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PSYCHIATRIC NEWS

AMERICAN PSYCHIATRIC ASSOCIATION

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Nickolay Khoroshkov/Shutterstock

After an 11-year hiatus, Atlanta is once again hosting APA's Annual Meeting. This year's meeting will be held May 14 to 18 at the Georgia World Congress Center. Save on fees by registering for the meeting now at the reduced advance-registration rates and reserving your hotel room through APA. Don't miss out on the excitement of exploring the cosmopolitan hub of the Southeast. See pages 6 and 7.

Overcoming Opioid Abuse in Rural U.S. Requires Varied Approach

Agriculture Secretary Tom Vilsack is tapped to lead a new interagency effort to address the misuse of prescription opioids and heroin in rural America.

BY AARON LEVIN

Opioid abuse is growing in urban and rural communities across the United States.

According to a report released in February by the Maine Rural Health Research Center that analyzed data from the National Survey of Drug Use and Health, 4.8 percent of urban U.S. residents over the age of 12 used opioids nonmedically in the past year, slightly more than the 4.4 percent in rural areas. However, as noted in the report, rural opioid users may face several challenges that make it difficult for them to access care.

For instance, the survey found that rates of past-year opioid use among rural youth were twice as high as the overall prevalence. About 8 percent of rural youth aged 12 to 19 and 9.5 percent of those aged 20 to 29 had used opioids in the previous year.

Other rural subpopulations with higher past-year use rates included those who were "unmarried, with low educational attainment, no insurance coverage, and low income," Jennifer Lenardson, M.H.S., and colleagues wrote. "These characteristics could make it more difficult for a rural patient to seek and complete substance abuse

see **Opioid Abuse** on page 25

Experts Discuss Efforts Required to Reduce Gun Violence

Working collaboratively to mitigate the known risk factors for firearms violence can lessen rates of injury and death, professionals say.

BY AARON LEVIN

Firearm injuries and deaths cost the United States $229 billion per year in medical treatment, legal fees, emergency services, security, law enforcement, mental health services, and lost income, said Georges Benjamin, M.D., executive director of the American Public Health Association.

As he spoke in February at the Washington Psychiatric Society's Presidential Symposium on Violence Risk Reduction at St. Elizabeths Hospital, there had already been 22 mass shootings (defined as four or more dead) in the country that month—and that was with three days still left to go.

"We have more guns than people in the U.S. (357 million guns versus 317 million people), but the percentage of households with guns has dropped from about 50 percent in 1975 to 32 percent in 2014," he said. "The protective value of a gun in the house is overestimated. Without minimizing criminal activity, homicide is usually committed using a handgun, by someone who knows the victim, by someone of the same race, during an argument or fight, aided by the use of drugs or alcohol."

Benjamin suggested three ways to reduce gun violence: make guns safer with technological checks on misuse; make people safer with their guns by improving gun safety practices; and creating a safer environment with guns. The latter includes universal background checks, permitting product safety oversight (now banned by law), and counseling for victims to break cycles of violence. He also called for restarting federal research on firearms injuries and violence, which has been effectively blocked by Congressional mandate.

Physicians could play a more active role in reducing gun violence by dis-

see **Gun Violence** on page 26

PERIODICALS: TIME SENSITIVE MATERIALS

INSIDE

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AMERICAN PSYCHIATRIC ASSOCIATION

FROM THE PRESIDENT

'Typical or Troubled': Early Intervention Program With Proven Effectiveness

BY RENÉE BINDER

Many of our members may not appreciate the role of the APA Foundation. It is APA's fundraising arm that is responsible for developing programs to promote mental health and provide public education.

I must admit that until I sat on the Foundation Board last year as president-elect, I never understood all of the fantastic programs that are accomplished through the APA Foundation. For example, there are programs related to workplace mental health, partnerships with the judicial system, and partnerships with faith-based organizations. In this column, I am highlighting just one of the programs, the "Typical or Troubled?" early intervention program. The importance of this program was illustrated to me during a recent session with one of my patients.

My patient was very upset about the suicide of a neighbor's 16-year-old son. She told me that she had recently been to the neighbor's house and noticed that the son was watching video games all the time. The neighbor told her that the son was starting to worry about getting into a good college and also had recently stopped being friends with some "popular kids" who the son said were starting to use drugs and alcohol. The neighbor also described her son's behavior as "typical" of adolescent struggles, and my patient and the neighbor jokingly reminisced about their own struggles when they were adolescents.

During her psychotherapy session, my patient agonized about how she and her neighbor may have missed obvious signs of the boy's distress. Her reaction was similar to how many people react whenever adolescents unexpectedly die as a result of suicide. We wonder whether the suicide could have been prevented. Were there signs of depression, substance abuse, or psychosis that were missed? Would early intervention have prevented the progression of more severe problems?

To prevent the type of tragedy that occurred with my patient's neighbor, the APA Foundation has developed the "Typical or Troubled?" program that helps train teachers, other school personnel, and parents to recognize the early signs of mental illness in middle-school and high-school students, while simultaneously breaking down stigma through the promotion of awareness, outreach, and education. In addition to identifying the warning signs of mental illness, "Typical or Troubled?" trains participants on how to have that crucial initial conversation about referring a patient to care. The program focuses on teachers, other school personnel, and parents because they are often the first individuals to notice problems.

Training people to recognize the signs and behaviors of possible mental illness is important because it will lead to referrals for treatment. The U.S. Department of Health and Human Services reports that approximately 20 percent of youth aged 9 to 17 have a diagnosable mental disorder. The most common disorders are anxiety, depression, posttraumatic stress disorder, substance abuse, and attention/conduct disorder. In addition, psychotic illness and bipolar disorder often begin to manifest in adolescence or earlier. According to a report by the American Academy of Child and Adolescent Psychiatry, symptoms of 50 percent of all diagnosable mental illnesses manifest by age 14, and 75 percent by age 24. In the juvenile justice system, 70.4 percent of youth have been diagnosed with at least one mental disorder.

There is good scientific evidence that

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IN THIS ISSUE

Register Now for 2016 Annual Meeting!

Don't miss the premier psychiatric event of the year—APA's 2016 Annual Meeting, which will be held May 14 to 18 in Atlanta. Register now to take advantage of advance registration fees and reserve your hotel room at preferred rates. To access the Annual Meeting website, go to http://www.psychiatry.org/annualmeeting. More information is available by calling the APA Meetings and Conventions Department at (703) 907-7822 or by emailing registration@psych.org.

Departments

PROFESSIONAL NEWS

APA Responds to Indonesian Psychiatrists For Stance Against LGBT Individuals

APA sends a strong response to the Indonesian Psychiatric Association for asserting that LGBT individuals are mentally ill and in need of treatment.

BY MARK MORAN

Recent statements by the Indonesian Psychiatric Association (IPA) in which the organization appears to classify gay, lesbian, bisexual, and transgender (LGBT) people as mentally ill, are counter to scientific understanding and could encourage violence and discrimination against LGBT individuals.

That's what APA CEO and Medical Director Saul Levin, M.D., M.P.A., and APA President Renée Binder, M.D., told the IPA in a letter outlining the most recent scientific findings regarding the development of sexuality and gender. The March 8 letter, addressed to Tun Kurniasih Bastaman, M.D., the president of the IPA, was in response to statements by the IPA appearing in Indonesian and Western news reports.

"With all due respect to you and to the Indonesian people, we advise that classifying homosexuality and gender expression as intrinsically disordered will only lead to coercive 'treatments' and violence against those who pose no harm to society and cannot change who they are," Levin and Binder said.

"[T]he latest and best scientific research shows that different sexual orientations and gender expressions occur naturally and have not been shown to pose harm to societies in which they are accepted as a normal variant of human sexuality," they wrote. "In fact, research shows that efforts to change an individual's orientation—so-called 'conversion therapy' or 'reparative therapy'—can be harmful and are linked to depression, suicidality, anxiety, social isolation, and decreased capacity for intimacy. For these reasons, APA's *Diagnostic and Statistical Manual of Mental Disorders (DSM)* does not classify people who are lesbian, gay, bisexual, or transgender as intrinsically disordered.

"We respectfully submit that the individuals within IPA who ushered through these changes in classification may have misunderstood the significance of recent scientific findings, which show that multiple factors, including both biological and environmental contributors, play roles in sexual orientation and gender identity. In short, one's orientation is not a choice."

A February 24 article in the *Jakarta Post* reported that "the leading Indonesian psychiatric body has classified homosexuality, bisexuality, and transgenderism as mental disorders, which it says can be cured through proper treatment."

The article cited IPA member Suzy Yusna Dewi, M.D., as saying, "We really do care about [LGBT individuals]. What we are worried about is, if left untreated, such sexual tendencies could become a commonly accepted condition in society."

Western news outlets have also reported the IPA assertions. A February 22 article in the *London Guardian* reported that "the Indonesian Psychiatric Association said transgender people 'can be categorised as persons with mental disorders,' which it said 'may cause suffering and obstacles in functioning as a human being.' "

The Guardian also reported that the IPA said homosexuals and bisexuals were in danger of developing a psychiatric disorder unless they "maintain their mental health by guarding their behaviour, habit, healthy lifestyle, and increasing their ability to adapt to their social environment."

The IPA's statements come amid reports of increasing violence against LGBT individuals in Indonesia and elsewhere in the Islamic world.

In their letter, Levin and Binder emphasized the science behind sexuality and gender, citing five peer-reviewed reports that underscore the involvement of genetics and/or intrauterine hormonal influences in their development.

For instance, Levin and Binder cited a 2007 Finnish study in the *Archives of Sexual Behavior* involving 3,261 Finnish twins aged 34 to 43 years. "Quantitative genetic analyses showed that variation in both childhood gender atypical behavior and adult sexual orientation was partly due to genetics, with the rest

see **IPA** on page 13

AARP Report Draws Attention To Alarming Rise in Drug Prices

Retail drug prices rose faster than inflation every year between 2006 and 2013, according to a report by AARP.

BY MARK MORAN

Retail prices for brand name, generic, and specialty prescription drugs widely used by Medicare beneficiaries increased by an average of 9.4 percent in 2013, according to an "Rx Price Watch" report published by the AARP.

In contrast, the general inflation rate was 1.5 percent that year. The average annual increase in retail prices for the combined set of drug products examined in the AARP report exceeded the corresponding rate of general inflation every year from 2006 through 2013 (see graph).

According to the report, the average annual retail cost of drug therapy for prescription drugs on the market since the end of 2005 and used to treat chronic conditions was $11,870. (That reflects the total price for a specific prescription that a pharmacy benefit manager bills to a health plan, not the out-of-pocket cost that a consumer would pay.) This amount represents an increase of $7,534 over the 2006 annual cost of $4,336.

The report "Trends in Retail Prices of Prescription Drugs Widely Used by Older Americans: 2006 to 2013," released in February, does not specifically reference drugs for psychiatric conditions. But a November 2015 report, "Trends in Retail Prices of Specialty Prescription Drugs Widely Used by Older Americans, 2006 to 2013," showed that retail prices for all but four categories of specialty prescription drugs rose faster than the rate of inflation in 2013. Among those, antidementia drugs rose by 39.5 percent; antipsychotic prices rose by 3.7 percent.

APA President Renée Binder, M.D., said the data in the AARP report are alarming. "Many of our patients with psychiatric illness have multiple comorbid medical conditions requiring the use of more than one prescription drug and may be especially affected by the rise in prices. APA is working with the AMA and other interested parties to help craft workable solutions to keep prescription medications affordable."

