell your colleagues? I would imagine most of you would.

Now pretend you have been diagnosed with depression. Would you tell your colleagues? According to available research, the answer is probably not. Studies indicate that physicians suffer from depression at a rate significantly higher than those in other professions. Moreover, physicians attempt and complete suicide at rates significantly higher than the general population. Why wouldn't a physician seek help?

Social stigma is a powerful force that shapes all of us, including those of us in the field of medicine. Many believe that mental illness is within the control of the individual and can be fixed with attitudinal and behavioral changes. Others consider mental illness a kind of character flaw. Studies show that the stigma of mental illness leads directly to our inclination to punish or discriminate against those with mental illness. Physicians are not immune from these attitudes.

In the early phases of medical training, depression is often perceived as a sign of personal weakness. A study by Wimsatt and colleagues found that among medical students who reported a previous depression diagnosis, most indicated they would be embarrassed if they were depressed and classmates knew. Many felt revealing their depression could negatively affect their professional advancement or cause them to be devalued. Interestingly, students with no prior depression associated depression and depressed individuals with inferior functioning and performance. Studies have found medical students also have negative beliefs about patients with other mental illnesses, including substance use and schizophrenia.

Stigma toward mental illness doesn't end in medical school. Given that most patients receive mental health care from a family practitioner, the negative impact of existing stigma could be significant. Studies looking at general practitioners' attitudes toward patients with mental illness compared with those without have found the most positive attitudes were held toward patients without a diagnosis of mental illness. Negative attitudes may be contributory to the physical health disparity between patients with comorbid mental illness.

Although the data are mixed, providers who work with patients with mental illness are also prone to stigmatizing patients. How can we expect better of other physicians if psychiatrists themselves struggle with stigmatizing these patients? The key may lie in focusing attention early in medical education.

Education has been found to be an effective approach toward reduction of stigma. As clerkship director, I emphasize to medical students the importance of appreciating the challenges faced by people with mental illness and the inspiring resilience of these individuals. I want my students to understand the suffering associated with mental illness as well as the person behind the diagnosis as a way to reduce stigma.

A contributor to the stigma is the perceived unpredictability of mental illness. This is anxiety provoking and can engender negative feelings toward the patient and their prognosis. Another factor is the impotence that trainees can feel about their inability to "fix" or "cure" a patient with a severe mental illness. This feels like failure. The bias that patients are in control of their experience and could "pull themselves up by their bootstraps" can result in students' feeling judgmental toward patients.

I find it's helpful to put mental illness in perspective. Patients with diabetes, cancer, heart disease, rheumatoid arthritis, and so on fail treatment, yet somehow it's easier to ascribe this to the illness rather than the individual struggling with the illness. Helping students to understand this bias can allow them to develop a different attitude toward patients with mental illness and can reduce stigma.

Finally, helping students to see the person behind the illness can be very powerful. We promote the progression of students from focusing on the symptoms that patients are exhibiting to connecting with the people behind the symptoms. This allows them to understand their suffering and promotes empathic attunement. I feel I have succeeded when my students reflect on how they feel about patients and how mental illness has impacted their patients' lives.

Efforts to reduce the stigma associated with mental health early in medical education can have a powerful effect downstream, particularly for those students who go on to practice in primary care, as most of my students do.

see **Integrated Care** on page 28

Heidi Combs, M.D., M.S., is an associate professor of psychiatry at the University of Washington and the psychiatry clerkship director at the University of Washington School of Medicine. Jürgen Unützer, M.D., M.P.H., is a professor and chair of psychiatry and behavioral sciences at the University of Washington, where he also directs the AIMS Center, dedicated to "advancing integrated mental health solutions."

RESIDENTS' FORUM

Making Peace With Patient Suicide

BY JOSEPH BISHARA, M.D., M.Ed.

Death gives pause to all who have yet to experience it. As physicians, we take an unspoken oath to do all we can to delay death. A mentor once told me that a physician has only two functions: to extend life and to alleviate suffering. When the agent of death is the patient, it's hard not to see how psychiatrists might feel they've failed at both functions.

Earlier this academic year, I learned one of my patients had taken his own life. Months after the event I decided to present an M&M case to my fellow residents, and now I find myself journaling my thoughts in this article. My goal was to give others an opportunity to experience it vicariously. And while I hope each of you never have this experience, I hope my thoughts might provide some guidance should you find yourself in a similar situation—although in reality, I'm not sure one can really be prepared to face this.

After receiving the news, I remember the sting. I literally couldn't hear well after that news. I finished up my morning clinic and took an afternoon didactics off. My faculty supervisor made it a point to reach out to me. I talked about how numb I felt. How I didn't know how I felt. How I couldn't stop going over the details and the what-ifs. I processed the event over the weekend and checked back in afterward.

I wanted to know "How should I feel?" I found myself experiencing denial like "Maybe it was an accident?" I had legal questions like "Did I keep records appropriately? Am I in legal trouble? Can I call the family?" I had moral questions like "Did I do my best for him?" and "Was my heart in the right place?" I was angry inwardly. I questioned my own ability: "Am I a good doctor?" I catastrophized a little: "Will I be forced to quit medicine? Maybe I'm just no good at this doctor thing." Philosophically, I wondered, "Am I responsible for another man's choices?" I had cultural/spiritual thoughts: "Is his family OK? Can I offer them comfort?"

I also experienced admiration for our field. Our little clinic helps a lot of people to find relief from suffering, and every staff member plays a part. I was concerned about my peers. I checked in with them and thanked them for all they do to take care of our patients. I checked in with my supervisor and the residents who had also known my patient. But then it hit. Sadness. I am sad that a man suffered and lost hope for relief coming in any way other than death. Of course that was entirely appropriate; however, it seemed like others with similar experiences were able to "get over it" rather quickly.

What helped? I surrounded myself with caring colleagues and was a caring colleague to others. Also, knowing that I had patients who needed a fully functional doctor compelled me to get better. Ultimately, I think taking joy in something larger than myself helped. I watched my kid try to put together a Lego model. I went jogging in a wooded neighborhood. I read poetry, listened to music, and played an instrument. And I found peace.

I found this conclusion to be freeing: patients have sovereignty over their own choices—in my personal view, a self-evident, inalienable right gifted by (and I have no other word for it) God. That means they get to choose. We can only help inform patients with therapy and stabilize them with medication so they make a good choice, but ultimately, they get to choose. PN

Joseph Bishara, M.D., M.Ed., is a PGY-3 psychiatry resident at the Indiana University School of Medicine.

CLINICAL & RESEARCH NEWS

Marriage May Decrease Future Risk Of Alcohol Use Disorder

The protective effect of marriage endured even when statistical analysis controlled for such factors as age, parental education, early-onset externalizing syndromes, or positive family history of alcohol use disorder.

BY MARK MORAN

Men and women in a first marriage to a spouse with no history of alcohol use disorder (AUD) are much less likely to experience AUD themselves, according to a report published last month in *AJP in Advance* and released at APA's 2016 Annual Meeting in Atlanta.

The study found that marriage generally was protective against the risk of alcohol use disorder: married men and women had, respectively, a 60 percent and 71 percent lower risk for onset of alcohol use disorder compared with individuals who remained single.

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"These results are consistent with the hypothesis that the psychological and social aspects of marriage, and in particular health-monitoring spousal interactions, strongly protect against the development of alcohol use disorder," Kenneth Kendler, M.D., a professor of psychiatry and human and molecular genetics at the Virginia Institute for Psychiatric and Behavioral Genetics and Virginia Commonwealth University, and colleagues wrote.

