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Psychiatrists Critical In Screening, Treatment of Alcohol Use Disorder

SEAN LYNCH, M.D., AND JEREMY KIDD, M.D.

SEE STORY ON PAGE 23

Advanced Gene Sequencing Study Recognized by *AJP* Editors

Employing an emerging tool known as single-nucleus sequencing, researchers collected gene expression data from over 400,000 brain cells to better understand how PTSD and depression differentially affect the brain's stress response. ***BY NICK ZAGORSKI***

The American Journal of Psychiatry (AJP) has long been a place where readers could find the top research on the pharmacology, neurobiology, genetics, and epidemiology of mental illness. In recent years, *AJP* has made a concerted effort to also be a hub for cutting-edge neuroscience that will guide the future of psychiatric care. An *AJP* report showcasing a technique known as single-nucleus RNA sequencing was named by the journal's editorial board as one of *AJP*'s "2023 Articles of Import and Impact."

Single-nucleus RNA sequencing (snRNAseq) allows researchers to study the gene expression of individual cells in complex tissue, such as in the human brain, where neurons and supporting cells are tightly intertwined. Rather than trying to separate brain cells, snRNAseq pops them open and collects the individual nuclei that house the

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PERIODICALS: TIME SENSITIVE MATERIALS

PSYCHIATRIC NEWS

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AMERICAN PSYCHIATRIC ASSOCIATION

FROM THE PRESIDENT

Celebrating the "B" in "DEIBA"

BY PETROS LEVOUNIS, M.D., M.A.

National Black History Month is an opportunity for us to collectively celebrate and reflect on the essential role that Black and African Americans have played in the history of our nation. Mental health care and, in particular, the profession of psychiatry have benefited from the contributions of luminaries like Solomon Carter Fuller, M.D., Chester Pierce, M.D., Clotilde Bowen, M.D., Bebe Moore Campbell, and many others whose lives and work have raised awareness of mental health and have advanced our field. Without their contributions, psychiatry would be decades behind where we are now.

As we celebrate their legacy and accomplishments, we reflect on the fact that equity is not shared by all Americans today and that there is still a great deal of progress and growth to be made. By embracing the principles of Diversity, Equity, Inclusion, Belonging, and Anti-racism (DEIBA), psychiatry is strong and maximizes our impact on the mental health of our nation.

APA is committed to fostering and growing diversity in the psychiatric workforce and investing in cultural competency for psychiatrists. For the past 50

years, through our SAMHSA Minority Fellowship Program, APA and the APA Foundation have not only contributed to workforce diversity but also developed educational and experiential opportunities to enhance cultural competency. Americans make up a broad tapestry of cultural heritage, and having a workforce that reflects that diversity—and can relate to it—is powerful. Importantly, culturally competent care makes patients feel that their concerns are being heard, understood, and taken to heart, and at the same time also results in well-documented positive health outcomes.

This is part of the reason that "belonging" was recently added as a core component of the DEIBA journey at APA. As psychiatrists, we know the healing effect of making a patient feel seen and heard. Patients who know that their psychiatrist is invested in their well-being is far more likely to keep up with their treatment and seek help if they need it. People who experience the authenticity of belonging trust us and work with us to achieve great medical outcomes.

Similarly, we make our trainees, medical students, and even undergraduate aspiring doctors from diverse racial and cultural backgrounds feel that there is a place for them in our profession and association. Even more importantly, we embrace the bidirectionality of cultural humility toward a true sense of belonging for all. The Future Leaders in Psychiatry Program (FLIPP), a new program introduced by APA's Division of Diversity and Health Equity, is one example of the work that APA does to invite college students from different cultural backgrounds, expose them to the rewards and challenges of psychiatry, and provide them with mentorship from leaders in our field. Engaging with students at this early stage in their careers builds mentor/mentee relationships that last for years.

Our Association is stronger when all voices are heard at APA as well. APA's minority/underrepresented caucuses are some of the most active and involved in the Association, and their exceptional work often translates into invaluable resources that we share with our patients, the public, and our partners in the House of Medicine. When members from different backgrounds truly "belong" in APA and come together to speak with one voice on behalf of psychiatry, people listen. **PN**

IN THIS ISSUE

DEPARTMENTS

A New Chapter in *Psychiatric News*: Embracing the Perfectly Imperfect

Adrian Preda, M.D., assumes the post of editor in chief of Psychiatric News *with this issue. He is a professor of clinical psychiatry and human behavior at the University of California, Irvine, School of Medicine, and his areas of interest include schizophrenia and other psychotic disorders, cognitive disorders, and clinical trials.* **BY ADRIAN PREDA, M.D.**

As the newly appointed editor in chief of *Psychiatric News,* I am excited to embark on this journey, one that resonates deeply with my personal and professional paths.

My passion for psychiatry was ignited during my medical school years in Romania, a time of profound transition soon after the fall of communism. This period taught me about the importance of resilience and adaptability, qualities that have been instrumental in my career. To date, I have spent half of my life in Romania and the other half in the United States where I trained and now practice as an academic psychiatrist.

Some of you know me through my scientific publications, some through my blog posts on VeryWell Mind or *Psychology Today*, some as a clinician practicing both psychopharmacology and psychotherapy, some as an educator and a mentor. Through this multitude of roles, I have continually found that psychiatry is an evolving journey—much like life itself. The inherent imperfection in our field, stemming from its complex and dynamic subject matter—the human mind and mental disorders—is not a weakness but a source of constant regeneration. This perspective will be the cornerstone of my tenure at *Psychiatric News.*

Looking ahead, I aim to foster a platform that celebrates diversity in thoughts and experiences, driving innovation and inclusivity in our discourse. *Psychiatric News* aims to be a forward-thinking and dynamic platform in the realm of not only mental disorders but also mental health and well-being. Our goal is to not only inform but also inspire, educate, advocate, and foster community within and beyond the field of psychiatry.

I am particularly enthusiastic about introducing digital innovations, focusing on underrepresented areas in psychiatry, and enhancing community engagement. Your voices and insights are invaluable to this vision, and I invite you to join me in shaping the future of our publication.

Together, we will navigate the ever-evolving landscape of psychiatry, embracing its imperfections and challenges as opportunities for discovery and growth. I look forward to this journey with you, our readers, as we continue to explore the depths and breadths of the human mind. I welcome your engagement and comments at apreda@psych.org. **PN**

Work Group Develops New Resources to Support IMG Members

A new APA resource guide provides vital information for international medical graduates (IMGs) before, during, and after residency, and a free initial immigration attorney consultation service launched this year connects IMG members to immigration lawyers. **BY KATIE O'CONNOR**

International medical graduates (IMGs) play an important role in the field of psychiatry. Those residing in the United States often work in the public sector and are more likely to accept Medicaid and Medicare. They are also more likely to work in medically underserved and health professional shortage areas.

The long path to becoming a psychiatrist in this country is not easy for IMGs, however. They face unique challenges, and studies show that their numbers within the psychiatric workforce may be dwindling in the United States. National Resident Matching Program data indicate that the overall number of IMGs entering psychiatry training as a PGY-1 declined from approximately 30% in 2013 to 16.1% in 2023. To help support APA's IMG members, the Joint Reference Committee created an IMG work group that had its first meeting in May 2022. The work group was charged with developing an action plan to address the unique needs of IMG members.