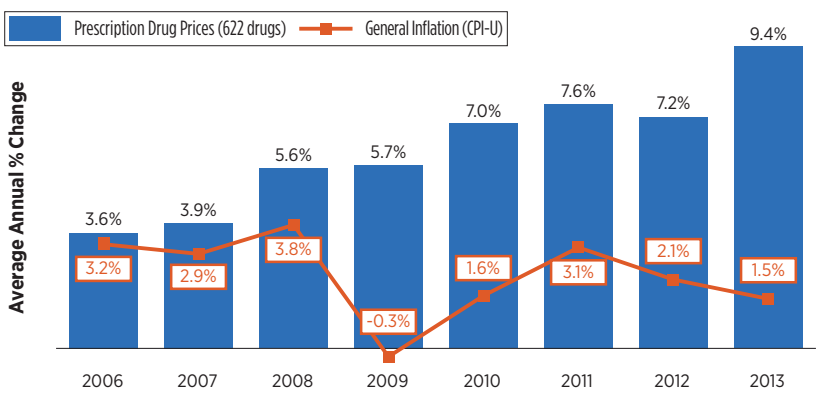
AARP President John Rother said the findings are attributable entirely to drug-price growth among brand name and specialty drugs, which more than offset often substantial price decreases among generic drugs. More importantly, the recent acceleration in overall prescription drug price growth could be an indication that lower-priced generics can no longer be relied upon to counterbalance the price trends seen in the brand name and specialty prescription drug markets.

"The AARP report provides new evidence that drug companies are raising prescription drug prices on patients indiscriminately," Rother said in a statement. "[The prices of] specialty and branded drugs alike are going up six times faster than inflation. The exorbitant increases make health care more expensive for families, taxpayers, and job creators and put a major strain on federal and state governments. It's going to take market-based policy solutions to deal with this unsustainable trend."

see **Drug Prices** on page 23

Average Annual Prescription Drug Prices Rising Steadily

Average prices for 622 prescription drugs widely used by Medicare beneficiaries have consistently risen faster than the rate of general inflation. In 2013, the increase in drug prices jumped 9.4 percent while the general inflation rate was 1.5 percent.



Source: AARP "Rx Price Watch Report," February 2016

PROFESSIONAL NEWS

Prenatal Alcohol Exposure May Be Driving Some Violent Behavior

Neurodevelopmental disorders associated with prenatal alcohol exposure may lead to poor judgment and affect regulation, and in some cases violence, according to Carl Bell, M.D.

BY AARON LEVIN

The mass shootings that leap to public attention mask a larger, ongoing epidemic of day-to-day killings and gun violence, Carl Bell, M.D., a staff psychiatrist at Jackson Park Hospital in Chicago, told an audience gathered for the Washington Psychiatric Society's Presidential Symposium on Violence Risk Reduction at St. Elizabeths Hospital in February.

"The existing evidence regarding the incidence of urban gun homicide flies in the face of conventional media analysis and public beliefs, which tend to focus attention on the sensational," Bell said. "The causes of urban youth gun violence are multidetermined and extraordinarily complex, so a multipronged strategy is likely to get the best results."

One focus of that strategy, Bell proposes, should be on decreasing the effects of fetal alcohol exposure—a factor he believes may be contributing to the violence on America's streets.

"Recent data indicate that a large proportion of urban children of color in special education, juvenile justice, foster care, and mental health clinics have histories of neurodevelopmental disorders—most likely due to fetal alcohol exposure," he said. These children have poor judgment and affect regulation and are easily frustrated, and at least some become violent.

The effects of alcohol on the etiology of violent behavior have likely been underestimated, asserted Bell. Up to half of the women who receive services at the hospital where Bell works don't know when they are in the earliest stages of pregnancy and continue using alcohol, he said.

"If you ask them, they'll say they stopped drinking when they became pregnant, but what they mean is they stopped when they knew they were pregnant."

Bell has conducted several studies whose results suggest that roughly one-third of patients in Chicago's poor communities may have a neurodevelopmental disorder associated with prenatal alcohol exposure. "Fetal alcohol exposure is a hidden epidemic in poor African-American communities ... ," he wrote in the May 2014 issue of *Psychiatric Services*.

Milbert O. Brown

"Fetal alcohol exposure is a hidden epidemic in poor African-American communities," comments Chicago psychiatrist Carl Bell, M.D. An easily available supplement has shown evidence of ameliorating symptoms, he said.

Managing fetal alcohol exposure and its consequences is not hopeless, said Bell. Recent research has pointed to the value of phosphatidylcholine supplementation both for pregnant women and their children. A recent study in the *American Journal of Psychiatry* reported that high-dose oral phosphatidylcholine taken during pregnancy resulted in fewer attention problems and less social withdrawal in offspring.

Researchers suspect the α7-nicotinic acetylcholine receptor gene CHRNA7, which "has been associated with schizophrenia, autism, and attention-deficit/hyperactivity disorder," may play a role in this response, wrote Randal Ross, M.D., a professor of psychiatry and pediatrics at the University of Colorado School of Medicine, Aurora, and colleagues in the article posted online December 7, 2015. "Maternal phosphatidylcholine treatment may, by increasing activation of the α7-nicotinic acetylcholine receptor, alter the development of behavior problems in early childhood that can presage later mental illness," the authors wrote.

"Choline supplementation can alter brain development following a developmental insult, and similar postnatal interventions may reduce the severity of some fetal alcohol effects," said Bell.

Other researchers have found that treating children aged 2.5 to 5 years with a nine-month course of choline improved scores on memory tests.

Behavioral interventions have also proved useful, he said. Developing a community's social fabric, encouraging adults to mentor youth, and offering programs to build social and emotional skills have proven to decrease risk-taking behaviors and youth gun violence.

Too often, attempts to solve the problem have focused solely on risk factors and how to ameliorate them, said Bell.

"But we must be smart enough to wrap at-risk youth in protective factors," he said. "Public health interventions that focus on the protective factors that prevent the risk factors from becoming predictive factors are the recommended approaches." PN

"Perinatal Phosphatidylcholine Supplementation and Early Childhood Behavior Problems: Evidence for CHRNA7 Moderation" is posted at http://ajp.psychiatryonline.org/doi/full/10.1176/appi.ajp.2015.15091188. "Fetal Alcohol Exposure Among African Americans" is posted at http://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201300409.

Origins of Violent Behavior Continue To Be Challenging to Pin Down

The possible neuropsychiatric influences on violent behavior must be carefully teased out of a patient's history.

BY AARON LEVIN

James Merikangas, M.D., has spent a lot of time in prisons.

Not, of course, as an inmate, but as a consulting neuropsychiatrist in more than 100 death penalty cases during his career, said Merikangas, speaking about what he has learned from his time behind bars at the Washington Psychiatric Society's Presidential Symposium on Violence Risk Reduction at St. Elizabeths Hospital in February.

His experiences have given him some insights into the origins of violent behavior on the part of the accused and convicted criminals he has evaluated or treated.

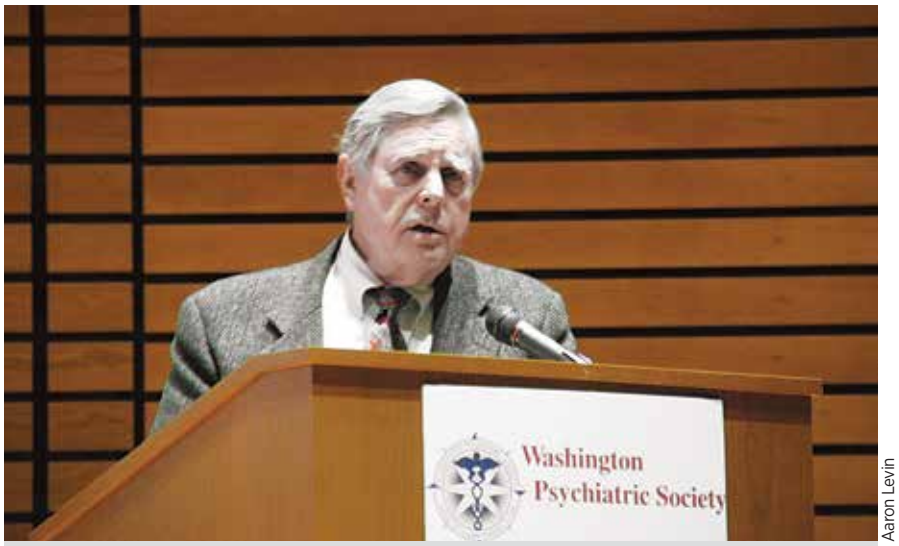
For instance, most of the people he has seen on death row had experienced parental violence as children, said Merikangas, a clinical professor of psychiatry and behavioral science at the George Washington University School of Health Sciences in Washington, D.C.

"The mix of child abuse, brain damage, and mental illness is a lethal combination," he said.

In adulthood, a history of prior violence or aggression, drug abuse, traumatic brain injury, psychopathology, or schizophrenia with comorbid substance use are also risk factors for violence.

Merikangas wants every bit of information he can find on the people he evaluates: personal, family, medical, social, educational, vocational, and military histories, as well as the specific circumstances that led to the crime, when possible. He requires a complete physical examination, including a neurological workup and a psychiatric interview. He orders blood and urine tests and calls for MRI, EEG, and PET scans.

see ***Violent Behavior*** *on page 11*



Aaron Levin

There is plenty of evidence but not enough research on the association between neuropsychiatric disorders and violence, according to James Merikangas, M.D.

ANNUAL MEETING

Kitty Dukakis to Share Experience With ECT Treatment

Kitty Dukakis will discuss her personal experience with electroconvulsive therapy at an Annual Meeting session whose goal is to expand treatment options for veterans.

BY VABREN WATTS

Former Massachusetts First Lady Kitty Dukakis is scheduled to speak at a special session at this year's Annual Meeting on the benefits of electroconsulsive therapy (ECT) and the need to destigmatize this often misunderstood but extremely effective tool in psychiatry's armamentarium.

The goal of the session, titled "Reexamining ECT: From Patient Perspectives on Stigma to Benefit for Veteran Mental Health," is to increase the use of ECT in Veteran Health Administration settings so that veterans with major depressive disorder (MDD) and posttraumatic stress disorder (PTSD) can obtain more rapid relief from symptoms. A 2014 study by the Department of Veterans Affairs observed that veterans with MDD and comorbid PTSD who received an average of 6.5 ECT treatments were almost twice as likely to be alive in the eight years following treatment than their counterparts with the same diagnostic profile who did not receive ECT.

It is also hoped that ECT will become an important component of a suicide prevention strategy among veterans; according to the Department of Veterans Affairs, a veteran dies by suicide once every 65 minutes.

Dukakis stated in her 2006 book, *Shock: The Healing Power of Electroconvulsive Shock Therapy,* that ECT saved her life. Dukakis, wife of former Massachusetts governor and 1988 Democratic presidential nominee Michael Dukakis, wrote that for 17 years she struggled with a disabling depression as well as alcohol use disorder, and prior to that drug addiction. Although she was at an all-time low in 2001, that's when her life took a turn for the better, she said.

"It is June 20, 2001," Dukakis wrote, "Michael's and my 38th wedding anniversary. It also is the end of my fourth month of depression, my crisis period. … I have run out of options, and I don't want to drink. … The alcohol is like an amnesiac, it is able to take me away from the darkness. Last night I was so afraid I was going to drink that I had them check me in here at Massachusetts General Hospital. Today I am going to try the only thing left: electroconvulsive therapy."

Courtesy of Penguin Group (USA)

At an Annual Meeting session on veterans mental health, Kitty Dukakis will speak about the benefits of electroconvulsive therapy, a therapy that she says saved her life and has the potential to do the same for others.