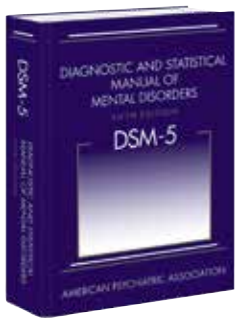
Kendler and colleagues from the Lund University in Malmö, Sweden, used a variety of Swedish national birth, health, and crime registries to assess the relationship between first marriage and subsequent registration for AUD in a large population-based Swedish cohort (n=3,220,628). They also sought to determine the degree to which this association can be explained by parental education, family history, and early history of criminal behavior or drug abuse. Of the more than 3.2 million individuals included in the sample, 72,252 met the criteria for AUD.

They found that while marriage to a spouse without AUD was strongly protective, marriage to a spouse with lifetime AUD significantly increased the risk for subsequent AUD registration in both men and women.

"As expected, we found a substantial main effect of those with a positive family history having a stronger risk for alcohol use disorder," the researchers stated. "More interestingly, we found robust evidence that the protective effects of marriage were stronger in those with a family history compared to those without. This effect is consistent with recent findings that severe problem drinkers show the greatest decrease in drinking

see ***Marriage*** *on page 25*

Diagnosing When Manic Features Present Requires Extra Care



Study results raise questions about whether the *DSM-5* three-symptom criteria adequately capture what is seen in clinical practice.

BY NICK ZAGORSKI

Among the many additions and revisions to APA's *Diagnostic and Statistical Manual of Mental Disorders* that appeared in its fifth edition *(DSM-5)* was the incorporation of "mixed features" as a specifier for both depression and bipolar disorder.

Previously, a patient had to be diagnosed as having a mixed episode—that is, presenting with both full depression and mania—while the new designation requires patients to meet only a certain level of symptoms in the mood opposite their predominant diagnosis.

Shefali Miller, M.D., a clinical assistant professor of psychiatry and behavioral sciences at Stanford University, commended this change to recognize mixed features. "It recognizes a phenomenon that's been long observed but never codified," she told *Psychiatric News*.

However, even this new distinction may not adequately capture the full spectrum of patients who have to cope with concurrent manic and depressive symptoms, based on a study by Miller and colleagues published April 15 in *AJP in Advance*.

The group assessed 907 adult outpatients with bipolar disorder and compared the prevalence of depression with mixed features using different diagnostic thresholds. More than 14,310 physician visits spanning seven years were included in the analysis.

Applying a strict *DSM-5*-based definition of depression with mixed features, which requires at least three symptoms on the Young Mania Rating Scale (YMRS) that do not overlap with any of the patient's depressive symptoms, resulted in mixed features being present in 6.3 percent of all visits; a more lenient cutoff that required only two nonoverlapping YMRS symptoms yielded a prevalence of 10.8 percent.

However, if the diagnosis was based only on meeting clinical scores for depression (Inventory of Depressive Symptomatology–Clinician-Rated Version [IDS-C] score of ≥15) and hypomania (YMRS score from 2 to 12) at the same visit, then the prevalence rose to 14.9 percent of all visits, with over 64 percent of patients meeting the criteria during at least one visit.

Not surprisingly, under the more lenient threshold, the most common symptom seen among patients presenting with mixed features compared with unipolar depression was irritability, which is considered an excluded YMRS symptom since it overlaps with an IDS-C symptom.

William Coryell, M.D., the George Winokur Professor of Psychiatry at the University of Iowa College of Medicine and a member of the *DSM-5* Mood Disorders Work Group, noted that these findings are consistent with those of other studies about the possible prevalence of mixed features, but that doesn't necessarily mean the *DSM* criteria need revision.

"When you're establishing a new diagnosis, there have to be some thresholds to make it clinically distinct," he told *Psychiatric News*.

Coryell acknowledged that the *DSM-5* requirements may not capture everyone who should get a mixed features diagnosis, but the available data suggest that the presence of three manic symptoms was the best cutoff.

"However, it doesn't mean that a diagnosis that's a little lower than the threshold isn't clinically meaningful," he added. "Psychiatrists should have heightened vigilance when any manic symptoms are perceived in a depressed individual."

Miller also believes that even one-time occurrences of manic symptoms are important, as they can inform prognosis and treatment. For example, three YRMS symptoms that a previous Stanford study had found to be predictive of antidepressant treatment-emergent mania—language-thought disorder, increased speech, and increased motor activity—were among the most prevalent in patients diagnosed with mixed features (along with irritability).

But she also thinks that continued discussion of the *DSM-5* definition is warranted. The question of whether to include overlapping symptoms when considering a mixed-features diagnosis is part of the debate, but a more salient issue revolves around whether the mixed-features criteria should be focused on scoring for individual symptoms.

As she explained, while people with mixed features show certain symptoms, a patient displaying that set of symptoms should not necessarily be diagnosed as having mixed features. Criteria that focus more on overall manic severity might be a more reliable approach.

This study was supported by a grant from the Stanley Medical Research Institute. PN

"Mixed Depression in Bipolar Disorder: Prevalence Rate and Clinical Correlates During Naturalistic Follow-Up in the Stanley Bipolar Network" is posted at http://ajp.psychiatryonline.org/doi/full/10.1176/appi.ajp.2016.15091119.

CLINICAL & RESEARCH NEWS

Army STARRS Study Hints at Association Between PTSD, Immune-Related Disorders

A genomewide association study of 13,000 U.S. Army soldiers identifies two genetic variants that may be associated with posttraumatic stress disorder.

BY AARON LEVIN

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Two coordinated genomewide association studies including more than 13,000 U.S. Army soldiers have found only elusive genetic associations with posttraumatic stress disorder (PTSD).

The studies were part of the Army STARRS collaboration, a multi-year, multimillion-dollar effort designed "to improve understanding of suicide and PTSD and related mental health risk and resilience in the U.S. Army."

Genetic studies of people with PTSD are valuable because only a small minority of individuals exposed to trauma develop the disorder. While the difference between those who do and do not develop PTSD could be due to social factors or preexisting risk factors, several twin studies have shown that genetic variation contributes to risk for PTSD symptoms.

For the current study, Murray Stein, M.D., M.P.H., a professor of psychiatry, family medicine, and public health at the University of California, San Diego, and colleagues analyzed DNA from two study groups within STARRS: The New Soldier Study (NSS) compared 3,167 patients with PTSD with 4,607 trauma-exposed control individuals; the Pre/Post Deployment Study (PPDS) compared 947 patients with PTSD with 4,969 trauma-exposed controls.

In the NSS group, a single-nucleotide polymorphism (SNP) on chromosome 19 was associated with PTSD in European Americans. A SNP on chromosome 5 was also associated with PTSD among African Americans. Neither of these associations were seen in the PPDS sample.

Within the African-American sample in the NSS, however, the authors observed genomewide significant association with PTSD for SNPs in anankyrin repeat domain 55 (*ANKRD55*) gene on chromosome 5. Why this association is limited to African Americans is not clear.

"[Controlling] for population stratification increases the likelihood of finding genetic variation that is not spuriously associated with ancestry markers and increases the chances of finding differences that are marked by variation in one group and not another," explained Kerry Ressler, M.D., Ph.D., a professor of psychiatry and chief scientific officer at McLean Hospital in Belmont, Mass., in an accompanying editorial.

The function of *ANKRD55* is not known but has been reported to be associated with certain autoimmune and inflammatory disorders, like multiple sclerosis, type 2 diabetes mellitus, celiac disease, and rheumatoid arthritis.

see ***Army STARRS*** *on page 31*

FDA to Regulate E-Cigarettes, Other Related Tobacco Products

From 2011 to 2015, electronic cigarette use among high school students jumped 900 percent, according to the Food and Drug Administration and the Centers for Disease Control and Prevention.