Composed of IMGs who attended medical schools around the world, the work group has been working diligently to develop a robust array of recommendations and actions that APA can take to address the numerous challenges IMGs experience while also raising awareness about the benefits they bring to psychiatry in this country. The work group was initially co-chaired by Vishal Madaan, M.D., APA's chief of education, and Daniel Castellanos, M.D., founding associate dean of graduate medical education at Creighton University School of Medicine-Phoenix. It was later co-chaired by Castellanos and Raman Marwaha, M.D., president of the IMG Caucus.

The needs of IMGs are numerous, multifaceted, and change throughout their careers, said Daniel Castellanos, M.D.

Marwaha noted the significant need to ensure IMGs thrive in the United States. Not only do they increase the diversity of the psychiatric workforce, but also they can play a hugely important role in filling significant workforce gaps, he pointed out.

"We all know there is a big workforce shortage right now," said Marwaha. "We need more psychiatrists, and especially more subspecialty psychiatrists. Yet we have a lot of excellent IMGs who are going unmatched year after year."

The work group focused specifically on IMGs working in the United States, regardless of their country of origin, from residency through seven years after medical school. The group outlined actions that APA could take in a nearly 70-page report for the Joint Reference Committee based on the results of a survey the work group conducted; more than 800 IMG members responded. Among the topics identified, IMGs expressed their need for assistance navigating the residency application process, access to mentorship opportunities, and support with the immigration and visa process.

Based on the results of the survey, the work group set out to develop a robust and far-reaching resource guide, which is available on APA's website. The resource guide includes detailed information tailored for IMGs. Its topics range from a list of observerships and clerkships in psychiatry for pre-residency IMGs to information on paths to career development in the United States for early career IMGs.

"The work group worked on this resource guide as a tangible, practical solution to help address issues ranging from observership opportunities to immigration and acculturation," said Madaan, who is also an APA deputy medical director. "We will review the resource guide on an annual basis to make sure it stays updated with the latest information IMGs need."

IMGs can play an essential role in addressing the ongoing psychiatric workforce shortage in the United States, said Raman Marwaha, M.D.

In addition, the APA medical student membership category is being expanded to include all medical school

see **IMG Members** *on page 4*

APA Board of Trustees Approves Practice Guideline For Borderline Personality Disorder

The Board also approved APA's 2024 operating budget and discussed in executive session the selection of a new APA CEO/medical director. **BY MARK MORAN**

APA's Board of Trustees approved a practice guideline on "Treating Patients with Borderline Personality Disorder" during its meeting this past December in Washington, D.C.

The guideline, written by APA's Guideline Writing Group on Borderline Personality Disorder and chaired by George Keepers, M.D., was reviewed and approved by the Assembly last November. Input on the guideline was included from the Council on Quality Care and other APA councils, as well as national and international professional and patient groups interested in the care of people with borderline personality disorder.

APA practice guidelines provide evidence-based recommendations for the assessment and treatment of people with psychiatric disorders and are intended to assist in clinical decision-making by presenting systematically developed patient care strategies in a standardized format. Borderline personality disorder is characterized in *DSM-5-TR* as being associated with a long-term pattern of instability of interpersonal relationships, unstable self-image, marked impulsivity, and/or affective instability that occurs across a broad range of personal and social situations. (Detailed information about the guideline will appear in a future issue.)

The approval of the practice guideline was one item on a packed agenda that included the selection (during executive session) of a new CEO and medical director to succeed outgoing CEO and Medical Director Saul Levin, M.D., M.P.A. The name of the individual will be announced after a contract has been finalized.

Also importantly, the Board received an update about PsychPRO, APA's clinical registry, from APA Director of Research Nitin Gogtay, M.D. He said in order to continue to build and expand PsychPRO, the registry will use multiple technology vendors to address its specific functional requirements. Until now, PsychPRO has utilized a single vendor for all functions, but this has placed limits on its growth. The goal is for APA to eventually administer the registry in house.

The Board discussed and approved the 2024 budget proposed by the Finance and Budget Committee for APA and for the APA Foundation. APA Treasurer Richard Summers, M.D., said APA's balance sheet is strong, with unrestricted net assets totaling $71.3 million as of October 2023, but revenue from meetings and book sales were down while expenses due to inflation were significantly up in 2023 and expected to continue into 2024. Trustees also voted to modify the APA budgeting process to allow for the Finance and Budget Committee to present a preliminary budget to the Board at its October meeting for its input on strategic initiatives and the final budget at its December meeting. At the end of 2023, a budget shortfall required a reduction in force of 21 APA staff positions, including 10 APA employees and 11 vacant positions. The 2024 budget, which went into effect on January 1, reflects this reduction in force.

Medicare Update

In his medical director's report, APA CEO and Medical Director Saul Levin, M.D., M.P.A., noted that although payment rates under the 2024 Medicare Physician Fee Schedule are 1.25% less than the 2023 rates, the Centers for Medicare and Medicaid Services (CMS) included an increase in reimbursement for the psychotherapy standalone codes and psychotherapy with evaluation and management (E/M) service codes (see *Psychiatric News,* https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2023.12.12.43.) Initially, CMS had included a bump only for the standalone codes, but after discussions with CMS, APA was successful in securing the increase to include psychotherapy and E/M, Levin told the Board.

Also included in the 2024 fee schedule are telehealth provisions for which APA had advocated. These include reimbursement for outpatient telepsychiatry in the patient's home at the

see **Trustees** *on page 13*

APA Podcast 'Finding Our Voice' To Return Next Month

APA Publishing's podcast for residents and early career psychiatrists, "Finding Our Voice," will return next month with the first of a series of four podcasts focused on the subject of thriving in training. The series, hosted by Sanya Virani, M.D., M.P.H., will draw its inspiration from the 2023 book *The Psychiatry Resident Handbook* edited by Sallie G. De Golia, M.D., and Raziya Wang, M.D., and published by APA Publishing.

Virani is co-creator and host of "Finding Our Voice," which launched in 2021 when she was APA's resident-fellow member trustee-elect. She is an assistant professor in the Department of Psychiatry and associate program director of the Addiction Psychiatry Fellowship at the University of Massachusetts Chan Medical School. She is also a former APA Assembly Area 2 resident-fellow member (RFM) representative.

Across four new monthly episodes, Virani and her guests will explore many aspects of training. The first in the series will drop on March 1, with guests De Golia and Wang and early career psychiatrist Csilla Lippert, M.D. Among the topics they will discuss are ways in which psychiatry's residency is different from that of other medical specialties, seeking a mentor, and differing experiences of supervision.

The second podcast, dropping on April 1, will feature Virani talking with Alka Mathur, M.D., a clinical associate professor on the affiliate faculty line at Stanford University, and Neal Amin, M.D., Ph.D., a clinical assistant professor at Stanford, both of whom contributed to the handbook's chapter on telepsychiatry. They will discuss their perspectives on the pros and cons of moving to a remote, digital workspace; COVID-19's acceleration of society's transition to reliance on video screens; and the challenges posed by new technology, including AI.

The third and fourth podcasts, dropping May 1 and June 1, will explore the topics of physician impairment and burnout, health, and wellness. **PN**

"Finding Our Voice" can be accessed on podcast services and at https://psychiatryonline.org/finding-our-voice.

IMG Members

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graduates who don't immediately qualify for the resident-fellow membership category and haven't matched into another specialty.