ECT was first introduced into psychiatric practices in 1938 as a treatment for depression, but by the 1960s use of the therapy—highly stigmatized as inhumane, particularly by the media—declined.

Dukakis admitted that she did have reservations for the therapy based on a brother-in-law's experience in 1951 with ECT, which she explained had left him in a "zombielike" state. However, she attributed this particular outcome to the time period in which the treatment was given—the "Dark Ages" of the procedure, she wrote.

Of course, Dukakis's outcome was totally different. "ECT gave me my life back," she wrote. "I feel good, and I feel alive."

Today, an estimated one million people worldwide are treated with ECT every year, 100,000 of whom are treated in the United States. Studies over the past two decades have shown ECT to be twice as effective as pharmacotherapy in treating major depressive disorder, as well as capable of significantly reducing suicidal thoughts in patients with severe depression (*Psychiatric News*, June 19).

The Food and Drug Administration recently proposed a rule to reclassify ECT devices from Class III (high risk) to Class II (low risk). "The change would significantly improve access to an effective and potentially lifesaving treatment," wrote APA CEO and Medical Director Saul Levin, M.D., M.P.A., and APA President Renée Binder, M.D., in a blog in support of the reclassification. The deadline for comments on the proposal was March 28.

Other speakers at the session will include Levin, who will give introductory comments, and Peter Hauser, M.D., a mental health services lead at the VA Long Beach Healthcare System and a clinical professor of psychiatry at the University of California, Irvine, who will chair the session. Richard Wiener, M.D., interim chair of psychiatry at Duke University, will give an overview of ECT and its use in VHA facilities and clinics, and George Petrides, M.D., an associate professor of psychiatry at the Hostra Northwell School of Medicine, will discuss the use of ECT for patients with schizophrenia. Mark George, M.D., a distinguished professor of psychiatry at the Medical University of South Carolina, will talk about another noninvasive method used to stimulate small regions of the brain, transcranial magnetic stimulation. PN

The session will be held Monday, May 16, from 9 a.m. to noon in room B407 at the Georgia World Congress Center.

Finalists for 2016 MindGames Announced: Game On!

Three residency programs—from Columbia University, Yale University, and the University of Texas Health Sciences Center at San Antonio (UTHSCSA)—are the finalist teams in this year's MindGames competition.

They will compete for the top prize at APA's 2016 Annual Meeting in Atlanta on Tuesday, May 17, at 5:15 p.m. in Room B206 at the Georgia World Congress Center

The finalists were announced at the meeting of the American Association of Directors of Psychiatric Residency Training in Austin, Texas, last month. The runner-up teams were from Montefiore Medical Center, East Carolina University, Jackson Memorial Hospital, SUNY Downstate Medical Center, Washington University St. Louis, St. Elizabeths Hospital in Washington, D.C., and the University of Virginia.

Now in its 10th year, MindGames tests the teams' knowledge of medicine in general, psychiatry in particular, and patient-care issues. The competition, hosted by Glen Gabbard, M.D., has become a popular attraction at the meeting.

The three trainees who will be playing for Columbia are Anthony Zhoghbi, M.D., Gabriella Rothberger, M.D., and Neil Gray, M.D.; for Yale: Katernine Blackwell, M.D., Chad Lane, M.D., and Javier Ballester, M.D.; and for UTHSCSA: Ella Cleaves, M.D., Kimberly Benavente, M.D., and Michael Miller, M.D.

MindGames is open to all psychiatry residency programs in the United States and Canada. The preliminary competition for this year's game began in February, when teams of three residents took a 60-minute online test consisting of 150 multiple-choice questions. The questions follow the ABPN Part I content outline, covering both psychiatry and neurology, with a few difficult history-of-psychiatry questions to make it interesting. The winners were the three top-scoring teams with the fastest posted times.

David Hathcox

Photo: The winners of the 2015 MindGames competition at APA's Annual Meeting in Toronto were (from left) Venkata Kolli, M.D., Varun Monga, M.D., and Rohit Madan, M.D., of Creighton University/University of Nebraska.

ANNUAL MEETING

Volkow Speaks on NIDA Efforts to Combat Prescription Opioid Crisis

Similar to the rate of prescriptions made for opioid painkillers, deaths related to prescription opioids have quadrupled from 1999 to 2010, reports the Centers for Disease Control and Prevention.

BY VABREN WATTS

As the misuse of and deaths related to prescription opioid painkillers continue to climb at epidemic levels in this country, the National Institute on Drug Abuse (NIDA) is one of a number of federal health agencies that have implemented efforts to address the public health crisis (see page 1). These efforts, according to NIDA Director Nora Volkow, M.D., include strategies involving the development of alternative pain treatments, increased access to

continued on next page

ANNUAL MEETING

easy-to-use drugs that can reverse the effects of an overdose, and more effective treatment for opioid addiction.

"The epidemic of prescription opioid use is a problem that has continued to grow over the past two decades," Volkow told *Psychiatric News*. "It is a problem that has been created by several factors including the health care system."

From 1999 to 2010, deaths due to prescription opioid drugs quadrupled, paralleling the increase in their legal sales in this same period, according to the Centers for Disease Control and Prevention. The 2014 National Survey on Drug Abuse and Health reported that approximately 1.9 million Americans met the criteria for prescription opioid use disorder based on their use of prescription painkillers within a given year, and 4.3 million people reported using prescription painkillers nonmedically within the same period.

Volkow said that there are two populations of people who are misusing prescription opioids: those who are initiating use of prescription painkillers to get a high because of an underlying addiction to substances and those who are given the medication for pain and subsequently become addicted.

REGISTER NOW FOR MEETING AND SAVE!

See box on page 3 for registration information. Advance registration fees are now in effect.

ANNUAL MEETING

"NIDA is trying to understand what is driving the epidemic and what interventions can keep the epidemic from further spreading. We are also trying to figure out what can be done to prevent people who are addicted to opioid prescription drugs from overdosing and [possibly] transitioning to heroin addiction," said Volkow.

With regard to the strategic area of finding alternative treatments for pain management, Volkow said, "Opioids are being overprescribed because there is really poor education on how to manage pain. There is a very high prevalence of people presenting with severe and chronic pain, yet there are very few alternative effective treatments. When you put these two factors together, you can understand how the health care system—start-

continued on next page

David Hathcox

Nora Volkow, M.D., says NIDA is funding projects aimed at developing nonopioid medications for pain management as well as behavioral and psychotherapeutic approaches for managing pain.

ANNUAL MEETING

ing some 20 years ago—had an overreliance on prescription opioids and assumed that the medications were safe."

To reduce misuse of opioid prescription painkillers, NIDA is funding research focusing on the development of nonopioid medications for pain management as well as behavioral and psychotherapeutic interventions to better manage pain. In addition, said Volkow, the agency is investigating "transformative types of approaches" involving use of transcranial magnetic stimulation and electroconvulsive shock therapy for modifying the function of certain neural networks that regulate pain.

Drug overdose is another target area of NIDA. According to the Drug Enforcement Agency (DEA), drug overdose is the leading cause of injury or death in the United States, surpassing deaths due to motor vehicle accidents and firearms. More than half of the 46,471 drug-related deaths in 2013 were caused by prescription opioid painkillers and heroin, according to the DEA. Volkow said that making naloxone—an overdose-

Caucuses to Meet

MONDAY, MAY 16

12:45 p.m. - 2 p.m.
Caucus on Religion, Spirituality, Psychiatry
Maple Room A, South Tower, Omni Atlanta Hotel At CNN Center

2 p.m. - 5 p.m.
College Mental Health Caucus
Magnolia, M2, North Tower, Omni Atlanta Hotel At CNN Center

ANNUAL MEETING

reversal drug—more accessible to the general public is a top priority at NIDA. The drug, which is an opioid receptor antagonist, was initially administered by injection, but last year the Food and Drug Administration (FDA) approved an intranasal version that allows people with no medical training to administer the drug (*Psychiatric News*, December 18, 2015). NIDA played a critical role in the development of the intranasal spray, working with Adapt Pharma Inc.

NIDA's third target area is identifying approaches and treatments that can lead to better outcomes, said Volkow. For example, better patient outcomes have been observed when treatment for opioid addiction is initiated during an emergency department visit for an opioid-related overdose, compared with being referred to an opioid treatment facility by emergency department staff. NIDA is also funding research to develop a treatment that will require less time in an opioid treatment clinic, such as a long-acting version of methadone that is effective for six months.

Volkow told *Psychiatric News* that NIDA is working on securing funding so that it can make grants to institutions to develop curricula on addiction screening and recognition aimed at clinicians, medical students, and nurses. As of now, she emphasized, basic training in this particular area is lacking. PN

Dates, times, and locations of the NIDA sessions related to the opioid epidemic will be published in the Annual Meeting program, distributed on site at the meeting.

Violent Behavior

continued from page 5

Neuropsychological exams are "extremely valuable," he said.

He looks, too, for neurologic soft signs. A high arched palate is associated with ADHD; an abnormal palmomental reflex with frontal lobe disease; loss of a sense of smell with dementia; and a short philtrum, hypertelorism, and sunken glabella are signs of fetal alcohol syndrome.

A differential diagnosis for violent behavior also includes inquiring about any congenital mental deficiency syndromes; developmental disorders; exposure to infections, toxins, brain trauma, or abuse; or psychiatric diagnoses.

Meningitis, measles, or encephalitis, for instance, may lead to brain damage and lack of judgment or control. Lead or alcohol exposure can be precursors to conduct disorder or ADHD. Conduct disorder as a child is associated with a tenfold increase in the likelihood of violence as an adult, he said.

Depression probably plays an underappreciated role as a source of violence, said Merikangas.

"Depression is a thought disorder, as well as a mood disorder," he said. "It's not just sadness."

Metabolic disorders, like hypoglycemia and thyroid abnormalities, should be checked out as well.

Merikangas emphasized that his observations drew on his own encounters with defendants, prisoners, and ex-cons. The field needed a stronger research underpinning than one person's observations, he said.

At present, research has been slowed by several obstacles: Sampling is biased by the refusal of states to allow full surveys of subjects. Confidentiality and privacy issues hamper full exploration of cases, especially during ongoing legal processes. Even the facts of each crime may be uncertain.

"You can't simply ask prisoners, 'What did you do?,' because the answer may be used against them in court," he said. "Or they might be lying." PN

The Washington, D.C. Psychiatric Society's website is http://www.dcpsych.org/.

ASSOCIATION NEWS

Returned Crew From Captivity Raised Thoughts for Later POWs

50 YEARS

The return of prisoners after the 1968 capture of a U.S. Navy ship sparked thinking about how best to bring home POWs or hostages.

BY AARON LEVIN

Korean Central News Agency/Korea News Service via AP Images

This 1968 photo shows Commanding Officer Lloyd M. Bucher, the captain of the *USS Pueblo*, and his crew while being held captive by North Korea. The *Pueblo* was classified as an environmental research ship, but was actually used for gathering intelligence.

The October 18, 1972, issue of *Psychiatric News* included a story about the return, nearly four years before, of U.S. Navy personnel captured by North Korean forces in what became known as the *Pueblo* incident.

The *Pueblo* was a Navy intelligence-gathering ship seized by North Korea on January 23, 1968. One American was killed and 82 others taken prisoner and harshly treated for 11 months before being released on December 23, 1968.

The men were quickly flown to the San Diego Naval Hospital for a Christmas Eve reunion with relatives, followed by intensive physical and psychiatric examinations. A summary of results of the latter was reported in the *American Journal of Psychiatry* in July 1972, an article that served as the basis for the news story and recounted here as part of our look back at 50 years of *Psychiatric News.*

Raymond Spaulding, M.D., and Charles Ford, M.D., organized a team of six Navy psychiatrists to evaluate the men.