BY VABREN WATTS

The Food and Drug Administration (FDA) last month finalized a rule extending its authority to all tobacco products including e-cigarettes, cigars, hookah tobacco, and pipe tobacco. The rule, which goes into effect August 1, makes the products subject to the Food, Drug, and Cosmetics Act and the Tobacco Control Act.

"This is an important landmark decision by the FDA," said Douglas Ziedonis, M.D., M.P.H., a substance abuse expert and chair of the Department of Psychiatry at the University of Massachusetts Medical School. "It closes loopholes in manufacturing as well as in marketing, especially marketing toward youth. The new ruling is a vital public health strategy," he told *Psychiatric News*.

Although the use of conventional cigarettes by youth has declined over the past decade, their use of other tobacco products has escalated rapidly. A survey by the FDA and the Centers for Disease Control and Prevention found that current e-cigarette use among high school students skyrocketed from 1.5 percent in 2011 to 16 percent in 2015, and hookah use has also risen significantly.

While there was previously no federal law prohibiting retailers from selling e-cigarettes, hookah tobacco, or cigars to people under age 18, the rule bans sales to minors and requires sellers to verify the purchaser's age using photo ID. In addition, the sale of tobacco products in vending machines (unless in an adult-only facility) and distribution of free samples is forbidden.

The new rule will require e-cigarette manufacturers to meet premarket approval requirements. They will have to either show their e-cigarettes are appropriate for the protection of public health or their products are similar to those on the market as of February 15, 2007.

iStock/RyanJLane

The tobacco product review process gives the agency the authority to evaluate ingredients, product design, and health risks, as well as their appeal to youth.

Under staggered timelines, the FDA expects that manufacturers will continue selling the newly regulated products for up to three years while the companies submit new tobacco product applications for FDA review. The FDA will issue an order granting marketing authorization where appropriate; otherwise, products will face FDA enforcement.

"Overall the best thing about this new regulation is its implications for protecting our youth," said Ziedonis. He told *Psychiatric News* that he would also like to see more discussion concerning legislation that shifts the legal age for use of tobacco products from 18 and 19 years to 21, which has been achieved in such states as California and Hawaii and in a few municipalities throughout country. PN

PSYCHIATRY & PSYCHOTHERAPY

What Is Neutrality in Psychotherapy Anyway?

FRANK YEOMANS, M.D., PH.D., AND EVE CALIGOR, M.D.

In our previous articles about narcissistic personality disorder (NPD) and how to treat it with an object relations psychodynamic approach, the issue of therapeutic neutrality emerged as central. It would be helpful to clarify what neutrality is.

A neutral stance on the part of the therapist can be instrumental in advancing dynamic therapy. However, it must be understood that a

*see **Psychotherapy** on page 30*

Frank Yeomans, M.D., Ph.D., is a clinical associate professor of psychiatry and director of training at the Personality Disorders Institute of the Weill Medical College of Cornell University. Eve Caligor, M.D., is a clinical professor of psychiatry at Columbia University College of Physicians and Surgeons. They are members of the Group for the Advancement of Psychiatry's Psychotherapy Committee.

CLINICAL & RESEARCH NEWS

Neuromodulation May Offer New Option for Patients With Psychiatric Disorders

New noninvasive therapies using electrical stimulation may one day help psychiatric patients who do not respond well to medications.

BY NICK ZAGORSKI

While the majority of pharmacotherapies for psychiatric disorders target chemical imbalances in the brain, a growing number of techniques employing neuromodulation—the application of magnetic or electrical energy to the brain to alter neurotransmission—have emerged in recent years.

"One might think that getting energy to the brain noninvasively would be difficult given the skull barrier, but it actually is surprisingly easy," said Andrew Leuchter, M.D., a professor of psychiatry

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at the David Geffen School of Medicine at the University of California, Los Angeles, and director of the neuromodulation division at UCLA's Semel Institute for Neuroscience and Human Behavior.

There are several critical nerves that connect important behavioral centers in the brain to the exterior of the head, chief among them being the trigeminal nerve, which reacts to sensations all across the face.

> "One might think that getting energy to the brain noninvasively would be difficult given the skull barrier, but it actually is surprisingly easy."
>
> —Andrew Leuchter, M.D.

A little over a decade ago, researchers at UCLA began to experiment with applying low-level current to the trigeminal nerve—via a patch worn on the forehead as a patient sleeps—as a treatment option for patients with drug-resistant epilepsy. They found that this external trigeminal nerve stimulation (eTNS) not only reduced symptoms of epilepsy

continued on next page

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continued from previous page

in patients but was also associated with improvements in mood.

"It made sense, as the trigeminal nerve feeds into the major centers for mood and anxiety in the brain like the amygdala," Leuchter said. Together with UCLA Professor of Psychiatry Ian Cook, M.D., Leuchter and colleagues began testing eTNS as an add-on therapy for patients with psychiatric disorders in 2009. Since then, they've shown positive results in small pilot studies for depression, attention-deficit/hyperactivity disorder, and most recently comorbid depression and posttraumatic stress disorder (PTSD) (*Psychiatric News,* March 18).

Another neuromodulation technique under exploration is transcutaneous vagus nerve stimulation (tVNS), a method by which electrical current is delivered to the vagus nerve via small clips on the ears.

Transcutaneous VNS is an outgrowth of traditional VNS, which is an FDA-approved electrical therapy for treatment-resistant depression.

Traditional VNS involves placing an electrode directly on the vagus nerve in the neck; however, as with the trigeminal nerve, the vagus nerve also has some more accessible fibers at the ear tips (which has been utilized by acupuncturists for a long time), and several small research studies have found that stimulating this region can produce modest symptom improvements in patients with depression and other psychiatric disorders.

While these two approaches are fundamentally similar (both the vagus and trigeminal nerves project to many of the same brain regions), there are methodological differences between the techniques.

"One critical limitation of tVNS is that the vagus nerve sends signals to the heart, so tVNS stimulation is limited to low frequencies like 30 Hertz or less to avoid potential cardiac problems," said Cook. "With eTNS you can use higher frequencies, which equates to raising the dose of medication."

Another difference between the two techniques is that eTNS requires the stimulation to be carried out over multiple hours at a time, whereas tVNS can be completed in daily sessions of 30 to 60 minutes.

"Just as all antidepressants aren't exactly the same, all neuromodulations aren't the same either," Cook said. "Having more arrows in the quiver is never a bad thing."

As for where these arrows can go in the future, Pedro Shiozawa, M.D., a professor of psychiatry at Santa Casa School of Medicine in Brazil who has carried out clinical studies with both techniques, told *Psychiatric News*, "I firmly believe that these strategies play a central part in modulating brain activity, not only facilitate the action of medications. Someday eTNS or tVNS alone may determine the clinical amelioration of psychiatric symptoms."

The results of a recent study comparing the effectiveness of tVNS with sham stimulation in over 100 patients with mild or moderate depression suggests Shiozawa's prediction may be accurate. Those who received tVNS therapy alone showed greater improvements in their depressive symptoms compared with a subgroup that received sham stimulation, a joint team of researchers at the China Academy of Medical Sciences and Harvard Medical School reported.

"The field is definitely growing strong," said Cook. "We still need to build up an evidence base, but I'm confident that electrical-based therapies will become important standards of care for many patients." PN

An abstract of "Trigeminal Nerve Stimulation for Comorbid Posttraumatic Stress Disorder and Major Depressive Disorder" is posted at http://onlinelibrary.wiley.com/doi/10.1111/ner.12399/abstract. An abstract of "Effect of Transcutaneous Auricular Vagus Nerve Stimulation on Major Depressive Disorder: A Nonrandomized Controlled Pilot Study" is posted at http://www.jad-journal.com/article/S0165-0327(15)30933-2/abstract.