Further, at the work group's recommendation, APA has implemented a free initial immigration attorney consultation service for IMG members. Through the service, IMGs have access to one free 30- to 45-minute consultation with an immigration attorney who can provide them with advice related to their visa or residency status.

Ensuring IMGs receive support from APA related to their visa or immigration status is an important aspect of supporting their overall well-being, Castellanos said. "People need this extra support," he said. "It's not just a person's physical and emotional health that plays into their well-being. If they have immigration insecurities, that's going to play into everything they do and impact them personally, professionaly, and financially."

In the effort to meet IMGs' need for greater connection, Marwaha noted that the IMG Caucus has started hosting webinars, the most recent of which was on residency applications and interviewing. "We did live mock interviews and had an amazing panel of program directors who gave advice," he said. The caucus plans to do more of those webinars, with topics ranging from research opportunities to ways to engage in advocacy.

IMGs add a lot of value to both APA and psychiatry as a field, Madaan said. "They represent very diverse perspectives," he said. "They've successfully navigated extremely challenging hurdles and life experiences and often bring with them a great deal of resilience to their training programs and workplaces. This is a unique strength and an exemplary trait that easily extends to patient care and well-being." **PN**

"IMGs in the U.S. have dual learning curves since they navigate immigration issues and acculturation along with clinical learning," said Vishal Madaan, M.D. APA's new free initial consultation with an immigration attorney "provides them an opportunity to get an informed response and guidance on personal immigration issues within seven days of their query."

The IMG resource guide is posted at https://www.psychiatry.org/psychiatrists/international/international-medical-graduates-resources.

APA Foundation Launches 'Where We Play' Initiative For Student Athletes

The new program supports the mental wellness of athletes, entertainers, and influencers. **BY ABIGAIL PALAZZO**

Kathleen Crapanzano, M.D., M.A.C.M., said that the mental health concerns of athletes should be addressed as early as possible to help achieve better outcomes as well as help them achieve their professional goals.

The APA Foundation (APAF) officially launched its new "Where We Play" initiative in Baton Rouge, La., last November in response to growing calls from U.S. Surgeon General Vivek Murthy, M.D., for more concerted action to combat the mental health crisis among youth and young adults. "Where We Play" encourages artists, athletes, entertainers, and their followers to see sports figures and performing artists as human beings who can excel in their chosen field while also taking care of their mental health needs. The Baton Rouge program is just the first of a series that will be held throughout the country.

APAF collaborated with APA member Kathleen Crapanzano, M.D., M.A.C.M., a professor of psychiatry and director of the psychiatry residency program at LSU School of Medicine in Baton Rouge, and partnered with Athletes for Hope (AFH). AFH is a nonprofit founded by world-class professional athletes who strive to make a social impact at the intersection of sports and philanthropy.

To hear firsthand from athletes about their mental health needs and to spread the message that mental health care works, APAF brought together current and former collegiate athletes, coaches, physicians, health care administrators, state and local policymakers, and community leaders.

Also attending were Louisiana state Sen. Cleo Fields; former Louisiana Health Department Secretary Courtney N. Phillps, Ph.D.; former Louisiana Department of Environment Quality Secretary and former NFL player Chuck Carr Brown, Ph.D.; and Women's Hospital CEO Emeritus Teri G. Fontenot. Topics of discussion included burnout, performance anxiety, and the effects of social media. The task of balancing high-demand athletics while attending college full time is a serious time commitment that may negatively impact a student athlete's mental health.

APAF Executive Director Rawle Andrews Jr., Esq., introduced the APAF's "Mental Health Care Works" campaign to the attendees, whose goal is to help change the culture around seeking treatment for mental illness and substance use disorders. He encouraged student athletes to take the first step in seeking help for mental health concerns before they interfere with other aspects of their lives.

In her keynote address, Crapanzano remarked: "Our society should support access to mental health care and develop policies that support mental health for all people. For college athletes in particular, addressing mental health concerns as early as possible

see **Student Athletes** *on page 6*

Abigail Palazzo is a communications specialist in APA's Division of Communications.

APA'S GOVERNMENT, POLICY, AND ADVOCACY UPDATE

APA Signs On to Coalition Letter on Parity in Medicaid, CHIP

The Child and Adolescent Mental Health Coalition sent a letter sharing suggestions on how the Centers for Medicare and Medicaid Services (CMS) could improve compliance with mental health parity in both Medicaid and the Children's Health Insurance Program (CHIP). The letter was sent to Daniel Tsai, the deputy administrator and director of the Center for Medicaid and CHIP Services.

"Now more than ever, families and children from infancy through adolescence need access to mental health screening, diagnostics, and a full array of evidence-based therapeutic services to appropriately address their mental and behavioral health needs," the letter stated. "Improving parity in Medicaid and CHIP is essential to addressing this need by supporting access to pediatric mental and behavioral health care."

The letter outlined numerous recommendations to improve Medicaid and CHIP plans' compliance with federal parity requirements, including aligning parity enforcement requirements for commercial payers with those for Medicaid and CHIP; taking advantage of existing and new data sources; and ensuring transparency.

In addition to APA, the Child and Adolescent Mental Health Coalition comprises 17 organizations, including the American Academy of Child and Adolescent Psychiatry and the American Academy of Pediatrics.

APA's letter is posted at http://APAPsy.ch/CAMH-letter.

APA, Partners Meet With Officials to Discuss Menthol Cigarette Ban

In early December, APA and its partner medical societies met with representatives from the Office of Information and Regulatory Affairs in the Office of Management and Budget, the Food and Drug Administration (FDA), and the Department of Health and Human Services. APA and its partners expressed their support for the FDA's proposed menthol cigarette and flavored cigar ban.

During the meeting, APA shared data on the health impact that menthol cigarettes have on youth and adolescents. Also shared were data on the link between nicotine use and the increased risk for current and future addiction to other drugs. APA is requesting swift action to finalize the rules to ban menthol cigarettes and flavored cigars, which were originally proposed in April 2022.

The letter is posted at http://APAPsy.ch/menthol-ban.

APA Responds to Proposed Rule on Information Blocking

APA sent a letter to the Office of the National Coordinator for Health Information Technology and CMS urging caution in implementing a proposed rule that would levy financial disincentives on clinicians who are considered to be guilty of information blocking. Information blocking refers to practices that are likely to interfere with the access, exchange, or use of electronic health information, except as required by law. As required under the 21st Century Cures Act, the agencies have proposed a rule to establish an information-blocking disincentive program for health care professionals to encourage them to share health information.

APA encouraged the federal agencies to start by supporting psychiatrists in acquiring, implementing, and using technology to share data rather than to begin by penalizing those who may not have the resources and information to comply with information-blocking restrictions. Disincentives would be implemented through Medicare value-based payment programs, and APA expressed its concern that this rule, as proposed, would decrease Medicare participation among psychiatrists and reduce access to care.

APA's letter is posted at http://APAPsy.ch/information-blocking-letter.

APA Opposes D.C. Bill to Change Board of Medicine Composition

Legislation in Washington, D.C., is under consideration to change the composition of the district's Board of Medicine, authorizing nonphysicians to oversee and regulate physicians. In early December, APA submitted written testimony by APA's CEO and Medical Director Saul Levin, M.D., M.P.A., to the D.C. Council's Committee on Health, urging the committee to oppose the bill.