About half the men reported feelings of anxiety during captivity, and 16 experienced depression, wrote Spaulding and Ford in 1972. A few factors were consistent among crew members who coped well with confinement, they said—faith (in their leaders), reality testing, denial, rationalization, and humor. (The last included the surreptitious extension of middle fingers in a propaganda photograph taken by the clueless North Koreans.)

"The men who did better would in general be characterized as bright and schizoid," wrote Spaulding and Ford. "[They] had an ability to isolate their affect and entertain themselves with fantasy."

"This was an opportunity for me to understand how men who were relatively healthy were able to handle stress in different ways," recalled Ford, now a professor of psychiatry at the University of Alabama at Birmingham, in an interview. "Some natural leaders emerged, although not always the senior officers. They made life better for the rest of the crew through their altruism while others fell apart."

Once home, most were found fit to return to duty, but at a second evaluation three months later, things had changed.

"In contrast to the bland but cooperative demeanor initially seen, many men were openly antagonistic and hostile toward both the Navy and their fellow crew members," wrote Spaulding and Ford. "There was evidence of considerable acting out with alcohol and drugs, minor traffic violations, and squandering of back pay."

A similar pattern was observed in American POWs released from Japanese and North Korean prison camps after World War II and the Korean War, said the authors. Perhaps some of those effects might have been averted by not rushing the ex-POWs home for "sentimental reasons," they said. "In retrospect there is a question whether the needs of either the men themselves or the U.S. Navy were best met by hastening their return to the U.S."

"We recommended a delay of several weeks in returning home after their release," recalled Ford. Such a pause was built into the return of previous generations of POWs, who traveled slowly, by ship, on their way home and had time to talk with comrades about their time in prison camps.

"It would be important to allow people to decompress, to readjust to their families, learn something about changes in the U.S., and talk about their experiences," he said. "That would probably reduce acting out and risky behavior."

The *Pueblo* incident and the return of its crew came during the heart of the U.S. War in Vietnam, during whose course several hundred U.S. servicemen were taken captive. Spaulding and Ford suggested that the *Pueblo* crew's experience might inform the ultimate return of those prisoners, and it may have done so in part.

The Vietnam War POWs spent a week with their families at Clark Air Base in the Philippines after their release in 1973 before returning to the United States, said Robert Ursano, M.D., who later studied the U.S. Air Force aviators in that group.

"The issue is how to foster the best recovery for returning POWs or hostages," said Ursano, now a professor and chair of psychiatry at the Uniformed Services University of the Health Sciences in Bethesda, Md., in an interview.

"Part of the recovery [of released prisoners of war or hostages] has to do with mental health, and part has to do with the challenges of facing the media and the stresses their families have dealt with," said Ursano.

"I think most people would say that it helps to have a graded re-entry and more time to accommodate," he said. "It comes down to the personal experience of the degree of trauma, deprivation, and maltreatment. If severe, it can burden a person for a lifetime."

Ford thought about those long-term consequences 45 years ago. He and Spaulding talked about doing an extended follow-up study of the *Pueblo* crew using a sister ship's men as a control group, but that was never authorized. Anecdotally, he heard that many of the men did not do well in later years, he said. "But I had the feeling then of being privileged to be a part of history." PN

"The *Pueblo* Incident: Psychological Reactions to the Stresses of Imprisonment and Repatriation" by Spaulding and Ford is posted at http://ajp.psychiatryonline.org/doi/abs/10.1176/ajp.129.1.17. An abstract of "Prisoners of War: Long-Term Health Outcomes" by Ursano and David Benedek, M.D., is posted at http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(03)15062-3/abstract.

From the President

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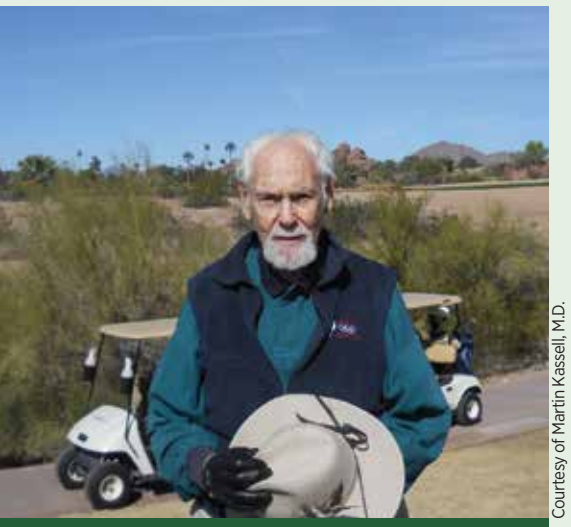
if psychiatric disorders are identified early and treated, long-term problems and disability can be prevented or at least mitigated. As we know, there are excellent treatments for adolescents who have psychiatric symptoms. Even adolescents who have symptoms consistent with the prodrome of psychosis can be treated using medication, psychosocial therapies, and supportive services. Early intervention in adolescents who are at high risk for developing schizophrenia may improve short-term clinical outcomes.

Since 2005, "Typical or Troubled?" has been implemented in over 1,500 schools in 38 states and territories and has resulted in the training of over 80,000 people in the early detection and identification of mental illnesses. The cost of "Typical or Troubled?" is covered by a grant to schools that apply for the program; they are then provided with a full set of an evidence-based, medically accurate education curriculum on mental illness and early identification. An emphasis on helping traditionally underserved communities means that the program has been developed in a number of different languages, such as Spanish and Creole. The Creole program, which was piloted in a large Haitian community in Miami-Dade, was met with great enthusiasm and participation. PN

More information on "Typical or Troubled?" is posted at http://www.americanpsychiatricfoundation.org/what-we-do/public-education/typical-or-troubled.

MEMBERS IN THE NEWS

LIVING LONGER, LIVING WELL

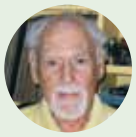


Courtesy of Martin Kassell, M.D.

BY LYNNE LAMBERG

Two million Americans are now age 90 or older, and this group includes more than 1,000 APA members. This is the conclusion of a two-part series on psychiatrists in their 90s whose active professional lives, community service, and leisure pursuits serve as role models for the rest of us.

Photo: Martin Kassell plays 18 holes of golf three times a week year round. He walks the course. "It's a beautiful setting, and a great way to exercise," he says.



Clinician, Teacher, Philosopher: A profile of Martin Kassell, M.D.

A three-times-a-week golfer. Painter of still lifes. Ham radio operator for 50 years.

Many people in their 90s would find any of these pursuits challenging.

Ninety-eight-year-old psychiatrist Martin Kassell, M.D., of Scottsdale, Ariz., relishes all of them. He also still practices and teaches psychotherapy and mentors young psychiatrists.

The Arizona Psychiatric Society (APS) will give Kassell its Career Achievement in Psychiatry Award this month, citing his more than four decades of compassionate patient care, support of peers, leadership, community service, education, advocacy, and clinical excellence. In 2013, APS gave Kassell its Howard E. Wulsin Excellence in Teaching Award. In 2015, he also received APA's Resident-Fellow Member Mentor Award.

Kassell began his psychiatry training at age 48. Before that, he practiced internal medicine in Philadelphia for 22 years. "My patients would get a little better or a little worse. … I no longer enjoyed my work," Kassell told *Psychiatric News*.

A weekend golf partner, a professor of psychiatry at Jefferson Medical College, also in Philadelphia, invited him to visit the psychiatry department. Spending a month there, attending lectures on psychoanalysis and psychotherapy, and observing patient care, Kassell said, reenergized him and refocused his interests.

After training in psychiatry at Jefferson from 1968 to 1971, he directed Jefferson's community mental health center until 1976. The center served about 2,000 severely chronically mentally ill patients, recently discharged from the state hospital, and others in one of Philadelphia's most economically deprived communities.

In 1976, thinking ahead toward retirement in a warmer climate, he accepted a position as chief of the psychiatry consultation and liaison service at Phoenix's Maricopa Medical Center. Two years later, he moved to the Arizona State Hospital, also in Phoenix, eventually becoming its clinical director.

After observing that chronically mentally ill patients often talked more freely with housekeeping personnel than with medical staff, Kassell said, he offered housekeepers training on what to say—and not to say—to patients, and invited housekeepers to team meetings.

He encouraged severely disturbed patients to paint a mural in their dayroom showing a window overlooking a garden and to rearrange furniture to their liking. This project enhanced patients' self-worth, he said, and gave them a stake in taking care of their surroundings.

He also arranged for patients, their family members or caretakers, and staff to meet informally, have coffee, and chat. One patient who had not left the hospital for 20 years, Kassell recalled, improved enough after such interactions to be able to go out for lunch.

From 1985 to 1994, Kassell directed the psychiatric unit in the Maricopa Durango Jail, a 75-bed facility, and the state's second largest psychiatric hospital. He incorporated the jail detention staff into the clinical treatment team, improving interaction between detention officers and inmates.

He also arranged to have students at the University of Arizona College of Medicine spend a day at the jail while on their psychiatry rotation, joining staff meetings, interviewing patients, and participating in group sessions. Until 2011, Kassell served as a forensic psychiatrist for the Maricopa County Superior Court.

Kassell lives today in Scottsdale in the house he shared with Evelyn, his wife of 59 years, who died in 2000. His daughter, Stephanie, lives with him. His son, Neal Kassell, M.D., is a professor of neurosurgery at the University of Virginia School of Medicine in Charlottesville.

Teaching and mentoring residents and early career psychiatrists, Kassell said, has been a key source of satisfaction throughout his career.

Today's emphasis on pharmacotherapy has come at the expense of psychotherapy, a still vital skill, he said. "It's not adequate to use a pill for everything that's wrong with a person," he said. "Psychiatrists need to find out about the person and his way of life.

"A good therapist is one who knows how to listen, not to engage in a conversation to satisfy curiosity, but rather to help the patient," Kassell said. "A good therapist also has to listen to what the patient is *not* saying."

"He's a wonderful teacher," noted Payam Sadr, M.D., immediate past APS president and an Arizona APA Assembly representative.

"He keeps up on the latest issues in psychiatry and shares his knowledge at our monthly APS meetings," said Sadr, who practices in Scottsdale and Phoenix and regards Kassell as a mentor. "He sees every day as a new day." PN

IPA

continued from page 4

being explained by non-shared environmental effects."

The authors of the Finnish study also drew on a Dutch study of gender atypical behavior (GAB) in 7- and 10-year-old twins and later sexual orientation, which found that genetic factors account for 70 percent of the variance in GAB for both boys and girls and that this phenomenon was substantially linked to homosexuality.

Additionally, Levin and Binder cited a 2011 review by Belgian researcher Jacques Balthazart, Ph.D., published in *Endocrinology* that concluded that "homosexual subjects were, on average, exposed to atypical endocrine conditions during development" and that "significant endocrine changes during embryonic life often result in an increased incidence of homosexuality."

Levin and Binder stated, "In addition, genetic and hormonal factors generally interact with environmental factors that have yet to be determined, though neither faulty parenting nor exposure to gay individuals causes homosexuality. The preponderance of opinion within the scientific community is that there is a strong biological component to sexual orientation and that genetic, hormonal, and environmental factors interact to influence a person's orientation. There is no scientific evidence that either homosexuality or heterosexuality is a free-will choice."

They concluded: "It is important to recognize that there is no evidence that attempts to change people's sexual orientation have ever been successful, even when the subject sincerely wants to change. In 1973, based upon a review of scientific research, the American Psychiatric Association determined that homosexuality is not a mental disorder and removed it from *DSM*. It is the position of APA that there is no rational basis, scientific or otherwise, upon which to punish or discriminate against LGBT people." PN

A blog on this issue by Levin with a link to the March 8 letter is posted at http://psychiatry.org/news-room/apa-blogs/apa-blog/2016/03/homosexuality-as-a-mental-disorder-simply-not-backed-up-by-science.