What's Best When Prescribing To Patients With Dementia?

The chair of the group tasked with writing APA's Practice Guideline on the Use of Antipsychotics to Treat Agitation or Psychosis in Patients With Dementia describes some of the challenges the group faced when putting these recommendations together and what he hopes will come of it.

BY NICK ZAGORSKI

On May 1, APA published its Practice Guideline on the Use of Antipsychotics to Treat Agitation or Psychosis in Patients With Dementia. The publication, which offers 15 evidence-based recommendations for how best to approach this critical pharmacological problem, is the result of hundreds of hours of review and discussion by a 10-member group of psychiatrists over the past two years.

Victor Reus, M.D., a professor of psychiatry at the University of California, San Francisco, and chair of the writing group, recently spoke with *Psychiatric News* about the process of putting together the practice guideline and the conclusions reached by the group.

Q *Why was the treatment of agitation or psychosis in patients with dementia selected as the next set of APA practice guidelines?*

A I was not on the original selection committee that prioritized these issues, but I know that the group tasked with deciding what issue to tackle looked at areas that are thought to be of clinically urgent concern and in which there is enough of an evidence base to provide meaningful recommendations for treatment.

Over the last 10 years, despite only modest evidence for short-term efficacy, and increasing evidence of morbidity and mortality associated with their use, antipsychotic drug usage in the treatment of dementia symptomatology has remained remarkably prevalent, with the drugs continuing to be prescribed long after the patient has stabilized. Clearly this was a clinical scenario that called for a thoughtful and considerate analysis of what should be considered a best practice.

Q *These are the first APA recommendations tailored toward a specific set of patients and symptoms. What sort of challenges presented themselves in developing these guidelines?*

A Our goal was to create guidelines that incorporated a critical review of the latest, best evidence on the topic but that were also informed by a consensus view of current clinical realities and exigencies. This can be difficult, especially in areas where the data are sparse or subject to differing interpretations and where the process requires almost unanimous agreement in the work group for a recommendation to go forward. The tension is between generating a guideline that addresses the clinical issue of concern but which may be more definitive in some statements than some would feel is warranted versus one that is more equivocating and generic in its recommendations, but does little to change practice.

Q *Was there any overarching theme among the numerous recommendations made?*

A Any antipsychotic might be useful for managing dementia-related psychosis or agitation in certain circumstances. The concern in the field at large has been that when people receive a prescription, it's never changed and it continues on indefinitely, which over time carries increasing risks of morbidity and even mortality. The problem is that many patients are never reassessed. But if you look at the literature, a majority of patients who respond continue to do quite well once the drugs are discontinued.

What is the optimal length of time a patient should take antipsychotics for dementia-related psychosis or agitation? This was an issue of disagreement within the committee, with most data suggesting somewhere in the three- to six-month range. However, we were able to come to a consensus statement that captures the intent that patients given antipsychotics should be reassessed sooner rather than later.

Q *Did you encounter any surprises as you went through the process of reviewing the large amount of literature?*

A I think the issue about the harms of antipsychotic use in people with dementia is backed by very consistent data, so there is no question that these drugs can have significant impairments in quality of life and cognition if used on a chronic basis and, in some individuals, carry a risk of sudden death, even in short-term use.

Victor Reus, M.D., chair of the APA Guideline Writing Group on the Use of Antipsychotics to Treat Agitation or Psychosis in Patients With Dementia.

I did find it unusual, given how widely antipsychotics are used, that there was not a better database of drug-to-drug comparisons that might have allowed for more specific recommendations.

Q *The committee recommended against the use of haloperidol (a first-generation antipsychotic) as a first-line agent. But there were no second-generation antipsychotics that stood out as preferred first-line agents, correct?*

A This was a continuing point of discussion among the members of the committee. The problem is that most of the data we reviewed came from studies funded from pharmaceutical companies looking for drug approval, and often the comparator drug is one that they strongly think will do worse, like a first-generation antipsychotic. So we do not have a lot of head-to-head research comparing the atypical antipsychotics.

Take quetiapine as an example. What we found was that it is frequently used at a lower dose equivalent compared with other second-generation antipsychotics, so while the results seemed more favorable, they may not be directly comparable.

Q *What do you hope clinicians will take away from the practice guidelines?*

A Given the very real harm statistics, I hope that we will see some significant alteration in practice within the next couple of years. Physicians have been reluctant to make changes in the past, and one of the reasons may be that many care settings don't have the resources needed to offer the behavioral interventions we know can be often effective in treating these patients; antipsychotics are used as a quick and easy alternative, but that excess usage can create unacceptable risks.

Unfortunately at this point there are not better pharmacologic alternatives than antipsychotics for some individuals, particularly in treating emergent agitation, which can be very harmful in its own right, so these medications still need to be a consideration. Having said that, antipsychotics need to be handled in a more controlled and rigorous fashion than is currently the case. PN

For more on this topic, see the *Psychiatric News* article "APA Publishes New Practice Guideline on Antipsychotic Use for Dementia," posted at http://psychnews.psychiatryonline.org/doi/full/10.1176/appi.pn.2015.5a1. The guideline can be downloaded from http://psychiatryonline.org/doi/book/10.1176/appi.books.9780890426807.

Marriage

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after the transition to marriage. Those at highest risk for alcohol problems appear to be the most likely to benefit from the protective effects of marriage."

The protective effect of marriage endured even when statistical analysis controlled for such contributing factors as age, parental education, early-onset externalizing syndromes, or positive family history of AUD, the authors noted.

Marc Galanter, M.D., a professor of psychiatry at New York University School of Medicine and an expert in alcohol use disorders, who reviewed the report for *Psychiatric News*, noted that lead author Kendler has done past important research on genetic vulnerability to alcoholism. "The current study illustrates how environmental issues can be comparably influential," he said. "The study shows how spousal influence can have a beneficial effect, making alcohol use disorder much less likely to emerge.

"This reflects spousal influence in a naturalistic setting, but in a clinical setting psychiatrists can utilize spousal, family, and other relationships to help promote recovery," he said. PN

"Effect of Marriage on Risk for Onset of Alcohol Use Disorder: A Longitudinal and Co-Relative Analysis in a Swedish National Sample" is posted at http://ajp.psychiatryonline.org/doi/full/10.1176/appi.ajp.2016.15111373.

New Age of Legalized Marijuana Calls for New Look at Science, Policy

The psychiatric and cognitive risks associated with cannabis use were among the topics covered at a two-day NIH meeting.

BY AARON LEVIN

The United States is engaged in "a new form of reefer madness," Alan Budney, Ph.D., a professor of psychiatry at Geisel School of Medicine at Dartmouth College, told an audience at a National Institutes of Health (NIH) conference on marijuana and cannabinoids in March.

"Legalization has brought new ways to smoke, eat, or vape cannabis, reinforced by high potency, attractive packaging, and heavy advertising," he noted. Such factors have likely contributed to growing numbers of people using marijuana and the public misperception that marijuana is a "safe" drug.

"We've lost the war to the legalization folks," he said.

At least 23 states and the District of Columbia have in some way legalized the possession or use of a drug still considered illegal by the federal government. As a result, scientists and policymakers are scrambling to learn more about the short- and long-term effects of cannabis on people.

The NIH conference brought together researchers from a number of disciplines to exchange knowledge on what Nora Volkow, M.D., director of the National Institute on Drug Abuse (NIDA), described as the "positives and negatives of states' legalizing marijuana." Volkow opened the two-day meeting on the NIH campus in Bethesda, Md.

"Tobacco and alcohol are the first and third leading causes of preventable death," said Volkow. "They are both legal, so what does this imply for the legalization, marketing, and expanded use of marijuana?"