D.C.'s Board of Medicine is currently composed of 10 physicians and four members of the public. The bill would reduce the number of physicians to six and add two physician assistants, one chiropractor, one podiatrist, and one acupuncturist. In addition, several nonphysician occupations (chiropractors and podiatrists) will move under the Board's purview. The bill's language makes sweeping changes to patient safety requirements and would authorize nonphysicians such as nurse practitioners and pharmacists to practice without physician supervision. **PN**

Inside Military's Only Inpatient Unit For Adolescent Behavioral Health

Reese Brown

The medical center at Virginia's Fort Belvoir, which opened in 2017, hopes to set a new precedent in military health care by providing inpatient mental health services to children of soldiers. **BY NICK ZAGORSKI**

What is the U.S. military's best kept secret? If you ask Army psychiatrist Keith Penska, M.D., it's at the Alexander T. Augusta Military Medical Center, located right outside Washington, D.C. It's at this center that one can find the Department of Defense's only adolescent inpatient behavioral health unit. At the annual meeting of the American Academy of Child and Adolescent Psychiatry, Penska and colleagues discussed the unit, which opened in 2017.

Much of military health services focuses on "getting soldiers back to combat readiness as soon as possible," explained Keith Denneny, N.P., D.N.P., who oversees the nursing staff at the unit. Part of that readiness includes soldiers knowing that their families have the support they need to maintain good health. (The military community includes about 1.6 million family members of active-duty personnel.)

That was one of the lines of argument Penska made during his pitch to hospital administrators for an inpatient psychiatric unit for youth several years back. At the time, the Alexander T. Augusta Military Medical Center already offered outpatient psychiatric care for children, including a four-week intensive outpatient program (where adolescents spend several hours each day at the medical center but go home each afternoon).

"With an inpatient unit, we could click on all cylinders," he said, noting that clinicians could seamlessly adjust the intensity of behavioral health care for adolescent patients without transferring them off site.

Penska also made the case for the educational opportunities that an inpatient unit could offer to medical residents in pediatrics and other specialties. And it helped that there was move-in ready space at the hospital, as the inpatient substance use disorder (SUD) unit had recently moved to a different floor.

The lobbying efforts worked, and on February 10, 2017, the medical center opened its Adolescent Inpatient Behavioral Health Unit. The unit started with six beds, though it ramped up to 11 beds and a team of 42, including two psychiatrists and a team of educators, social workers, therapists, nurses, and behavioral health technicians. Following the COVID-19 pandemic, the number of beds dropped to eight due to staffing shortages.

The unit serves youth aged 12 to 18 (18-year-olds must still be in high school) and treats youth presenting with most psychiatric issues, with the exception of severe eating disorders and primary substance use disorders.

In addition to treating patients via medications, psychotherapy, and family therapy, the staff help the adolescents stay up to date with their schoolwork and offer a range of recreational activities.

"With our patients, downtime is danger time," Penska said. "We have art therapy, we bring in animals that they play with, we have visits from the chaplin, and more; we are always looking for fresh ideas."

Penska said that admissions have risen continually since the opening of the center, rising from 155 patients in 2018 (its first full year) to 189 in 2022. The most common reasons for admission include psychosis, depression accompanied by suicidal ideation, and severe adjustment disorders, he said.

Any child of an active-duty servicemember or retiree is eligible for services at the inpatient center, though patients primarily arrive from the surrounding Washington metropolitan region. Penska said the unit has on occasion treated youth transferred from locations abroad.

For instance, he noted, "Guam doesn't have a single inpatient psychiatric facility on the whole island." In these situations, the family typically cannot go back as their home location does not have adequate psychiatry facilities for the youth. "The family has to accept a reassignment, which can lead to some difficult conversations."

The average length of stay for youth seen at Fort Belvoir's Adolescent Inpatient Behavioral Health Service unit is about 12 days, Penska said, which he noted is longer than at civilian inpatient units.

Before youth are discharged from the hospital, they are required to have a confirmed follow-up appointment with their primary care physician and an established aftercare plan (for example, securing a spot in an intensive outpatient program or residential treatment facility).

Penska noted that 30-day readmission rates for patients seen in the unit have been consistently about 4% to 5% across the first five years, which is lower than national averages for youth.

"It could be partially due to the military population being slightly healthier on average and that all our patients have established health care," he said. "But I think the longer stays and focus on aftercare contribute significantly." **PN**

Student Athletes

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will lead to better outcomes and help them achieve their professional goals."

AFH ambassadors included Ali Newland, an LSU softball player; Deja Griffin, a soccer player for Southern University; Katie Dickens, a professional beach volleyball player, coach, and former player at LSU; and Janice Miller, a mental health advocate and the mother of Arlana Miller, a former Southern University cheerleader who died by suicide in May 2022.

During the event, student athlete Deja Griffin shared her story of recovering from an injury as a college athlete. As a freshman at Southern University, Griffin was injured and unable to play soccer for the next two seasons. Not only did she struggle to maintain her mental health in the aftermath of her injury, she considered dropping out of school, which meant the loss of structure provided by teammates, practices, and games to motivate her.

Jaleel Green, M.D., a second-year psychiatry resident at Louisiana State University and former college football player, offered the following advice to student athletes: "The one message they should take away is that they should begin to develop a sense of identity outside of their respective sport. Whether their athletic career is over after college or they play professionally, the transition to post-career is extremely difficult without having an identity outside of the sport."

Last month, APAF hosted a "Where We Play" event at Belmont University in Nashville, Tenn., featuring world champion swimmer Allison Schmitt and Nigerian-born Christian pop and gospel singer Blessing Offor.

Look out for more "Where We Play" events in the coming year and learn more about the initiative's accomplishments at https://apafdn.org/whereweplay. **PN**

Medical Student–Run Clinic Supports Those Seeking Asylum

Students at New York Medical College operate the Center for Human Rights, which connects individuals seeking asylum with physicians who provide medical evaluations. For some students, the work has inspired them to pursue psychiatry. **BY KATIE O'CONNOR**

During her most recent medical evaluation of an individual seeking asylum in the United States, Rebecca Martin, M.D., conducted the interview while the client was waiting for a bus. "It was running late," Martin said. "We were really worried we were going to miss our window and not be able to do the evaluation and then have to reschedule the whole thing with the eight people who were involved."

But luckily Martin was able to conduct the evaluation, thanks in no small part to the diligent efforts of the students who run the Center for Human Rights at New York Medical College (NYMC). Martin is the center's faculty advisor and clinical associate professor and palliative medicine consultant at Westchester Medical Center, a hospital affiliated with NYMC.

The NYMC Center for Human Rights is one of 19 Physicians for Human Rights programs across the country. Physicians for Human Rights is a nonprofit organization that advocates for human rights through medicine and science. The Center for Human Rights is entirely run by students who help physicians like Martin conduct pro-bono forensic psychological and medical evaluations for people seeking asylum, as well as for those who are victims of sex and labor trafficking.

These student-run programs were largely started in direct response to the migrant crisis in New York City and elsewhere across the country, explained Rahim Hirani, a third-year medical student at NYMC. Hirani and Kavya Tangella, a second-year medical student at NYMC, are executive directors of the center, which began in 2017.

Sarah El Halabi, M.D., M.S., APA's resident-fellow member trustee-elect, learned about the center during grand rounds and was inspired. She is a PGY-3 at Westchester Medical Center. "Hearing how these students are trying to be helpful to people who have absolutely no resources was immediately moving to me as a citizen of the world," she said.