PSYCHIATRY & PSYCHOTHERAPY

Narcissistic Personality Disorder: Challenge of Understanding and Diagnosis


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

This is the first of a two-part series.

The topic of psychotherapy in psychiatry easily leads to consideration of the personality disorders. Among APA's treatment guidelines, those for borderline personality disorder uniquely recommend psychotherapy as the primary modality of treatment. While guidelines have not been developed for other personality disorders, the complex nature of these disorders calls for a comprehensive biopsychosocial approach including general psychiatric management, judicious use of psychopharmacology, and a central role for psychotherapy. We focus in this column on narcissistic personality disorder (NPD).

NPD has an estimated prevalence of 1 percent to 6 percent and can be associated with significant functional impairment and psychosocial disability. Review of a series of our clinical cases of NPD reveals, first, a high level of initial misdiagnosis and long periods of inappropriate treatments, typically targeting refractory depression. This phenomenon can lead to lost years in patients' lives and the risk of suicide. Diagnostic confusion reflects at least in part the wide variety of clinical presentations, spanning a wide range of severity, that can characterize NPD. This is further complicated by a high level of co-occurence between NPD and other psychiatric disorders, notably affective disorders, especially bipolar disorder, substance misuse, and other personality disorders. Thus, the first requirement in adequately treating NPD is careful assessment and consideration of differential diagnosis.

Both the diagnosis and treatment of NPD require a coherent conceptualization of the disorder that can unify a wide range of clinical presentations. The *DSM* system has in the past focused on a descriptive characterization that emphasizes grandiosity (in fantasy or behavior), the need for admiration, entitlement, and a lack of empathy. However, these criteria do not cover core psychological features of the disorder, including difficulty with self-esteem, feelings of inferiority, emptiness and boredom, and affective reactivity and distress and do not describe the depressive and masochistic types of the disorder. The publication of *DSM-5* and, in particular, of the Alternative Model for Personality Disorders included in Section III, begins to address psychological processes or structures in its understanding of personality disorders, emphasizing the centrality of Self and Interpersonal functioning. This approach is compatible with a longstanding tradition within psychodynamic psychiatry that understands and characterizes personality disorders in terms of the psychological processes underlying and organizing personality functioning and pathology, focusing

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.

on identity formation. This model can account for shared features that unify the various presentations of NPD.

One clinically useful psychodynamic perspective on NPD emerges from object relations theory. This model emphasizes the role of a particular form of identity formation as responsible for the faulty self and interpersonal functioning that characterizes NPD across different presentations and levels of severity. Object relations theory understands identity as reflecting the internalization of affectively charged experiences of self and other throughout the course of early development. Grossly speaking, those experiences sort out into two groups of experiences: those based on gratification and associated with loving feelings and those based on pain and frustration and associated with hateful feelings. In the course of successful psychological development, these polarized experiences of self and other become integrated into a complex and deep experience of self and of significant others, corresponding with normal identity formation. However, some individuals continue through life with extreme, highly positive or highly negative, caricatured views of self and other that are activated by external events, organizing inaccurate perceptions of interactions with others and consequent maladaptive behaviors. This polarized experience of self and others, described in terms of identity formation that is overtly unintegrated or "split," is characteristic of borderline personality disorder (BPD).

*see **NPD** on page 27*

CLINICAL & RESEARCH NEWS

Large Trial Suggests Testosterone Offers Moderate Benefits

Older men who took testosterone gel for one year showed some improvement with respect to mood and depressive symptoms.

BY NICK ZAGORSKI

As men get older, their testosterone levels commonly drop, and as these changes take place, some men experience decreased energy, sexual function, and mood. While previous trials of testosterone treatment in men aged 65 and older have consistently found testosterone increased muscle mass and decreased fat mass, the data on its effects on physical performance, sexual function, and more have been inconsistent.

"In extreme cases of hypogonadism due to testicular disease, absolutely

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[testosterone treatment] is an important therapy," said Harrison Pope Jr., M.D., a professor of psychiatry at Harvard Medical School and director of the Biological Psychiatry Laboratory at Boston's McLean Hospital. "But when you're in the gray zone and seeing a patient with mild depression and a lower sex drive than normal for his age, we just don't know where testosterone therapy stands."

Pope told *Psychiatric News* that the insufficient evidence to support testosterone for improving the physical and mental health of older men has led to a differing of opinions about whether or not it's a viable option for patients: "You see viewpoints ranging from these anti-aging clinics that swear by the power of testosterone to more conservative clinicians who don't think it should be used at all."

In 2003, Pope and colleagues published a pilot study of 22 men with depression (including younger men) that found treatment with testosterone gel reduced symptoms of depression (*Psychiatric News*, February 7, 2003); a larger follow-up of about 100 patients several years later, though, failed to replicate this effect.

In the February 23 issue of the *New England Journal of Medicine*, a team of researchers reported on the effects of one year of testosterone gel treatment on the physical activity, sexual function, and vitality and mood of 800 men 65 years and older with low testosterone levels. The results are part of Testosterone Trials—a coordinated set of seven double-blind, placebo-controlled trials that are also examining the effects of testosterone gel on cognitive function, cardiovascular risk, anemia, and bone density.

In the *NEJM* paper, the authors described how testosterone therapy produced a clear and robust improvement in both sexual desire and erectile function when compared with a placebo gel, but there were no significant changes in physical function (measured by walking distance over time) or fatigue.

Men who took testosterone gel for 12 months reported improvements in positive and negative mood symptoms (as measured by the Positive and Negative Affect Scale) and depression levels (as measured by the Patient Health Questionnaire).

Pope, who was not involved in this study but has collaborated with some of the investigators, was cautious about what the results of the trial say about the effects of testosterone on the mood of men with low testosterone levels.

"By enrolling a large number of participants, the investigators could identify statistically meaningful changes in depression, but were they clinically meaningful changes?" he asked.

Pope noted that testosterone therapy is not a quick solution, and questions about long-term safety, especially cardiovascular problems associated with the treatment, linger.

"Suppose you are convinced that testosterone offers a genuine effect, you face a difficult quandary. You can commit that patient to testosterone for several years or more, without a clear knowledge of the risk-benefit ratio," he said.

"But, this therapy does suppress natural testosterone production, so if you decide to take the patient off testosterone after a year or so, it may take weeks or even months for the factory to come back online," he continued.

The results of the other components of the Testosterone Trials will be forthcoming, including the important issue of cardiovascular safety and effects of testosterone therapy on cognition.

"I do believe in my heart that testosterone therapy does offer some antidepressant properties in men with low testosterone," Pope said. "But it's not a consistent effect, and that is important. A physician should exercise sound clinical judgment that considers all of a patient's physical and emotional condition." PN

"Effects of Testosterone Treatment in Older Men" is posted at http://www.nejm.org/doi/full/10.1056/NEJMoa1506119.

CLINICAL & RESEARCH NEWS

Neanderthal DNA May Whisper 'Mood Disorder' Over Millennia

Intriguing hints of a connection between Neanderthal DNA and modern-day depression may also point to new ways of using big data.

BY AARON LEVIN

AP Photo/Martin Meissner

Perhaps it's not quite right to blame psychiatric illness on ancestors who lived 50,000 years ago, but a recent story in *Science* reveals how far back in time lie the sources of modern disorders.

Genetic contributions from the Neanderthals preserved over the millennia appear to affect current risk of depression, tobacco use disorder, blood clotting, skin lesions, and other conditions, wrote John Capra, Ph.D., an assistant professor of biological sciences at Vanderbilt University; Corinne Simonti, B.S., a graduate student in Capra's lab; and colleagues in the February 12 *Science*.

"We hope this leads to a better understanding of how humans evolved and the influences on how we get sick," said Capra at a news briefing during the annual meeting of the American Association for the Advancement of Science in Washington, D.C., in February. "But the effects seen in modern environments do not tell us what these genes were doing 50,000 years ago."

When anatomically modern humans moved out of Africa and into Europe and Asia, some of them met and mated with the Neanderthals. Present-day Eurasian populations contain an estimated 1 to 4 percent of Neanderthal DNA, and some alleles are found in modern humans at disproportionately higher than expected levels.

Neanderthals had lived in Europe and Asia for hundreds of thousands of years and so were well adapted to a colder climate and its pathogens. Offspring of the two populations thus might have been slightly better adapted in some ways to that environment, preserving Neanderthal DNA in the genome of modern humans.

Capra's team compared high-resolution maps of Neanderthal haplotypes with data on 28,416 present-day humans from the Electronic Medical Records and Genomics (eMERGE) Network, a consortium linking genetic and medical diagnostic data from patients in seven academic medical centers across the United States.

Using genomewide complex trait analysis, they found significant but small contributions to risk of actinic keratosis (2.49 percent), mood disorders (0.68 percent), and depression (1.06 percent) from the Neanderthals. The Neanderthal alleles are enriched near genes known to be associated with depression, wrote Capra and Simonti.

A second approach, a phenomewide association study, also found associations with hypercoagulable state and tobacco use disorder.

The latter finding had nothing to do with tobacco, a New World plant. Rather, it is connected to a single-nucleotide polymorphism involved with reuptake of the neurotransmitter γ-aminobutyric acid (GABA).

In fact, the clinical significance of these associations varies considerably, Kenneth Kendler, M.D., a professor of psychiatry at Virginia Commonwealth University in Richmond, told *Psychiatric News*.

"We can speculate that an ability to have blood clot quickly would have been useful in the Paleolithic era, when the Neanhderthals were likely to pick up a lot of cuts and scrapes and infections," said Kendler. "But it might not be so helpful today when we are more concerned about clotting in our arteries."

However, the signals for psychiatric illnesses, while intriguing, are less strong, said Kendler. "There are some slight hints that our Neanderthal heritage might have introduced variants that affect the risk for depression and smoking, but there's nothing more definitive."

There was another lesson to be drawn from the encounter between ancient DNA and modern illness, said Capra.

"This kind of research shows how important it is to have large databases and for the scientific community to have access to them," he said. "eMERGE was developed to understand the genetics of disease, not to study evolution." PN

"The Phenotypic Legacy of Admixture Between Modern Humans and Neandertals" is posted at http://science.sciencemag.org/content/351/6274/737.full. A video of the news briefing with John Capra, Ph.D., and Corinne Simonti, B.S., is posted at http://www.eurekalert.org/aaasnewsroom/2016/webcast/?b=2.

PSYCHIATRY & INTEGRATED CARE

Integrated Care Plays Role in VA Medical Home

BY ANDREW POMERANTZ, M.D.

The Veterans Health Administration (VA) has been a leader in integrated care since 2007 and continues to innovate on behalf of the millions of men and women it serves. This month, Andrew Pomerantz, M.D., one of the pioneers of integrated care, describes the evolution of integrated care at the VA and its applicability to health care in general.

—Jürgen Unützer, M.D., M.P.H.

The Veterans Health Administration (VA) has the largest integrated health care system in the United States, with more than 8 million enrollees. Like the general population, most veterans with mental disorders present first in primary care settings and, also like other populations, many either decline referral to mental health clinics or do not engage in care even if they initially accept referral. Evidence developed in research trials over the past 20 years suggests that many such individuals can be successfully treated in an appropriately resourced primary care setting, without relying on often scarce specialized mental health clinics. Translation of this research into common practice has been slowly growing.