Among other topics, experts addressed the relationship between cannabis and psychomotor performance, cognition, and mental illness, including addiction.

Cannabis is the most commonly used illicit drug in the United States and is often associated with car crashes, explained former NIDA researcher Marilyn Huestis, Ph.D., an adjunct professor of epidemiology and preventive medicine at the University of Maryland School of Medicine in Baltimore. The tetrahydrocannabinol (THC) in cannabis impairs psychomotor performance, contributing to accidents.

"Any cannabis product found in blood increases the risk of a fatal car crash by 2.8 times," she said, adding that psychomotor impairment resulting from cannabis can continue for three weeks after last use.

The effects of combining cannabis and alcohol are different from the effects of either drug alone. Driving simulator tests have found that while higher concentrations of alcohol in the blood are associated with drivers speeding up, the opposite is true in drivers who have high concentrations of THC in their blood; these drivers often slow down, possibly because they understand that they might be impaired.

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Furthermore, there are differences in how chronic and occasional cannabis users process the drug, so coming up with a single biomarker level to incorporate in legislation is difficult, said Huestis.

Cannabis use is also associated with cognitive impairment, which often persists following acute intoxication, explained Madeleine Meier, Ph.D., an assistant professor of psychology at Arizona State University.

Studies suggest that "more frequent, persistent, and earlier-onset cannabis use is associated with greater cognitive impairment," but less is known of the mechanism of action underlying cognitive impairment, whether cognitive ability improves with abstinence, or whether there are individual differences in susceptibility to cognitive impairment following cannabis use, she said.

"Multiple, prospective epidemiological studies indicate that use of cannabis increases risk of later psychosis, independent of confounding and intoxication effects," said Anne Eden Evins, M.D., M.P.H., an associate professor of psychiatry at Harvard Medical School and director of the Center for Addiction Medicine at Massachusetts General Hospital.

According to Evins, there is strong support indicating that cannabis use worsens the symptoms of preexisting psychosis, good evidence that it can precipitate schizophrenia in those at risk, but only mixed support for the likelihood of cannabis as a cause of a psychotic disorder that may not otherwise have occurred.

"Cannabis is a component—one cause among other factors—that contributes to psychiatric illness," she added. "However, it is a preventable risk factor, so prevention or delay of onset is important, especially among siblings of schizophrenia patients."

Cannabis use disorders are similar to other addictions, said Dartmouth's Budney. For instance, users who meet use disorder criteria for "dependence" often display withdrawal symptoms, have difficulty quitting, and have high relapse rates. Although there are currently no pharmacotherapies to treat cannabis use disorder, behavioral treatments have been shown to help patients, he noted.

In addition to developing new strategies to prevent cannabis use disorder and improve treatment, Budney said greater efforts need to be made to provide accu-

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Alcohol Use May Lead to Dire Consequences in Older Adults

Although drinking rates for older adults are less than that of young adults, adverse consequences related to alcohol use for people aged 65 and older are greater.

BY VABREN WATTS

Most people are familiar with the risks associated with underage drinking—alcohol can alter brain development, impair judgment, and increase risks of accidents and even death—and the ongoing efforts to curb use in this group.

In contrast, steps to prevent and treat older people who misuse alcohol are often not taken, despite the fact that misuse in this population can have equally dire consequences, according to Shilpa Srinivasan, M.D., an associate professor of neuropsychiatry and behavioral science at the University of South Carolina School of Medicine. Srinivasan chaired a session on this topic at the annual meeting of the American Academy of Geriatric Psychiatry in March.

Vabren Watts

Rebecca Payne, M.D., and Shilpa Srinivasan, M.D., say alcohol screening should also be routine in primary care settings, regardless of a patient's age.

"We really wanted to call attention to the fact that the occurrence of alcohol misuse in older adults doesn't stop once an individual turns 65 or crosses the threshold into the geriatric age range," Srinivasan said during an interview with *Psychiatric News*.

According to the 2013 National Survey on Drug Use and Health (NSDUH), 2.1 percent of people aged 65 and older engaged in past-month heavy drinking (defined as having five or more drinks per day in at least five days) and 9.1 percent engaged in past-month binge drinking (five or more drinks in at least one day).

"We know that heavy drinking is not as prevalent as it is in people aged 18 to 25, yet it is still present," said Rebecca Payne, M.D., an assistant professor of

see ***Alcohol*** *on page 30*

MED CHECK

BY VABREN WATTS

Brintellix to Be Marketed as Trintellix

Beginning this month, the antidepressant ***Brintellix (vortioxetine)*** will be marketed in the United States under the name Trintellix, according to a statement released last month by Takeda Pharmaceuticals, which holds the license to market the drug in the United States, and Lundbeck, which manufactures the drug. This brand name change, which has been approved by the Food and Drug Administration (FDA), is in an effort to decrease the risk of prescribing and dispensing errors resulting from name confusion with the anti-blood clotting medication ***Brilinta (ticagrelor)***.

No other changes will be made to the formulation, label, or packaging of the medicine. Because of the lag time associated with manufacturing bottles with the new brand name, the FDA has warned that health care professionals and patients may continue to see bottles labeled with the brand name Brintellix during the transition period. To reduce the risk of name confusion during this transition, the FDA recommends prescribers include the generic name of the medication they are ordering.

FDA Approves First Medication For Parkinson's-Related Psychosis

Nuplazid (pimavanserin) tablets, manufactured by Acadia Pharmaceuticals Inc., last month became the first medication approved by the FDA to treat psychosis in patients with Parkinson's disease (PDP).

Some studies suggest that up to 50 percent of all patients with Parkinson's disease will experience hallucinations or delusions during the course of their illness—believed to be in part due to the elevated dopamine levels produced by common Parkinson's disease medications. Pimavanserin is a selective-serotonin inverse agonist that preferentially targets 5-HT2A receptors, while avoiding activity at dopamine and other receptors commonly targeted by antipsychotics.

A trial of adults with PDP who were randomly assigned to take 40 mg of pimavanserin or placebo daily for six weeks revealed that those taking pimavanserin experienced fewer and less severe hallucinations and delusions without worsening the primary motor symptoms of Parkinson's disease. The most common adverse effects reported by patients taking pimavanserin included peripheral edema, nausea, and confusional state.

Nuplazid is expected to be commercially available this month, according to Acadia.

FDA Committee Votes Down Adding Abuse-Deterrent Label To Apadaz

The FDA's Anesthetic and Analgesic Drug Products Advisory Committee and Risk Management Advisory Committee in May voted 16-4 in favor of approving KemPharm's ***Apadaz***—a prodrug of ***hydrocodone*** and ***benzoic acidic*** combined with ***acetaminophen***—for its proposed indication in treating acute pain, but voted against inclusion of an abuse-deterrent labeling for the product.

KemPharm claimed that evidence suggested the Apadaz would remain in an inactive state (prodrug) until it reached the intestinal tract where it would be converted to an active form of hydrocodone—thereby reducing the likelihood of the medication being snorted, injected, or smoked. However, the FDA disagreed with such claims, citing findings to suggest that Apadaz was hydrolyzed rapidly and completely before reaching the intestinal tract.

"[W]hile it is inevitable that there will be different points of view when evaluating new molecular entities with abuse-deterrent properties, we will continue to work collaboratively with the FDA to complete the review process of Apadaz," KemPharm President and CEO Travis Mickle, Ph.D., said in a press announcement.

FDA Warns About Compulsive Behaviors Reportedly Linked to Aripiprazole

The FDA in May issued a warning that the antipsychotic ***aripiprazole*** may increase compulsive or uncontrollable urges to gamble, binge eat, shop, and have sex.