Medical students Rahim Hirani (left) and Kavya Tangella (right) are executive directors of the Center for Human Rights at New York Medical College. They are among the students who keep the center running and support medical and psychological evaluations that Rebecca Martin, M.D. (center), and others conduct for people seeking asylum.

Students Devote Time to Connecting Asylum Seekers, Physicians

Martin emphasized the vital role that the students play in the center's operations. "There is no way that I, as a physician evaluator, could do this if it was not without the support of the students," she said.

The students are responsible for administrative tasks and coordinating times with lawyers, physicians, and asylum seekers whose schedules may rarely overlap. When organizations or lawyers reach out to the center seeking an evaluation, the students search their network for an available physician who can conduct the interview within the timeline, which is usually dictated by court hearings.

The students sit in on the evaluations, learning from the physicians how best to conduct such interviews while taking diligent notes. They then write up affidavits (sometimes as long as 10 single-spaced pages, Martin said) and work with the physician to edit them.

The evaluations are designed to corroborate the client's claims of persecution and abuse, which helps them to secure asylum in the United States. They involve learning about clients' social,

see **Asylum** *on page 10*

From left: Sarah El Halabi, M.D., M.S., and Kate Morant, M.D., are photographed at APA's 2023 Annual Meeting in San Francisco. Morant and colleagues will present at APA's 2024 meeting on the student-run Center for Human Rights and how participation in such programs may encourage students to pursue psychiatry.

Medical Student Advocacy for Addiction Training Brings Results at Emory University

A group of medical students who felt their curriculum lacked adequate training on substance use disorders took matters into their own hands. ***BY CAROLINE CHIVILY, M.P.H., KAITLIN COLE, ALISON MARTIN, REBECCA DURHAM, AND JUSTINE W. WELSH, M.D.***

Despite the rising number of overdose deaths and an estimated 17.3% of people aged 12 or older meeting criteria for substance use disorders (SUDs) in 2022, many medical education curricula lack fundamental teachings to prepare future physicians to properly treat and counsel patients with SUDs and to change the clinical climate surrounding substance use. Our team of medical students sought to increase education in addiction psychiatry/medicine and harm reduction in our medical school curriculum at Emory University School of Medicine through a student-led advocacy initiative.

Our initial efforts focused on introducing medical students to important harm reduction principles from the beginning of their training. In the context of annual overdose deaths rising above 100,000 in 2022, we first added a student-led training on naloxone administration to reverse opioid overdose and naloxone co-prescription for first-year medical students. We also added content on counseling patients with or at risk of developing SUDs to a motivational interviewing session for first-year students. This included materials on screening for SUDs, guidelines for prescribing opioids, and a new case-based learning session about alcohol use disorder.

Given the complexity of SUDs and implications in virtually every field of medicine, we sought to integrate addiction psychiatry/medicine and harm reduction content throughout both the preclinical and clinical curricula. Collaboration with the pharmacology thread director has resulted in addiction-related content in nearly every course of the preclinical curriculum. To enhance the already existing reproductive health curriculum, our group created a series of handouts on substance use during pregnancy with plans to integrate this information into the OB-GYN clerkship. We are also collaborating with several clerkship directors to create a pediatric injury prevention workshop, facilitate outpatient addiction psychiatry opportunities, and distribute Alcoholics Anonymous and Narcotics Anonymous meeting schedules to students during their primary care rotations.

To adequately prepare future clinicians, medical school curricula must be constantly adapted to the evolving medical field in which they operate. Change can be slow when topics are stigmatized, as is the case for addiction. The well-established existence of biases among both students and health care professionals makes early career education crucial. At our institution, faculty have previously highlighted the need for more addiction-related content in the curricula of medical school and residency training programs; however, student-initiated advocacy was the catalyst to make many of those necessary changes.

Student advocacy may present with its own challenges, but it has the unique capacity to drive change. For this initiative, change was established through persistent lobbying for the inclusion of content to many faculty members and administrators over the

see **Addiction Training** *on page 11*

Caroline Chivily, M.P.H., Kaitlin Cole, Alison Martin, and Rebecca Durham are medical students at the Emory University School of Medicine. Justine W. Welsh, M.D., is an associate professor of psychiatry and behavioral sciences at Emory.

RESIDENTS' FORUM

There's an App for That? Digital MH Should Be Integrated Into Training

BY ELIZA DECROCE-MOVSON, M.D., AND GERMAN VELEZ, M.D.

As child and adolescent psychiatry fellows, we are often reminded of our work after our days are done. Even relaxing by watching a favorite reality television show makes us think of our training. A commercial may air for a mood medication that reminds us of the thorough education we've received from supervisors and mentors about prescribing, but we may also receive stark reminders of significant gaps in our medical training. Commercials advertising mobile apps designed to improve mood and sleep, for example, seem to run just as frequently as ads for medications approved by the Food and Drug Administration (FDA). Both medications and digital apps target similar symptoms and are marketed directly to consumers. Our patients could question us about either of these options during consultations, yet our training has prepared us to speak about only one of them.

There are options for practicing psychiatrists who need guidance on mental health apps, such as APA's App Advisor. But many residency and fellowship programs are missing a crucial opportunity to train the next generation of psychiatrists to guide their patients through the labyrinth of digital mental health care options available. It is time to commit to the development of curriculum, research, and advocacy to familiarize and train psychiatry residents and fellows to be competent in digital psychiatry.

Many children face barriers to accessing traditional therapy, including time and financial constraints, long waiting lists, and a scarcity of trained professionals. This significant need for care among youth underscores the urgency to explore innovative therapeutic options, including digital solutions like the apps patients see advertised on television. As health care professionals, recognizing and adapting to these evolving treatment modalities are crucial to providing comprehensive care.

The development of digital technologies is having a large impact on mental health care. Some are practical tools like medication reminders and symptom trackers. Others offer online consultations and advanced therapies like virtual reality and serious games (games that are designed to educate or change behaviors). The widespread use of smartphones makes app-based platforms a convenient treatment option

Eliza DeCroce-Movson, M.D., and German Velez, M.D., are child and adolescent psychiatry fellows at Weill Cornell Medicine and the Columbia College of Physicians and Surgeons Department of Psychiatry. Velez is also APA's resident-fellow member trustee.

for patients, regardless of their location or schedule. This was particularly important to many patients during the COVID-19 pandemic, when social distancing was essential. Despite advancements, the quality of digital mental health tools is varied. Some companies offer evidence-based therapies, while others present products that are less clearly so or are even ethically ambiguous.

For many physicians, the term "digital health" is synonymous with telemedicine or electronic medical records, rather than including therapeutic apps or comprehensive treatment services accessible via a phone. Patients expect their doctors to guide them through the digital mental health landscape, not realizing that the physicians might be as unfamiliar with it as they.

Today's trainees are in a prime position to address this challenge. We have grown up with technology and are generally more adept with it than our senior colleagues. Many of us have personal experiences with mental health apps. We have the opportunity to use our training to develop expertise in digital psychiatry, benefiting our patients and contributing to the field. For this to happen, residency and fellowship programs need to prioritize education in digital psychiatry. We require mentorship, exposure, and structured training to confidently recommend digital health solutions to our patients, just as we do with pharmaceutical and lifestyle recommendations.