In 2007, the VA funded 97 facilities to begin providing integrated care in primary care clinics through its Primary Care–Mental Health Integration (PCMHI) initiative. PCMHI blends together two key components:

- Care management (CM), based on the collaborative care model, which has been described in previous issues of this publication. CM provides support for primary care providers as well as follow-up and, if indicated, additional assessment services for co-located collaborative care clinicians.

- Co-located collaborative care (CCC). This component adds mental health professionals to primary care teams to serve as consultants as well as deliver brief interventions to veterans identified by universal screening or during a clinical encounter. These embedded clinicians primarily treat individuals with mild to moderate symptoms of depression, anxiety, alcohol use, and

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Andrew Pomerantz, M.D., is the national mental health director for integrated services at the Veterans Health Administration and an associate professor of psychiatry at the Geisel School of Medicine at Dartmouth. 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."

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other conditions such as chronic pain, insomnia, and stress. They also assist in assuring that those individuals with more complex illness whose care cannot be managed in primary care successfully engage in more specialized care. They also serve as resources for the primary care teams caring for individuals who have completed specialty mental health care.

In 2010, the VA began the transformation of primary care to the Patient Aligned Care Team (PACT), the VA's version of the patient-centered medical home. These teams include services beyond traditional primary care, including the PCMHI providers. Although in the early years, special funding was provided to implement integrated care programs, they are now mostly built by reassigning staff from specialized mental health clinics to work in primary care. The VA is using an evidence-based blended facilitation model, developed and tested in one of its research centers, to assist development in many sites. As in other systems, experience has shown that clinicians making such a transition need training, and not all are comfortable with the brief, problem-focused assessments and interventions effective in primary care and prefer to work in specialized programs.

Although national policy outlines basic requirements, individual facilities can design and staff clinics based on

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local factors. Anecdotal reports from the many programs that have included psychiatrists report improved effectiveness, efficiency, and reach. The presence of a psychiatrist obviates the need to refer patients into specialty clinics when the need for direct psychiatric assessment arises, meaning more patients can be managed entirely within primary care by the interprofessional team. Psychiatrists typically serve as supervisors for care managers, consultants to the primary care providers, back-up for the non-M.D. mental health providers, and other functions. A few clinics have used psychiatrists to assist in treatment planning for complex, high-utilizing patients, mirroring a trend in the private sector.

One key to building successful integrated care clinics in the VA is immediate access within primary care. Making care immediately available at the time of a primary care visit helps to avoid the attrition invariably associated with delays of any length between problem identification and mental health assessment and treatment. Indeed, national program evaluation has demonstrated a substantial increase in the percentage of the primary care population identified with and treated for mental illness. Other national and program-specific findings have shown improved engagement in care for those who are first treated in PCMHI prior to specialty mental health care, improvement in guideline concordant care for depression in primary care, reduction of referrals to specialty care, and improved antidepressant prescribing by primary care providers.

CLINICAL & RESEARCH NEWS

Like any new clinical initiative, integrated care continues to evolve and mature. Medication management and psychotherapy are increasingly being delivered to patients in distant clinics and, increasingly, directly to the home, using interactive clinical video. Self-help websites and apps are now frequently used, and integrated clinicians often incorporate them in their work. Adapting traditional time-consuming treatments to this brief model of care has been a significant challenge. Reducing 12 to 16 one-hour sessions of evidence-based psychotherapy to one to four 30-minute sessions without loss of efficacy is challenging. The VA has recently begun training clinicians in brief problem-solving training, and other efforts are under way to develop brief therapeutic and care management interventions for chronic pain, insomnia, and other conditions. Some of these interventions are currently in clinical trials. A recent randomized, controlled trial of such brief therapy for posttraumatic stress disorder has yielded significantly positive results.

The VA has demonstrated that the use of integrated care for assessment and treatment of common mental health conditions preserves more intensive resources for those with more serious or complex illness and increases availability of those resources. Such a stepped-care approach can be an important tool to help solve the mental health access problem prevalent throughout much of U.S. health care as well. Although the funding mechanisms in the VA are different, the basic principles are the same and applicable to any setting. PN

CLINICAL & RESEARCH NEWS

Framingham Study Suggests Dementia Rates May Be Falling

The study also found that participants improved in most indicators of cardiovascular health.

BY VABREN WATTS

Many experts predict that as people live longer, the prevalence of dementia will climb. However, a study published February 11 in the *New England Journal of Medicine* now suggests the incidence of dementia may be falling.

"Currently, there are no effective treatments to prevent or cure dementia," coauthor Sudha Seshadri, M.D., a professor of neurology at Boston University School of Medicine, said in press statement. "However, our study offers hope that some of the dementia cases might be preventable—or at least delayed—through primary (keep the disease process from starting) or secondary (keep it from progressing to clinically obvious dementia) prevention."

Currently 47.5 million people worldwide have some form of dementia, according to the World Health Organization. The total number of people with dementia is projected to reach 75.6 million in 2030 and almost triple to 135.5 million by 2050, barring medical advances to prevent or cure the disease.

To assess the progression of dementia in a sample of adults over time, Seshadri and her colleagues analyzed data from 5,205 people aged 60 and older who were participants in the Framingham Heart Study, a community-based, longitudinal cohort study that was initiated in 1948. Since 1975, the cognitive status of the original cohort has been regularly monitored via the Mini-Mental State Examination, neurological and neuropsychological examinations, and subjective memory questioning.

By using statistical models adjusted for age and sex, the researchers determined the incidence of dementia during each of four distinct periods: from the late 1970s to early 1980s (first epoch), from the late 1980s to early 1990s (second epoch), from the late 1990s to the early 2000s (third epoch), and from the late 2000s to the early 2010s (fourth epoch). The researchers also examined the interactions between epoch and age, sex, apolipoprotein E ε4 status, and educational level.

The researchers found a progressive decline in dementia over the 30-year period, with incidence rates, relative to the first epoch, declining by 22 percent, 38 percent, and 44 percent during the second, third, and fourth epochs, respectively. This risk reduction was observed only among persons who had at least a high school diploma.

The participants in the Framingham Heart Study also had improvements in most indicators of cardiovascular health, with the exception of a trend toward increasing prevalence of diabetes and obesity.

"Our study offers cautious hope that some cases of dementia might be preventable or at least delayed," the researchers concluded. "However, it also emphasizes our incomplete understanding of the observed temporal trend and the need for further exploration of factors that contribute to this decline in order to better understand and possibly accelerate this beneficial trend."

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

An abstract of "Incidence of Dementia Over Three Decades in the Framingham Heart Study" is posted at http://www.nejm.org/doi/full/10.1056/NEJMoa1504327.

Questions Raised About Best Treatment For Refractory Schizophrenia

A meta-analysis of 40 trials finds clozapine is on par with, but not significantly better than, olanzapine and risperidone, but experts question the generalizability of the samples that were enrolled into the blinded randomized, controlled trials.

BY NICK ZAGORSKI

Despite adequate treatment with antipsychotics, an estimated one-third of all patients with schizophrenia experience persistent psychotic symptoms. For these patients, most experts agree clozapine is the best treatment option.

But a study in the March *JAMA Psychiatry* has raised a question as to whether clozapine is significantly better than several other antipsychotics when it comes to treating refractory schizophrenia.

In a meta-analysis led by Stefan Leucht, M.D., of the Department of Psychiatry and Psychotherapy at the Technical University of Munich, researchers included 40 randomized clinical trials of antipsychotics used to treat treatment-resistant schizophrenia in more than 5,000 patients.

The authors then developed a network model to compare the efficacy of these agents with each other; a total of nine antipsychotics were included in the comparison: chlorpromazine, clozapine, fluphenazine, haloperidol, olanzapine, quetiapine, risperidone, sertindole (not available in the United States), and ziprasidone.

When considering both overall symptom improvement as well as improvements in just positive or negative symptoms, clozapine, olanzapine, and risperidone came out on top.

According to what former APA President Jeffrey Lieberman, M.D., chair of the Department of Psychiatry at Columbia University and New York Presbyterian Hospital and director of the New York State Psychiatric Institute, told *Psychiatric News*, these results agree with current medical practice.

The slight surprise was that the meta-analysis found little evidence that clozapine was significantly superior to the other two agents. For example, in comparison with sertindole, clozapine was found to reduce overall schizophrenia symptoms by an additional 0.40 points (measured by Positive and Negative Syndrome Scale [PANSS]), falling in between risperidone (0.32 point reduction) and olanzapine (0.46 point reduction).

"That is an interesting result, but I don't think intrinsic clinical practice will change because of these findings," said Lieberman, who was not involved in this study. "For reasons we admittedly still don't understand, clozapine does have a unique superiority in treating refractory patients, and that has been shown consistently across studies, both randomized trials and other types."

Jeffrey Lieberman, M.D.

Jeffrey Lieberman, M.D., says that this new analysis may point to trends in how heterogeneous patient populations respond in clinical studies rather than indicate the medication's true efficacy.

Lieberman continued, "Instead, I think these results highlight the trend in clinical research wherein as the number of studies examining a particular medication increases, the population of enrolled patients becomes broader in their clinical criteria." (In the meta-analysis by Leucht and colleagues, clozapine was featured in 20 of the 40 analyzed studies—more than any other antipsychotic agent.)

According to Lieberman, the result of this heterogeneity may be that a combination of lower symptom severity, heightened patient expectations, and other factors conspire to reduce drug response, increase placebo effect, and produce results that might be underrepresentative of the medication's true efficacy.

This was an idea echoed by the authors of the meta-analysis, as well as Christoph Correll, M.D., and John Kane, M.D. (who led the landmark 1988 study that demonstrated the potential of clozapine and helped re-introduce its clinical use in the United States), who wrote an editorial response to Leucht's study.

Both groups noted that the current meta-analysis excluded several open-label studies that showed a strong superiority for clozapine in treatment-resistant schizophrenia, such as the Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) study. The question then is, what do these open-label findings mean?

"The fact that the studies with positive results were unblended and mostly unrandomized could be interpreted in one of two ways," Kane and Correll wrote. "The positive findings are due to bias on the part of the treating clinicians, patients, and raters, or the patients in the open studies are more representative of the severely ill patients who benefit the most from clozapine but are less likely to enroll in complex and demanding randomized clinical trials.

"Thus, the biggest concern about the validity of the findings from [this] meta-analysis by Samara et al. is the question regarding the generalizability of the samples that were enrolled into the blinded RCTs," they said.

When you consider trials that looked at clozapine therapy for first-episode psychosis, the medication generally performs no better than other antipsychotics, Lieberman told *Psychiatric News*. "The superiority only manifests in severely ill, treatment-resistant patients."

The study authors, editorial authors, and Lieberman all agreed that new, randomized clozapine studies that feature a large but representative population are crucial to address the current uncertainties.

"Our analysis suggests that more trials comparing clozapine with other [second-generation antipsychotics] in patients with more severe illness and using high clozapine doses are warranted," Leucht and colleagues concluded.

Leucht's meta-analysis was supported by a grant from the German Federal Ministry of Education and Research. PN

An abstract of "Efficacy, Acceptability, and Tolerability of Antipsychotics in Treatment-Resistant Schizophrenia" is posted at http://archpsyc.jamanetwork.com/article.aspx?articleid=2488040. An abstract of "Clozapine for the Treatment-Resistant Schizophrenic: A Double-Blind Comparison With Chlorpromazine" is posted at http://archpsyc.jamanetwork.com/article.aspx?articleid=494368.

Drug Prices

continued from page 4

He added that during an election season, the skyrocketing price of prescription drugs was bound to become a focus of attention. "One of the most important issues for voters is reducing these prescription price hikes and protecting hardworking Americans from price gouging," he said.