The announcement comes after a search of the FDA Adverse Event Reporting System (FAERS) database and the medical literature in the 13 years since the approval of the first aripiprazole product (***Abilify***) in November 2002 revealed a total of 184 case reports (167 U.S. cases, which included adults and children) in which there was an association between aripiprazole use and impulse-control problems. The specific impulse-control problems reported include pathological gambling (n=164), compulsive sexual behavior (n=9), compulsive buying (n=4), compulsive eating (n=3), and multiple impulse-control problems (n=4).

All 167 FAERS cases reported that the patients experienced new urges leading to compulsive behavior only after starting aripiprazole treatment, and within days to weeks of reducing the dose or discontinuing aripiprazole treatment, all of the patients reported that the intense urges resolved. None of the patients had a history of pathological gambling, compulsive sexual behavior, binge eating, or compulsive shopping prior to starting aripiprazole treatment, and none were reported to have concurrent substance abuse disorder or symptoms of mania at the time they developed the impulse-control problems.

"Although pathological gambling is listed as a reported side effect in the current aripiprazole drug labels, this description does not entirely reflect the nature of the impulse-control risk that we identified," the FDA stated in the announcement. "As a result, we are adding new warnings about all of these compulsive behaviors to the drug labels and the patient Medication Guides for all aripiprazole products," including ***Abilify***, ***Abilify Maintena***, ***Aristada***, and generics.

The FDA advises health care professionals to make patients and caregivers aware of the risks associated with aripiprazole when prescribing and ask patients who are taking the medication specifically about any new or increasing urges. The agency also recommends the close monitoring of patients at higher risk for impulse-control problems, including those with obsessive-compulsive disorder, bipolar disorder, substance use disorder, alcohol use disorder, or other addictive behaviors. Any side effects involving aripiprazole should be reported to the FDA MedWatch program. PN

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rate information to the public about cannabis use and its risks.

"Finally, we really need a new road for cannabis regulatory science," he added. "The problem is that science moves slowly. It's still going to take a while, but that's where the answers will come from." PN

Videos from the conference "Marijuana and Cannabinoids: A Neuroscience Research Summit" are posted at https://videocast.nih.gov/Summary.asp?File=19570&bhcp=1 and https://videocast.nih.gov/Summary.asp?File=19573&bhcp=1.

JOURNAL DIGEST

BY NICK ZAGORSKI

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Combination Pharmacotherapy For Psychotic Depression Improves Medication Adherence

Patients with psychotic depression who take a combination of antidepressants and second-generation antipsychotics may be more likely to continue taking their medications compared with those on antidepressant monotherapy, according to an analysis published in the *Journal of Managed Care & Specialty Pharmacy*.

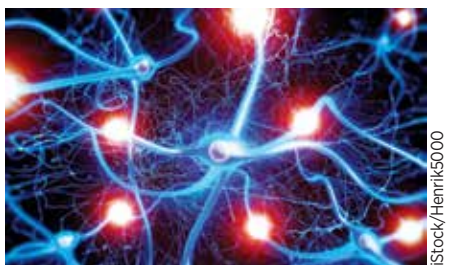
Researchers at the University of Texas at Austin assessed medication adherence and persistence (the number of days before treatment discontinuation) among two groups of Texas Medicaid patients who were diagnosed with severe major depressive disorder with psychotic features. The analysis included 510 patients using antidepressant monotherapy and 416 patients using the combined antidepressant-antipsychotic therapy.

They next measured adherence using two measures: the proportion of days over 12 months in which the patient was "covered" by prescription claims for their medications (proportion of days covered, or PDC) and the number of days that medication was supplied to the patient over the year (medication possession ratio, or MPR). For both measures a ratio of 80 percent or better was considered adherent, and in both cases the authors found that adherence was higher among patients taking both antidepressant and antipsychotic medication compared with antidepressant medication alone (38.7 percent versus 28.4 percent, respectively for PDC and 43.5 percent versus 34.1 percent for MPR).

Antidepressant persistence was also longer for dual-therapy patients, with an average of 172 days before discontinuation compared with 130 days for antidepressant monotherapy.

The authors noted these findings provide evidence that supports current recommendations for treating psychotic depression, though they acknowledged that the results reflect only prescription claims and not usage and that the Medicaid-based sample may not be generalizable to the broader population.

Medication Adherence and Persistence in Patients With Severe Major Depressive Disorder With Psychotic Features: Antidepressant and Second-Generation Antipsychotic Therapy Versus Antidepressant Monotherapy. Kim-Romo D, Rascati K, Richards K, et al. *J Manag Care Spec Pharm.* May 2016; 22(5):588-96. http://www.jmcp.org/doi/abs/10.18553/jmcp.2016.22.5.588



iStock/Henrik5000

GABA-A Receptor May Initiate Synaptic Pruning

Synaptic pruning—a process during which unnecessary connections between neurons are removed—is believed to be important for optimal learning. However, the process that triggers synaptic pruning is not known.

Now, a study published in *eLife* has identified the α4βδ GABA-A receptor as the potential initiator of the synaptic pruning process.

Researchers from SUNY Downstate Medical Center and Tianjin Medical University in China found that mice lacking this receptor did not show a decrease in the density of their synaptic connections in the hippocampus following the onset of puberty, while synapses in normal mice decreased by 50 percent over the same period.

The researchers also found that the synaptic loss was accompanied by decreased expression of kalirin-7, a protein that controls the remodeling of the cellular scaffolding; this suggests a physical mechanism by which the connections can be pulled back.

When the mice with deletions of α4βδ GABA-A receptor performed some learning tasks, the authors found that while they could initially learn a spatial location (e.g., learn to avoid an area associated with a mild foot shock) at the same rate as normal mice, they were far less adept at re-learning that location if some changes were made.

"These findings may suggest new treatments for 'normalizing' synaptic pruning in conditions where this process occurs abnormally, such as autism and schizophrenia," the study authors wrote. "Future studies will test how these additional factors alter synaptic pruning in adolescence and will test drugs that target these inhibitory receptors to manipulate adolescent pruning."

Afroz S, Parato J, Shen H, Smith S. Synaptic Pruning in the Female Hippocampus Is Triggered at Puberty by Extrasynaptic GABAA Receptors on Dendritic Spines. *Elife.* May 2, 2016 [Epub ahead of print] https://elifesciences.org/content/5/e15106

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Long-Term Use of Lurasidone Benefits Patients With Schizophernia

Long-term treatment with the antipsychotic lurasidone is associated with sustained symptom improvements in patients with schizophrenia with minimal effects on weight, glucose, and lipid profiles, according to a study published in *CNS Spectrums*.

A total of 251 people with schizophrenia who had participated in a six-week placebo-controlled trial continued in a 22-month open-label study, during which they received one flexible dose of lurasidone (40 mg to 120 mg) daily.

Of the 251 patients who entered the open-label trial, 26.7 percent completed all 22 months of this trial, and those who completed the full extension had an average reduction in their Positive and Negative Syndrome Scale (PANSS) total score of 27 points (from 96.5 to 69.5). The patients also had a 9 mg/dl reduction in total cholesterol, only a 0.1 percent increase in their glucose levels (measured by HbA1c), and they gained only an average of 0.8 kg.

About 15 percent of the patients discontinued the open-label trial specifically due to an adverse event; relapse of schizophrenia symptoms (12.4 percent), akathisia (10.8 percent), and somnolence (10.8 percent) were the most commonly reported adverse events.