This task is challenging, but vital. By embracing digital mental health in our academic training, we can better care for our patients and drive innovative change. If we fail to adapt, we risk being left behind in the rapidly evolving health care landscape. **PN**

More information on APA's App Advisor can be accessed at https://www.psychiatry.org/psychiatrists/practice/mental-health-apps/the-app-evaluation-model.

Post-Pandemic Psychiatric Education: Where Are We Now, Where Are We Headed?

Getty Images/iStock/Kateryna Onyshchuk

This article was written by APA's Task Force on the COVID-19 Pandemic of the Council on Medical Education and Lifelong Learning.

The COVID-19 pandemic rapidly transformed and disrupted every aspect of our society. We witnessed the pandemic's extraordinary impact on health care systems in general, and mental health care specifically, throughout the world. The education of medical students, residents, and fellows was seriously disrupted, leading to rapid accommodations that were reflexive and not fully understood in terms of the preparation of the workforce to care for patients and communities with growing mental health needs. Trainees and faculty continue to confront serious emotional, psychological, logistical, technical, and social challenges.

Undergraduate and Graduate Medical Education

We do not yet have a full accounting of the impact on the knowledge, skills, and professional development of medical students when schools were forced to shut down and most learning became virtual. One uniform observation, however, is how the overall level of clinical exposure, supervision, and feedback has been tangibly compromised due to multiple systemic factors during the pandemic.

Presumably, as the pandemic fades and medical education returns to a new equilibrium, newer generations of students may not suffer the same limitations on their clinical, psychological, and moral development as the current students in training. Those affected are a sort of "lost generation" who came into their professional identity during the pandemic. These trainees may feel insufficiently prepared to undertake the next stage of their medical career. For this particular group, it would be worthwhile to provide supplemental training opportunities in an optional and nonpunitive fashion in both undergraduate medical education (UME) and graduate medical education (GME) sectors. An optimal balance must be struck between an empathetic, compassionate attitude in medical education and the need for proper development of clinical competency and professionalism in our future generation of physicians.

An important step to highlight in the transition from UME to GME is recruitment. A big question is looming on how to best proceed, for both institutions and applicants, beyond academic year 2023-2024, which is another virtual recruitment cycle as per national organizations' recommendations.

During the pandemic, we observed the emergence of new curriculum content in residency education, such as pandemic- and disaster-related topics as well as telepsychiatry. In terms of curriculum delivery, a nuanced approach needs to be employed in determining whether to return to traditional learning methods, continue virtual learning, or adopt a hybrid model.

Diversity, Equity, and Inclusion

Throughout the pandemic, both trainees and faculty expressed moral concerns about health inequities becoming even greater than before, tethered to the growing public awareness of the social determinants of health and the ravages of "isms" and phobias (for example, racism, sexism, ageism, homophobia, and transphobia) on communities from which our patients come. Despite this, we have observed a disconcerting national trend over the past year in which the funding for diversity, equity, and inclusion programs is being cut in higher education and corporate America. Regardless of the political winds, it is imperative that we continue to promote diversity, equity, and inclusion in psychiatric education to nurture a conducive learning environment for all of our trainees and faculty.

Challenges involving the psychiatric training of international medical graduates (IMGs) must also be addressed, given how important IMGs are in delivering mental health care across the United States.

Wellness

Some of the universal stressors throughout the pandemic impacting every phase of psychiatric education included risk of illness/death due to exposure; isolation from social/professional support system; physical/mental/emotional exhaustion; and significant feelings of guilt, helplessness, hopelessness, cynicism, and injustice regarding "abandoning" disadvantaged patients without virtual access during a time of increased threat and loss. That last impact in particular may have resulted in moral injury and burnout that many trainees and faculty have experienced.

A silver lining of the pandemic is the raised awareness of the emotional and logistical toll experienced by health care workers who served during the public health crisis. This has translated into an increased focus and proactive stance by educational institutions toward addressing trainees' mental health. It is time for us to double down on this momentum in developing robust, sustainable wellness pathways for our trainees and faculty with appropriate support from our institutions.

Faculty Development

The transition from traditional learning to virtual learning has exposed generational differences in the ease and comfort with which each group has adopted the new modalities. Addressing the varying needs of both faculty and trainees requires time and thoughtful consideration. This highlights the glaring need for appropriate, dedicated educational time for our faculty and training directors now more than ever.

Workforce Development

A crucial area that needs attention is the psychiatric educator workforce. During the pandemic, we witnessed an alarming number of educators leaving academia, which underscores the need for recruitment and retention efforts. High-quality resources should be allocated to develop junior faculty. Instead of budding educators having to pay the institutions for professional development opportunities such as Master Teacher Programs, talented faculty should be actively recruited and provided with incentives (stipend, reduction in clinical requirements, professional mentoring, and so on).

Clinically, the pandemic greatly exacerbated mental health issues among children and the gap between the need for care and the availability of psychiatrists and mental health professionals who can care for them. The workforce shortage in this area is not new—despite the exponentially rising demands, there has not been a corresponding course correction in supply, which calls for our urgent attention.

Opportunities for Innovation

While it is understandable to keenly feel the losses we suffered in our education system, we would be remiss if we did not recognize and capitalize on the unexpected gains borne out of the pandemic-related changes. Prior to the pandemic, the innovations in psychiatric education occurred mostly on an incremental basis. The speed and uniformity with which we adopted virtual learning and telepsychiatry practice were unprecedented, demonstrating that we (and the systems in which we work) are indeed capable of paradigm-shifting innovations. We need to conduct a systematic evaluation of the education innovations implemented during the pandemic to ensure that they are indeed relevant and effective going forward.

Conclusion

Since March 2020, we have been training the next generation of psychiatrists in uncertain times within a rapidly evolving landscape, yet ultimately, our mission is the same—to prepare trainees to be clinically competent and aware of their strengths and areas that need improvement as part of their lifelong learning process. Our workforce in psychiatry has never been more important, and the cultivation of our trainees—as well as their teachers, supervisors, and mentors—is paramount. Managing the lingering impacts of this pandemic will require considerable information, flexibility, honesty, and a commitment to understand and respond to the changing health care and social environments. In addition, we as psychiatric education leaders must go beyond curriculum reform to collaborate with other stakeholders to advocate for resources necessary for retooling our infrastructure and bringing about evidence-based innovations that will help advance our field. **PN**

The members of the Council on Medical Education and Lifelong Learning Task Force on the COVID-19 Pandemic are Eindra Khin Khin, M.D., Marshall Forstein, M.D., Erick Hung, M.D., Ana Ozdoba, M.D., Mary Vance, M.D., Kevin Ing, M.D. (fellow), and Nancy Rodriguez, M.D. (fellow).

ETHICS CORNER

Navigating Boundaries in the Context of Culture, Ethnicity, and Religion

BY CHARLES C. DIKE, M.D., M.P.H.

A Muslim psychiatrist, prominent in the small Muslim community of the state in which he practices, was approached by Jay (fictitious name), a member of the same Muslim community who secretly identifies as nonbinary, to provide psychiatric evaluation and treatment to them (Jay's pronoun). Jay had been reluctant to seek mental health treatment for themself and at least one other member of their family who is under their tutelage but was emboldened by their shared religion. The psychiatrist, however, is torn. While he understands the importance of offering care to individuals in his community who usually avoid mental health treatment, he wonders if he will be able to avoid boundary violations as he is bound to meet the potential patient(s) at community events.