Since 2004 the AARP Public Policy Institute and the University of Minnesota's PRIME Institute have collaborated to report an index of manufacturers' drug price changes for three "market baskets"—brand, generic, and specialty drugs; recently, a combined market basket (that is, brand, generic, and specialty) has been added to the series to view the price change trend across all types of prescription drugs in the U.S. market. This year's report is based on 2011 data from the Truven Health MarketScan Research Databases and a Medicare Part D plan provider.

At the November Interim Meeting of the AMA House of Delegates, physicians approved new AMA policy calling for an end to direct-to-consumer advertising, citing its effect on drug prices. Delegates who voted for the policy said that although some patients may be prompted to visit a physician because of increased awareness of an illness or treatment stemming from advertising, the DCTA's ultimate is to drive demand for a product, resulting in increased pharmaceutical prices.

Psychiatrist and AMA Board Chair-elect Patrice Harris, M.D., M.A., said that the vote in support of an advertising ban reflects concerns among physicians about the negative impact of commercially driven promotions and the role that marketing costs play in fueling escalating drug prices.

"Direct-to-consumer advertising also inflates demand for new and more expensive drugs, even when these drugs may not be appropriate," she said. "Patient care can be compromised and delayed when prescription drugs are unaffordable and subject to coverage limitations by the patient's health plan. In a worst-case scenario, patients forego necessary treatments when drugs are too expensive" (*Psychiatric News*, December 10, 2015). PN

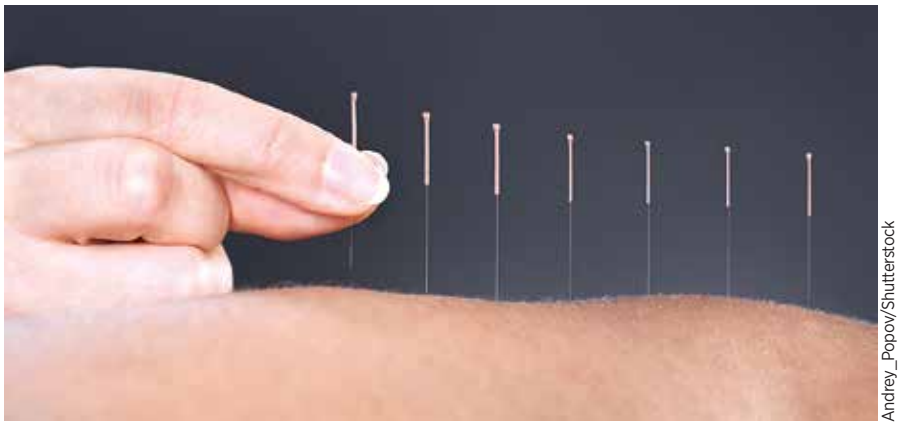
"Rx Price Watch Report: Trends in Retail Prices of Prescription Drugs Widely Used by Older Americans: 2006 to 2013" is posted at http://www.aarp.org/health/drugs-supplements/info-08-2010/rx_price_watch.html.

CLINICAL & RESEARCH NEWS

Acupuncture for Depression: Pros, Cons, and Other Sticking Points

While the lack of an effective placebo control will likely prevent solid evidence of efficacy, acupuncture may be a viable option for some patients.

BY NICK ZAGORSKI



Andrey_Popov/Shutterstock

Albert Yeung, M.D., sees both the promise and limitations of acupuncture to help treat people with psychiatric issues such as depressed mood, fatigue, or insomnia.

Yeung said that while many patients have told him that acupuncture helped them to feel better, tracking down evidence to support these reports can be challenging.

There have been dozens of studies evaluating the effectiveness of acupuncture alone or in combination with medications to treat mood disorders in the past few years. And at first glance, many of them appear to provide evidence that acupuncture is a promising treatment option.

For example, a meta-analysis that included 13 trials and over 1,000 patients with depression found that combining acupuncture with selective serotonin reuptake inhibitors (SSRIs) improved average therapeutic response by about 20 percent over the first six weeks compared with SSRIs alone. This research was published in the November 2015 issue of the *Journal of Affective Disorders*.

"Upon closer examination, however, these studies have several limitations that make the data inconclusive," said Yeung, the director of Primary Care Research at the Depression Clinical and Research Program at Massachusetts General Hospital.

As Yeung explained, the nature of acupuncture is such that it's nearly impossible to design any definitive clinical comparison studies. For starters, acupuncture is highly individualized when considering the background and technique of the practitioner and the exact symptom presentation of the patient.

Another problem is there is no way to create a good placebo with which acupuncture can be compared. Sticking people with needles in nonacupuncture points is not ethical, and even if it were, the needle would still induce the release of the body's endorphins, which contribute some of the positive effects of acupuncture. In contrast, sham needles—blunt devices that press against the skin but then retract—are only moderately effective at simulating acupuncture.

"Anyone with even limited acupuncture experience should be able to tell the difference" between sham and real needles, Yeung said.

With these drawbacks, as well as the fact that most clinical trials involve only small numbers of participants, it is not surprising that both the APA Practice Guidelines for the Treatment of Patients With Major Depressive Disorder and a Cochrane review on acupuncture for depression—both published in 2010—do not recommend acupuncture as a treatment option for people with depression.

In response to the Cochrane review, Hugh MacPherson, Ph.D., a senior research

see **Acupuncture** on page 27

RESIDENTS' FORUM

Sleepless in Psychiatry: How to Survive on Call

BY AMANDA HARRIS, M.D.

Call—one of the most dreaded aspects of residency training. It is often looming over our heads; a thief stealing our sleep, our nights, and weekends, and at times our sanities. Despite the fact that call is one of the most challenging aspects of our training, it can also "give back" in the form of unique learning experiences that leave us feeling accomplished, independent, and confident in our skills as new physicians. Maintaining this cognitive reframe about call is not always easy, but these tips can help you stay on the positive side of the split:

Know your role: Preparing for call starts with knowing the role. Review the "call guide," talk to senior residents, and ask to follow them (even briefly) on a "buddy call." Understanding your roles and responsibilities will help you triage and manage multiple situations at once. Some helpful questions to think about:

- What services am I covering? What is the sign-out process?
- Who is my backup attending? How do I reach the attendings? What cases do they want and/or need to be contacted about?
- What types of questions do residents typically receive in each call location?
- Nuts and bolts: Where do I find the pager? keys? Where can I eat/sleep? How do we track patient encounters?

Remember: your main goal on call is to get patients through to the morning or the next workday safely. You don't have to (and frankly cannot) solve all of a patient's problems or nail a complicated diagnosis at 3 a.m. Give thorough sign out to the day team. Team members will pick up where you left off with more time, resources, and rest on their side!

Know your limits: While residency training is often focused on learning to diagnose and treat different illnesses, it is also a time to learn about yourself. Take time to reflect on who you are on call—are you anxious, frustrated, excited? How does stress affect your judgment? The demands of our work can often leave us feeling like we need to be super-doctor, but we are only human. It is natural to have emotional and physical reactions to challenging work situations, especially when sleep deprived. Try some of these strategies to improve your self-care while on call:

- Pay attention to nutrition: choose healthy meals and water over coffee and fast food.
- Take short breaks (even if multiple patients are waiting to be seen): even five minutes can help you re-charge and re-focus.
- Prevent fatigue—get adequate sleep and exercise before call. Reduce use of alcohol and hypnotics for sleep while off-duty.

Know your team: Whenever you are caring for patients, you are working as part of a team. This may be difficult to remember while on call (when staffing is lower and it is easier to feel isolated); however, this is when you need to harness the power of teamwork the most! Lean on your nurses (who may be more familiar with a patient's baseline or effective management strategies), the primary team (if you are in the consulting role), and medical/surgical consulting services (if your patient is medically ill). Don't be afraid to ask for help from your attending backup! We are still in training, and we deserve supervision and guidance in moments where we are unsure.

Although it appears daunting, you will survive call—we all do! Your comfort level and confidence will increase with each call you have under your belt. And don't forget to reward yourself in the morning with a well-earned breakfast and nap.

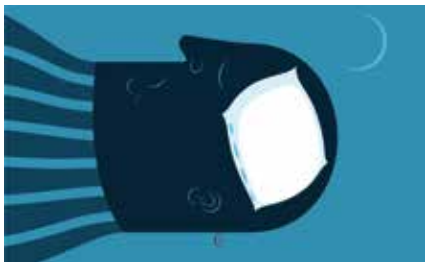
To learn more about this topic and many others, check out the *Resident's Guide* chapter "Sleepless in Psychiatry: How to Survive on Call." PN

This article is based on information from APA's *Resident's Guide to Surviving Psychiatric Training*. The guide was written by residents and fellows, for residents and fellows, to help them with the day-to-day challenges of training. The guide offers practical advice on more than 50 topics and can be accessed free at psychiatry.org/residents.

Amanda Harris, M.D., is a PGY-3 psychiatry resident at the New York University School of Medicine.

JOURNAL DIGEST

BY NICK ZAGORSKI



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People Taking Sedatives For Insomnia May Be More Likely To Have High LDL

A large population analysis has found that people with insomnia (including those with difficulty falling asleep, prolonged nocturnal waking, and undesired early morning waking) do not have higher cholesterol levels than those with healthy sleep patterns.

However, in the subset of people with insomnia who took sleeping pills, a roughly twofold increased risk of having high low-density lipoprotein (LDL) was observed.

Study author Nicholas Vozoris, M.D., a respirologist at St. Michaels Hospital in Toronto, noted that the observed association between sleeping pill use and elevated LDL cholesterol was concerning given the rising rate of sedative use in recent years, but he also noted that the results might reflect that people taking sedatives have a more severe form of insomnia that contributes to the higher cholesterol values.

He said that additional research is important to confirm this association and delineate if a specific type of sedative might be responsible for elevating LDL levels.

This study, which made use of data from the National Health and Nutrition Examination Surveys, was published in the journal *Sleep*.

Vozoris, N. Insomnia Symptoms Are Not Associated With Dyslipidemia: A Population-Based Study. *Sleep*. 2016;39(3): 551-558. http://www.journalsleep.org/ViewAbstract.aspx?pid=30481

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Large Population Study Finds Link Between Age at Starting School And ADHD Diagnosis

The age at which a child enters school may influence his or her risk of being diagnosed with attention-deficit/hyperactivity disorder (ADHD) and receiving ADHD medication, according to a study published in the *Journal of Pediatrics*.

Researchers in Taiwan examined cohort data from 378,881 school-aged children (aged 4 to 17) between 1997 and 2011 and grouped all those who received either a diagnosis of ADHD and/or prescription for ADHD medication by birth month.

They found that as a whole, children born in August were more likely to be diagnosed with ADHD than those born in September (the cut-off birthdate for school enrollment is August 31 in Taiwan). The association between ADHD diagnosis and birth month was less prevalent as diagnosis age increased; an August birth was associated with 1.62 increased odds of ADHD diagnosis in preschool children, as well as 1.44 increased odds in adolescents.

"Our findings emphasize the importance of considering the age of a child within a grade when diagnosing ADHD and prescribing medication to treat ADHD," the authors wrote.

Chen M, Lan W, Bai Y, et al. Influence of Relative Age on Diagnosis and Treatment of Attention-Deficit/Hyperactivity Disorder in Taiwanese Children. *J Pediatrics*. March 10, 2016. [Epub ahead of print] http://www.jpeds.com/article/S0022-3476(16)00160-8/abstract

see ***Journal Digest*** *on page 28*

Opioid Abuse

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treatment given the difficulties inherent in accessing specialized treatment from a remote location."

"Here in South Carolina, the average income in rural areas is $10,000 less than in urban areas, and people generally have less education," said addictions specialist Kathleen Brady, M.D., Ph.D., a professor of psychiatry and behavioral sciences at the Medical University of South Carolina, in an interview with *Psychiatric News*.