Correll C, Cucchiaro J, Silva R, et al. Long-Term Safety and Effectiveness of Lurasidone in Schizophrenia: A 22-month, Open-Label Extension Study. *CNS Spectr.* Apr 6, 2016. [Epub ahead of print] http://journals.cambridge.org/action/displayAbstract?fromPage=online&aid=10256817&fulltextType=RA&fileId=S1092852915000917

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Raising Body Temperature May Decrease Symptoms of Alzheimer's

The reduction in core body temperature associated with aging may exacerbate some of the manifestations of Alzheimer's disease, according to an animal study reported in *Neurobiology of Aging*.

Researchers at Université Laval in Quebec compared the body temperature of 3x-Tg mice—mice genetically modified to express symptoms of Alzheimer's—with age-matched controls. By the time the mice reached 12 months, the body temperature of the 3x-Tg mice was 1 degree Celsius lower than the age-matched controls.

If these mice were exposed to a prolonged cold environment (24 hours at 4 degrees Celsius), it aggravated key pathological markers of the disease such as overphosphorylated tau proteins and higher levels of soluble amyloid beta fragment. Conversely, if the mice were exposed to a warmer environment (28 degrees Celsius) for several days, these pathological markers decreased and the memory function of the animals improved.

"Our findings suggest that it is worth exploring the treatment of thermoregulation among seniors suffering from Alzheimer's," author Frédéric Calon, Ph.D., said in a press statement. "If our conclusions are confirmed, it would be a relatively easy therapeutic option to implement because body temperature can be increased through physical activity, diet, drugs, or simply by increasing the ambient temperature." PN

Vandal M, Phillip W, Tournissac M, et al. Impaired Thermoregulation and Beneficial Effects of Thermoneutrality in the 3xTg-AD Model of Alzheimer's Disease. *Neurobiol Aging*. March 29, 2016. [Epub Ahead of print] http://www.neurobiologyofaging.org/article/S0197-4580(16)30008-2/abstract

Integrated Care

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Greater empathy for mental health can shape the attitude of primary care physicians as well as their practice. By starting mental health treatment in primary care, physicians send a strong message to their patients that mental health is part of overall health and that they are in the right place to get help.

As medical students move through training and become the next generation of physicians, we should aim to reduce stigma toward mental illness, amplify empathy and understanding, and ultimately provide better care for persons with mental illness. PN

LETTERS TO THE EDITOR

Another Origin of Violence

I'm writing in response to an article in the April 1 issue of *Psychiatric News* regarding the "origins of violent behavior" and featuring James Merikangas, M.D., who has served as a consulting neuropsychiatrist in more than 100 death penalty cases.

There was an extensive review of factors that Dr. Merikangas considers in forming his opinions—factors with which we are familiar or that make sense to us intuitively. There are thorough medical, neurological, and psychiatric evaluations; there is a remarkable array of lab tests, scans, and other procedures.

Years ago at an APA Annual Meeting, I attended a workshop on the predictors of violence. The main presenter was Renée Binder, M.D., now APA's outgoing president.

To me, such sessions are a good investment of time if you take home one important point, one "pearl" that stays with you. That certainly happened in this instance. Dr. Binder went through the predictors that we know or would guess—history of violence, presence of psychosis, and so on—and along the way discussed one that had not occurred to me: perceiving oneself as a victim. Not only did I take that home with me, but it's like a song I can't get out of my head. I hear it playing everywhere there is violence.

Consider the spectacular, American-style killings that happen so often. (Remember that a man may lose his job or his wife or flunk out of school for good reason, but that's not the point. It's how he *perceives* it that matters here.) Consider everything from road rage and barroom brawls to terrorism and war. Consider gangs.

I wrote on this subject for *California Psychiatrist,* and before submitting it for publication, I asked Dr. Binder for references or anything she might add. She was very helpful and generous with her time. She said that her awareness of this point came not from a particular study or studies, but from her cumulative experience as a forensic psychiatrist.

I realize that a "predictor" is not the same as an "origin," the latter referring to a contributing cause, while the former may be just a correlate. Things like scars, chronic subdurals, and jail terms may be more a result of a violent tendency than its cause. It is important to make this distinction. Nonetheless, as I see it, a perception of victimhood is a contributing cause of violence, and thus should be listed with "origins." PN

WALTER T. HAESSLER, M.D.
Temecula, Calif.

Psychotherapy

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neutral stance is not the same as indifference or blankness. It should also be understood that absolute neutrality is impossible, and the concept should guide, rather than shackle, the therapist.

A therapist can, and should, be highly concerned about his/her patient's well-being and can be intensely involved in the therapy and still have a neutral stance. Further, it is important to appreciate that when taking on a new patient, the therapist is not neutral: the therapist sets up treatment conditions that support the patient's increasing freedom from symptoms along with his increasing autonomy and satisfaction in life. Few therapists would agree to join a patient whose stated goal was to get past his/her ambivalence about killing him/herself so as to be free to die by suicide. Neutrality comes into play only after the treatment frame (method of treatment and goals) has been set in place.

From the point of view of psychotherapy based on modern object relations theory, neutrality means that the therapist maintains an observing stance, while avoiding siding with any of the forces involved in the patient's conflicts: urges to act, internal prohibitions against acting, and the constraints of reality. The reason for neutrality is that if the therapist maintains an observing stance in relation to these conflicting forces, the patient will be more likely to join the therapist in observing, reflecting upon, and eventually solving his or her problems. Addressing the patient's conflicts in this way will not only help the patient deal with the specific conflict at hand, but will also help him/her achieve more autonomy moving forward in dealing with internal conflicts and life challenges. The simplest example is asking the therapist for advice about doing something. Rather than offer an opinion, the neutral therapist helps the patient explore the motives that would lead the patient to act and those that would stop the patient from acting. This exploration may uncover motives that were hidden from the patient's awareness.

Neutrality may go beyond this basic level to elucidate information about the patient's view of self in relation to others. An object relations perspective emphasizes how specific internal relationship paradigms determine the patient's experience of self and others. These internal images strongly influence the patient's behavior and can also influence the behavior of the other in interaction with the patient.

In the case of NPD, being arrogant and devaluing can provoke oth-

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Poll

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Americans want to see improved mental health care and access."

"The fact that a vast majority of Americans, 80 percent, agree that someone's mental health has an impact on their physical health just shows the need for us to improve the nation's mental health system," said APA CEO and Medical Director Saul Levin, M.D., M.P.A. "It also illustrates the importance of collaborative care between psychiatry and other medical specialties. APA will continue its hard work to make both goals, mental health reform and collaborative care, a reality."

The poll also found that public perceptions of mental health are improving but still have a way to go. About 45 percent of respondents agree that there is less stigma against mental illness than there was a decade ago; however, 31 percent say they would not vote for a political candidate who was diagnosed with a mental illness, even if the candidate had been treated for it.

Other key findings of the poll:

- Only 15 percent of respondents agree that the mental health needs of military veterans are being met in the current mental health system.
- 80 percent of respondents agree that a person's mental health has an impact on his or her physical health.
- Nearly 20 percent of respondents have personally sought care from a mental health professional, and 29 percent know a family member who has.
- Nearly 50 percent of respondents say they either do not know or are not sure how to access mental health care for themselves or a loved one.

"It is encouraging to see the progress in reduced stigma of mental illness over time, but the poll clearly shows that we have a long way to go before the majority of Americans view mental illness the same as physical illness," Binder said. "Mental illness is no different than physical illness. There is help available, and treatment works." PN

Alcohol

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clinical neuropsychiatry and behavioral science at University of South Carolina School of Medicine. Yet, high alcohol consumption by older adults can have a more negative impact in this population, Payne said. (The National Institute on Alcohol Abuse and Alcoholism considers seven drinks to be the maximum amount for people aged 65 and older in a given week. Drinking beyond this amount puts this population at risk of serious alcohol problems.)