Dilemmas such as these are not uncommon. Similar concerns arise in patient-psychiatrist relationships in which there is ethnic, religious, language, and cultural concordance, as well as in small rural areas where everyone practically knows everyone else. Issues of boundary crossings or violations are of primary concern, as well as the potential for breach of confidentiality.

Boundary crossings occur when a psychiatrist's behavior deviates from the usual (and strict) professional conduct expected in a patient-psychiatrist relationship, often in a manner that does not harm but may in fact benefit the patient. In contrast, in boundary violations, such deviations from the norm are harmful and exploitative of the patient. They may be beneficial to the psychiatrist at the expense of the patient. Most psychiatrists are familiar with the slippery slope model of boundary crossings/violations taught in residencies, which has been misinterpreted by many psychiatrists to mean that all boundary crossings may lead psychiatrists down a slippery slope that ultimately ends in boundary violations. Consequently, psychiatrists avoid humane interactions with patients that fall out of the norm of usual psychiatric care such as accepting an inexpensive gift from a patient.

To address this quagmire, Richard Martinez, M.D., proposed a view of boundary interactions with patients that balances the potential of harm/exploitation of patients with potential benefits to patients, including improved therapeutic alliance. Behaviors such as sexual intimacy with or obtaining financial advice from a patient, attending a patient's wedding or the funeral of a patient's family member, making coffee for a patient, hugging a grieving patient, to mention a few, fall into categories proposed by Martinez and require the balancing described earlier. The context and the psychiatrist's intention in adopting the atypical behavior are important considerations, but so is the patient's (or other's) interpretation of the psychiatrist's behavior. Unfortunately, harm can occur to a patient despite a psychiatrist's best intentions; thus, the psychiatrist must be at heightened alert whenever a boundary is likely to be or has been crossed, even when such crossing is likely to enhance the therapeutic alliance.

Charles C. Dike, M.D., M.P.H., is chair of the APA Ethics Committee and former chair of the Ethics Committee of the American Academy of Psychiatry and the Law. He is also a professor of psychiatry; co-director of the Law and Psychiatry Division at the Yale University School of Medicine; and medical director in the Office of the Commissioner, Connecticut Department of Mental Health and Addiction Services.

Back to Jay. The psychiatrist Jay approached is right to be concerned. In addition to the understandable discomfort that would arise whenever their paths crossed in community events, the risk of violation of confidentiality is high. Unlike other subspecialties of medicine, identifying someone as a patient, a breach of confidentiality, carries more weight and meaning when the physician is a psychiatrist.

Weighing the options in such cases and making a decision can be frustrating. On the one hand, attending Jay's celebrations or family member's funeral may enhance the therapeutic alliance; on the other hand, not attending may leave the impression that the psychiatrist does not care. There are other considerations as well—attending the funeral may have unintended consequences, including creating an erroneous perception of intimacy. Then, there is the added challenge of treating family members with similar reasons as Jay for seeing the psychiatrist. Also, purposely ignoring a patient in public may seem odd and culturally inappropriate.

Jay may not appreciate the challenges involved in their request of the psychiatrist. However, the relative scarcity of psychiatrists means that most psychiatrists face these kinds of scenarios and must therefore develop a plan for addressing them. For example, should the psychiatrist elect to honor Jay's request, I recommend an initial appointment before accepting them as a patient, to discuss said challenges and establish a strict modus operandi, addressing areas such as how to relate with each other in public, the psychiatrist's inability to attend important events concerning Jay or their family members, and other countercultural restrictions that a treatment relationship may engender. It would be important for Jay to understand the ramifications of their request in order to make an informed decision to proceed. Jay may ultimately elect to not receive treatment from the psychiatrist as a result, in which case the psychiatrist should encourage them to seek treatment and refer them to a trusted, culturally humble, and sensitive colleague. **PN**

"The Concept of Boundaries in Clinical Practice: Theoretical and Risk-Management Dimensions" is posted at https://ajp.psychiatryonline.org/doi/10.1176/ajp.150.2.188. The article by Martinez, "A Model for Boundary Dilemmas: Ethical Decision-Making in the Patient-Professional Relationship," is posted at https://connect.springerpub.com/highwire_display/entity_view/node/87813/full.

Asylum

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educational, or work histories; their experiences of ill treatment; the injuries they may have experienced; and what led them to flee their countries of origin. In addition to the traumas clients may have already outlined with their lawyers, Martin said she typically talks with the clients about their early life stressors, as well as any disabilities, injuries, or diagnoses of mental or substance use disorders they may have.

The clients often have incredibly harrowing stories to share. Many have experienced gang violence, domestic violence, or other forms of extensive abuse in their countries of origin, Martin said. Further, crossing the American border often included still more traumatizing experiences.

Psychological and medical evaluations can make a massive difference to clients in securing them asylum in the United States. According to Physicians for Human Rights, 90% of asylum requests that include an evaluation performed by a volunteer with the organization are successful, compared with a national average of about 30%.

"My work with the clinic and learning to write objective affidavits has influenced my decision to pursue a career in forensic psychiatry," said Kate Morant, M.D., a PGY-3 psychiatry resident at Westchester Medical Center. She will be presenting on the clinic with Tangella and faculty supervisor and psychiatrist Lidia Klepacz, M.D., at APA's 2024 Annual Meeting in New York. The session will explore how such clinics increase trainee interest in working with marginalized populations, potentially through forensic psychiatry.

The Biggest Challenge: Not Enough Physicians

Tangella and Hirani said that the greatest challenges they experience in doing this work is the lack of physicians to conduct the evaluations. From April to September 2023, the clinic received 40 requests for evaluations, but 11 had to be rejected because physicians weren't available.

Martin encouraged her fellow physicians to volunteer their time. The work does not have a strict time commitment, and evaluations can be done whenever the physician has availability. It also does not require malpractice insurance because the physician is not treating the client.

Tangella and Hirani said their experiences with the program have influenced their plans for the future. Hirani isn't yet certain what he wants his career to look like exactly. "But I do know this for sure: Whatever I do, I will continue to be involved in the kind of work this clinic does," he said.

Tangella said sitting in on the evaluations inspired her to go into psychiatry. "Being part of an evaluation was eye-opening and really impactful for me," she said. "The first two years of medical school can feel really monotonous and like you're not doing much, but this work gives us purpose and helps us feel as though we're making a difference." **PN**

More information on the student-run clinics associated with Physicians for Human Rights is posted at https://phr.org/issues/asylum-and-persecution/student-asylum-clinics/. More information on NYMC's Center for Human Rights is posted at https://www.nymc-chr.org.

Mental Health Matters: The Ripple Effect on Youth Violence

Getty Images/iStock/ryasick

Violence impacts many youth, which increases their risk to commit violence themselves. Psychiatrists are critical to identifying and treating these youth and breaking the cycle. ***BY CARA STAUS, C.P.H.R.M., F.A.S.H.R.M.***

Youth violence is a significant public health emergency and affects thousands of young people daily. The ripple effect of this violence is far reaching and impacts families, communities, and schools. The exposure to violence has disrupted our youth's development and can lead to long-lasting mental health issues such as impaired decision-making, difficulty coping with stress, isolation, and delays in learning.

Research on youth involved in violence has increased the understanding of risk factors linked to violence. For example, toxic stress resulting from bullying (physical, mental, and cyber), food insecurity, and living in impoverished communities or in homes with violence contribute to the likelihood of youth experiencing violence and/or mental health issues. Exposure to violence often leads to disruption in a young person's life, and manifests in different forms, such as missed school, displaying at-risk behaviors, substance use, or isolation. Violence prevention is central to promoting teen mental health and wellness.