"More people work in manual labor jobs that can lead to injury and pain and the use of opiate prescription drugs," said Brady, who was not involved with the Maine study. "The problem is made worse because there are fewer physicians and fewer treatment options in rural areas."

In January, President Barack Obama named Secretary of Agriculture Tom Vilsack to lead an interagency effort focused on addressing the opioid epidemic, which resulted in nearly 19,000 overdose deaths in 2014. Vilsack has chaired the White House Rural Council since 2011, giving him firsthand experience addressing challenges in rural America.

At a National League of Cities meeting in Washington, D.C., on March 8, Vilsack outlined the federal government's plans to address the opioid epidemic.

"For a start, we need to do a better job of training doctors about prescribing opioids," Vilsack said. In October 2015, the president announced a commitment by more than 40 medical groups to training more than 540,000 providers on appropriate opioid prescribing over the next two years.

Lance Cheung/USDA

Opioid addiction is costly in terms of health care services, lost productivity, and law enforcement, says Secretary of Agriculture Tom Vilsack.

"We also want to focus resources on expanding medication-assisted treatment programs," he said.

Buprenorphine can be used in office-based practices to transition people off opiates, but doctors need additional certification to prescribe it, and not many rural or primary care practitioners have that certification, said Brady. Expanding the number of clinicians certified to prescribe buprenorphine in rural areas could increase access to those seeking treatment for opioid use disorders.

The USDA offers grants for expanding broadband access and telemedicine in rural areas, and the administration is looking to triple the funding for those grants, said Vilsack.

Overall, the Obama administration's Fiscal 2017 budget will include $920 million in new funding over two years for states to expand access to medication-assisted treatment for opioid use disorders.

Another $50 million will be earmarked for the National Health Service Corps to support 700 substance use disorder treatment providers in areas of greatest need, and $30 million has been allotted for evaluating the effectiveness of medication-assisted treatment programs.

The FDA is also working with drug companies to reformulate medications so that they present less potential for abuse, addiction, or overdose (*Psychiatric News*, March 18).

Vilsack praised the reformulation of naloxone into a nasal spray so that it can be easily used to rescue overdose victims and noted that federal grants were available to make the medication available to police, emergency medical technicians, and other first responders. He also called for a "general prescription" that would allow anyone—especially family members of opioid users—to have naloxone available for emergencies.

Vilsack's task force is working closely with the 49 states that have prescription drug monitoring laws (Missouri is the one exception) to create interstate data-sharing systems that would minimize doctor-shopping, especially in regions where people with opioid use disorders can easily move back and forth across state lines.

Vilsack called on political leaders at every level to step up in the campaign against the ravages of opioid abuse.

"We need to encourage people to seek support and then do everything we can to make sure that the resources, the staff, and the medications are all available when the time is right for recovery and that recovery is sustained," he concluded. PN

"Rural Opioid Abuse: Prevalence and User Characteristics" is posted at http://muskie.usm.maine.edu/Publications/rural/Rural-Opioid-Abuse.pdf. "Prescription Opioid Misuse, Abuse, and Treatment in the United States: An Update" by Brady and colleagues is posted at http://ajp.psychiatryonline.org/doi/full/10.1176/appi.ajp.2015.15020262.

Gun Violence

continued from page 1

cussing firearms in the same way they discuss other risk factors for injury, said Benjamin. "Too many doctors don't ask if there is a gun in the home or if it is stored safely."

Two-thirds of gun deaths are suicides, a fact that presents a logical place for clinicians to intervene to reduce gun deaths, said forensic psychiatrist Liza Gold, M.D., a clinical professor of psychiatry at Georgetown University School of Medicine.

"Suicide risk assessment is a process, not an event," said Gold. "The problem is that there are no standardized assessment models or tools."

APA last issued such a model in 2003, but it needs updating now, she said.

A systematic suicide risk assessment should combine semistructured tools, clinical interviews, and patient self-report, as well as information from family members, other treating clinicians, and psychiatric records.

"We cannot predict who will die by suicide, but we can mitigate risk," she said. Suicide attempts are often impulsive, arising in moments of crisis, and depend on the immediate availability of lethal means, so reducing access to lethal means has the potential to cut suicide rates.

"Access to firearms increases risk of suicide for all members of the household, independent of psychopathology," said Gold. Thus, when talking to patients, the discussion should focus not on politics or rights, but on reducing risks of injury or death for the patient and all the members of the patient's household.

Two special subpopulations that have great familiarity with guns are military service members and veterans, said Elspeth Cameron Ritchie, M.D., M.P.H., a retired Army psychiatrist and the chief of mental health at the community-based outpatient clinics at the Washington, D.C., Veterans Affairs.

Suicides among members of the Armed Forces increased markedly beginning in 2005, two years into the war in Iraq, from about 11 per 100,000 to a peak of about 27 per 100,000 in 2012; it dropped below 22 per 100,000 in 2013.

Violence against others by returned service members has also been a source of concern, said Ritchie. In one well-known series of events in 2002 at Fort Bragg, N.C., two returning soldiers murdered their wives, and there were two cases of murder-suicides. Army investigators noted certain common elements: a rapid return from the war zone, marital infidelity, easy access to a gun in the home, and stigma against seeking mental health care.

In this case and others, the antimalarial drug mefloquine also has been hypothesized as a possible risk factor for violence and suicide among some service members, and it has been largely phased out by the Department of Defense, said Ritchie.

Overlapping risk factors characterize both suicides and homicides among military personnel, said Ritchie: perpetrators are mainly young and male; many experience pain from injuries or have been diagnosed with a traumatic brain injury or PTSD; relationship problems are a recurring theme, as are misuse of alcohol and the ready availability of weapons. Stigma—whether from a soldier's commanders, military peers, or self—is common.

"Multiple individual, unit, and community factors appear to increase risk of suicidal or violent behavior," said Ritchie.

The Army is attempting to reduce population-based risk by decreasing stigma, substance abuse, family problems, and untreated behavioral health issues, she said.

Overall, reducing violence in any segment of American society must be a joint effort, said Benjamin.

"We have to figure out how we address these barriers and work in a more collaborative way, not just with the health system but across the social services system and the criminal justice system," he said. PN

NPD

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In contrast to BPD, NPD can be seen as characterized by a superficially unified identity, created as an attempt to escape from the distress of internal fragmentation. However, this Self-structure does not provide the integrated experience of self and others provided by normal identity formation. Rather, the sense of self in NPD is based on the individual's attribution to the self of all characteristics and affect states that are desirable and good, while relegating to others all that is devalued. This pathogenic Self-structure, referred to as the "grandiose self," protects the individual from the distress of internal fragmentation but at the expense of a superficial and fragile self-concept based on needing to be exceptional and associated with difficulty establishing mutual relations with others. Whenever the individual experiences something that could become a building block of the self—an interest, an idea—aggressive and critical elements in the person's mind attack it as not good enough, interfering with the individual capacity to take in anything of value. Thus the grandiose self provides some degree of stability but at the expense of stasis and internal emptiness. It is as though the individual has developed a personal narrative that absorbs all that is good but does not correspond to human emotional complexity or to the reality of life.

The therapist encountering the NPD patient can keep this view of the patient's psychological structure in mind, as a way to empathize with the patient and to think about how to organize clinical intervention. These treatment considerations will be the subject of the next Psychotherapy in Psychiatry column. PN

References for this article are posted at http://psychnews.psychiatryonline.org/doi/full/10.1176/appi.pn.2016.4a13.

Acupuncture

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fellow of health sciences at the University of York in England and acupuncturist, carried out a large randomized trial comparing acupuncture with other structured therapies like counseling.

The results of this trial suggested that incorporating regular sessions of either acupuncture or humanistic counseling, which aims to help people realize their potential and creativity, improved depressive symptoms in the participants after 12 months when compared with usual care alone (medication or psychiatric referral), with the two approaches showing similar improvement levels.

"Acupuncture and counseling were also both cost-effective when considering improvements in the patients' quality of life in relation to the extra costs," MacPherson said.

As Yeung pointed out, since the publication of the APA practice guideline and Cochrane review years ago, there has been growing recognition that activities such as yoga, meditation, and acupuncture can provide some psychological benefits with a minimal side effects.

"More and more psychiatrists may find their patients asking about acupuncture or related natural therapies, so they should be aware of both the potential limitations and costs involved," Yeung told *Psychiatric News*. PN

An abstract of "The Benefit of Combined Acupuncture and Antidepressant Medication for Depression: A Systematic Review and Meta-Analysis" is posted at http://www.jad-journal.com/article/S0165-0327(15)00052-X/abstract. "Cost-Effectiveness Analysis of Acupuncture, Counselling, and Usual Care in Treating Patients With Depression: The Results of the ACUDep Trial" is posted at http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0113726.

Journal Digest

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Experimental Drug May Improve Brain Repair Following TBI

Following a traumatic brain injury (TBI), immune cells converge at the trauma site to initiate healing, but their activity can also trigger unwanted inflammation that can lead to further neurological damage.

Researchers at the University of Kentucky have been testing a novel compound called MW151 that can reduce the levels of specific pro-inflammatory chemicals called cytokines while preserving other immune functions.

A previous study by Linda Van Eldik, Ph.D., and colleagues found that post-injury administration of MW151 suppressed acute cytokine up-regulation and downstream cognitive impairment in an animal model of mild TBI.

In the current study, Van Eldik's group found that low-dose administration of MW151 suppressed levels of the cytokine interleukin-1 beta (IL-1β) while not affecting the migration or activity of microglial cells that clear out cellular debris in a different animal model of TBI called midline fluid percussion injury. The findings appeared in *PLoS One*.

"TBI represents a major unmet medical need, as there is currently no effective therapy to prevent the increased risk of dementia and other neurologic complications, such as posttraumatic epilepsy, neuropsychiatric disorders, and postconcussive symptoms such as headaches, sleep disturbances, memory problems, dizziness, and irritability," Van Eldik said in a press statement.

Bachstetter A, Zhou Z, Rowe R et al. MW151 Inhibited IL-1β Levels After Traumatic Brain Injury With No Effect on Microglia Physiological Responses. *PLoS One*. 2016;11(2): e0149451. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4752278/

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Anxiety Disorders Linked With Altered Perception of Stimuli

When it comes to emotional experiences, people with anxiety tend to overgeneralize, according to a report in *Current Biology*.

A research team in Israel trained a group of people with and without generalized anxiety disorder (GAD) to associate a distinct tone with one of three outcomes: monetary loss, gain, or no consequence. Following this training, the researchers presented the participants with a new set of tones (the three original plus six of similar frequency to both the loss and gain tones) to the participants and asked if any of them sounded familiar.

Compared with controls, patients with GAD were much more likely to overgeneralize, or mistake a new tone for one of the ones they heard in training, with a slightly higher rate of error for tones associated with loss.

Subsequent imaging analysis showed that the GAD patients had different levels of brain activation during the training phase of the study, and some of this activity persisted even after the training was complete.

"We show that in patients with anxiety, emotional experience induces plasticity in brain circuits that lasts after the experience is over," senior author Rony Paz, Ph.D., of the Weizmann Institute of Science in Israel said in a press statement. "Such plastic changes occur in primary circuits that later mediate the response to new stimuli, resulting in an inability to discriminate between the originally experienced stimulus and a new similar experience. ... Importantly, they cannot control this." PN

Laufer O, Israeli D, Paz R. Behavioral and Neural Mechanisms of Overgeneralization in Anxiety. *Curr Biol*. Mar 2, 2016. [Epub ahead of print] http://www.cell.com/current-biology/abstract/S0960-9822(16)00073-7