"Older adults are more likely to have medical comorbidities and take medications for those comorbidities," Payne told *Psychiatric News*. Combining alcohol with such medications can lead to adverse effects, including an increased risk for falls and potential worsening of any present cognitive impairment.

The first step to treating alcohol use disorder or heavy drinking in older adults is to use screening tools, such as the Michigan Alcohol Screening Test-Geriatric Version (MAST-G) and its shorter version (SMAST-G). Other screening tools are the Alcohol Use Disorders Identification Test and the CAGE Questionnaire.

"Because patient visits are short in duration in some clinical settings, asking [patients] about drinking can fall by the wayside," Srinivasan said. "These scales can be easily and quickly used in busy clinical practices to identify people who are drinking excessively."

If older patients are found to consume alcohol at unhealthy or risky levels, Srinivasan advises clinicians to be prepared to have a conversation with the patient about the consequences of drinking and possible treatment options, which may include psychotherapy, pharmacotherapy, or a combination of both.

There are currently three medications approved by the Food and Drug Administration for alcohol use disorder: naltrexone, acamprosate, and disulfiram. While none of these medications is known to have contraindications that are specific for older adults, she did note disulfiram use does carry an increased risk of tachycardia.

Both Payne and Srinivasan cautioned physicians to be mindful of possible interactions of any of the three pharmacotherapies intended for alcohol use disorder with other medications used to treat comorbid conditions. PN

"Alcohol Use Disorders in Older Adults," the American Geriatric Society's practice guideline for screening older patients for alcohol use disorders, is posted at http://www.annalsoflongtermcare.com/article/5143.

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ers to be defensive and even devaluing in response. This reaction of the other becomes part of a vicious cycle that can support the patient's unfortunate worldview that everyone is striving to impose his/her superiority on the other. Such a worldview precludes any possibility for mutuality or intimacy in relationships.

Therapists may have an initial internal reaction to the NPD patient that is similar to that of others in the patient's life: to feel angry at being devalued, and either to have the urge to strike back or to masochistically submit, accepting the patient's devaluation. In these instances, the therapist's emotional reaction to the patient is countertransference—reactions that can inform the therapist about the make-up of the patient's internal world.

Neutrality and countertransference are intimately related: the therapist dedicated to maintaining a neutral position is more likely to observe his/her countertransference rather than to act on it, while the therapist who acts on his/her emotional reaction is deviating from a neutral position. In some instances, remaining neutral consists of not "taking the bait" to react, instead reflecting on the urge to react and using it to better understand the patient.

In the case of the patient with NPD, the therapist's neutrality is an implicit challenge to the patient's view that all relations are based on a superior/inferior paradigm—an invitation to reflect on it. By remaining neutral, the therapist avoids both the risk of mirroring the patient's grandiosity and the alternative risk of submitting to the patient in a way that would help him/her maintain the grandiosity.

Remaining neutral in the heat of the intense emotional reactions that emerge in therapy is not easy, but it should be a skill we all strive to master. The therapist may be the only person in the patient's life who manages to maintain this stance. In so doing, the therapist, with honest curiosity, invites the patient to participate in a shared goal: understanding what is going on internally and in interactions with others. This could be the first step in helping the patient move away from an internal world where defensive self-aggrandizement trumps any movement toward mutuality and intimacy. PN

Army STARRS

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The authors also reported significant pleiotropy was observed for PTSD and rheumatoid arthritis and psoriasis in the European American samples.

"Intriguingly, all of these immune-related disorders have been associated, to different extents, with environmental and psychological stress exposure," commented Ressler.

"This set of findings adds to the literature the idea that although a number of different genetic and trauma-related mechanisms intersect to create increased risk for PTSD, some of these mechanisms may directly involve inflammatory responses," Ressler continued. "In fact, inflammation as a mediator—or a result—of dysregulated stress responses, in part via dysregulated hypothalamic-pituitary-adrenal regulation, is increasingly being appreciated as an important component of a variety of stress-related syndromes, including depression and PTSD."

Stein and colleagues noted that while the association of *ANKRD55* with PTSD in African American participants was "small in magnitude," the findings may help to elucidate "the nature of PTSD and its association with other illnesses."

The authors concluded, "The finding of pleiotropy between PTSD and rheumatoid arthritis and psoriasis should further motivate the study of immune-related factors in PTSD, their potential contribution to comorbidity with inflammatory disorders, and a possible role for anti-inflammatory treatments in PTSD."

The findings appeared online May 11 in *JAMA Psychiatry*. The study was sponsored by the Department of the Army and supported by the Department of Health and Human Services, National Institutes of Health, and National Institute of Mental Health. PN

"Genomewide Association Studies of Posttraumatic Stress Disorder in 2 Cohorts of US Army Soldiers" is posted at http://archpsyc.jamanetwork.com/article.aspx?articleid=2521460. The related editorial, "The Intersection of Environment and the Genome in Posttraumatic Stress Disorder," is posted at http://archpsyc.jamanetwork.com/article.aspx?articleid=2521459.

Gaza

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toms of posttraumatic stress in about 30 percent of exposed children, he said. Those symptoms included bedwetting, night terrors, sudden drops in school achievement, and general misbehavior.

Today the organization employs 70 professionals of all kinds. It draws on graduates of programs in medicine, psychology, and nursing and provides them with a two-year training program in community mental health. The first year includes didactic modules in psychiatry, clinical psychology, child development, social psychology, counseling, and psychotherapy. The second year is devoted to clinical training in community settings, both in clinics and in schools, primary care clinics, and hospitals.

Many challenges remain, said Abu Jamei. The GCMHP receives no government funds, said Abu Jamei. It depends on a consortium of donors, including the Swedish and Swiss development agencies and the Norwegian representative to the Palestinian Authority.

Medications are available but expensive. Ordinarily, the GCMHP buys about $90,000 worth of drugs a year to give to patients who cannot afford them, although that figure has risen to $125,000 since the 2014 fighting because of the increased patient load.

Maintaining clinical skills is not easy, given the difficulties of travel in and out of Gaza. "Professionals feel abandoned by the international community after the fighting stops," Abu Jamei. "We need to connect with others in our field to gain more skills and experience. It is good to bring in people from abroad, but it would be better to send our people out for long-term internships. I would like the opportunity to have a Gaza psychiatrist come to the U.S. for trauma training."

Staff members receive short training courses from foreign (mainly European) experts who visit once or twice a year for a week at a time, said Abu Jamei.

Last year, a Swedish team that included a child psychiatrist and a pediatric neurologist trained staff and parents on aspects of autism. A German group offered a one-week course on psychodrama, and German and Swiss teams are in the midst of a three-year program providing supervision for a "care-for-caregivers" program.

Ultimately, it will be the GCMHP's patients—especially the youngest—who will benefit from reconstruction and renewed contact with the rest of the world, he said. "Children in Gaza, like all children, have a right to good health, hygiene, food, and education, but also to play." PN

The website of the Gaza Community Mental Health Programme is http://www.gcmhp.com/en/Default.aspx.

Global

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grad went on to outline several actions to help advance the global mental health infrastructure, including more recognition of the burden of mental health disorders in terms of medical care cost, disability, lost life, and lost productivity, as well as an international campaign to destigmatize mental disorders that may lead to more people seeking mental health services.

"It will require a collaborative effort from major international organizations, governments, and foundations to enhance the infrastructure for mental health care throughout the world," Summergrad told *Psychiatric News.*

The study was funded by Grand Challenges Canada. PN

An abstract of "Scaling-Up Treatment of Depression and Anxiety: A Global Return on Investment Analysis" is posted at http://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(16)30024-4/fulltext. The accompanying editorial by Paul Summergrad, M.D., "Investing in Global Mental Health: The Time for Action Is Now," is posted at http://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(16)30031-1/fulltext.