Psychiatrists are integral to recognizing these at-risk situations youth face. Because there is no stereotypical profile of a violent youth offender, early identification, assessment, and intervention are key.

Monitoring and acting when warning signs are exhibited may reduce the risk for violence. Maintaining open dialogues between parents, teachers, and health care professionals may help identify warning signs for violence and determine whether emergency intervention is required. Communication is a critical component in developing plans to reduce risk. Key warning signs to consider include the following:

- Increased irritability.
- Intense expression of anger or impulsivity.
- Social isolation.
- Expression of intent to commit a violent act.
- Lack of coping skills.

Informed consent, documentation, and duty to warn are key risk mitigation strategies. These strategies help to complement and strengthen one another, working together to minimize risks in a comprehensive, sustainable, and long-term manner.

- Prior to treating the patient, obtain proper written consent from the person with the legal authority to consent on behalf of the patient. This includes consent to speak with other health care professionals or school counselors as deemed appropriate.
- Conduct a complete history and mental status assessment, which may include a review of medical records and collateral information from the child's current and former behavioral health professionals, school counselors, and primary care physician.
- Document contemporaneously, and complete thorough risk assessments.
- Document changes in behavior, such as social disconnection, bizarre statements, or out-of-character actions.
- Document assessment of whether the patient was a victim of bullying, cyberbullying, or perpetuating bullying.
- Document expressions of thoughts of harm to self or others and aggressive behavior and note if the patient has any access to weapons.
- Document use of drugs or alcohol.
- Be aware of your state's specific laws regarding duty to warn.

Treating youth who demonstrate violent tendencies can be arduous. Maintaining open lines of communication between parents, school professionals, and other providers may help to identify warning signs for violent behavior sooner. Remember to consistently document communications, assessments, and follow-up actions taken in the medical record.

Understanding your state's laws on duty to warn and confidentiality regarding reporting and disclosure is critical. If you have any questions regarding your duty to warn, do not hesitate to contact your risk management professional or seek legal counsel. **PN**

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Cara Staus, C.P.H.R.M., F.A.S.H.R.M., is assistant vice president in the Risk Management Group of AWAC Services Company, a member company of Allied World. Risk Management services are provided as an exclusive benefit to insureds of the APA-endorsed American Professional Agency Inc. liability insurance program.

Addiction Training

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course of several years, ultimately leading to formal approval from our institution's Executive Curriculum Committee. Curricula have limited space, leading to hesitancy to add new information. Other topics may need to be cut or reduced to allow this change. In our case, several naloxone trainings were conducted prior to advocating for the topic to have a permanent place in the curriculum. Allies within the faculty became particularly important in demonstrating the sustainability of the naloxone training and other curriculum proposals beyond graduation of the student educators.

As we continue to tackle obstacles and embrace the unique strengths associated with student-led change, our hope is to create an addiction psychiatry/medicine thread and advocate for space throughout every part of the curriculum to teach students about SUDs, the identification and treatment of patients with SUDs, and prevention measures. We are eager and optimistic for continued, lifesaving change and hope that our efforts serve as a guide to other medical students and schools as they embrace the teaching of addiction-related competencies in their curricula. **PN**

"Opiate Use Disorders and Overdose: Medical Students' Experiences, Satisfaction With Learning, and Attitudes Toward Community Naloxone Provision" is posted at https://pubmed.ncbi.nlm.nih.gov/29198489/. "HHS, SAMHSA Release 2022 National Survey on Drug Use and Health Data" is posted at http://apapsy.ch/NSDUH-2022-Data. The "2021 NSDUH Annual National Report" is posted at http://apapsy.ch/NSDUH-2022-Report. "Dr. Rahul Gupta Releases Statement on CDC's New Overdose Death Data" is posted at http://apapsy.ch/Overdose-Data. "Stigma Among Health Professionals Towards Patients With Substance Use Disorders and Its Consequences for Healthcare Delivery: Systematic Review" is posted at http://apapsy.ch/SUD-Stigma.

Artificial Intelligence at APA and on the Hill

BY SHABANA KHAN, M.D., AND DARLENE KING, M.D.

Federal and state governments have been grappling with ways to regulate the role of augmented or artificial intelligence (AI) across industries. With the significant increase in technological sophistication of AI technologies signified by last year's release of GPT4 by OpenAI's ChatGPT, new applications for AI are being considered, tested, and deployed in health care settings. Policymakers are racing to catch up and to apply existing regulatory frameworks to AI or to make new rules.

AI-enabled technologies have the potential to improve health care equity, access, and quality, but they can also pose critical risks to patient safety and privacy. APA expert members have been convening discussions to develop policy perspectives and establish guardrails for the practice of psychiatry. These perspectives focus on the importance of the role of the clinician when AI systems are being used and of not ceding clinical decision-making to AI. These discussions also focus on patient protections, including informed consent, data protection, and research on the impact of AI on bias, equity, and effectiveness. APA members can watch a recording of a recent APA member webinar about AI in psychiatry.

Oversight of AI-enabled technologies is complex for a few reasons. First, AI models learn and change the longer they are deployed, leading to the Food and Drug Administration (FDA) establishing a pathway for AI developers to describe the learning algorithm of their technology rather than re-applying for FDA approval when their model changes. Second, some AI technologies fit into existing regulatory pathways (for example, clinical decision supports) and some do not (for example, "chatbot" psychotherapy). Broadly, our current health care regulations were not built for AI, and this reality has different impacts based on the technology in question.

Recently, the Health Subcommittee of the House of Representatives Energy and Commerce Committee hosted a hearing on AI in health care. The committee members' remarks and questions during the hearing were instructive regarding the Congress' perspective on AI. Key lines of inquiry included striking a balance between innovation and safeguards, the role of federal agencies such as the FDA and the Centers for Medicare and Medicaid Services in overseeing and supporting AI-enabled technologies, patient privacy, and automated claims denials. While witnesses noted that clinicians should be the "ultimate deciders" in treatment with AI providing decision support, they were largely optimistic about the potential for AI to reduce administrative burden, identify new treatment options, and enhance the precision and effectiveness of existing treatments. Witnesses further noted that AI deployed in non-health care settings can still have profound health impacts (for example, in conjunction with consumer "wellness" apps).

Policymakers need clinical insights to make difficult decisions about regulating potentially innovative—and potentially harmful—technologies in clinical settings. APA members can get involved in state and federal efforts to inform the future of technology-assisted care by contacting their district branch leadership or APA's policy team at apatelepsychiatry@psych.org. **PN**

Shabana Khan, M.D., is chair of APA's Committee on Telepsychiatry. She is also an assistant professor of child and adolescent psychiatry and director of Child and Adolescent Telepsychiatry at NYU Grossman School of Medicine. Darlene King, M.D., is an assistant professor in the Department of Psychiatry at UT Southwestern Medical Center, deputy medical information officer at Parkland Health, and chair of APA's Committee on Mental Health Information Technology.

"The Basics of Augmented Intelligence: Some Factors Psychiatrists Need to Know Now" is posted at https://www.psychiatry.org/news-room/apa-blogs/the-basics-of-augmented-intelligence. The recording on AI in psychiatry is posted at http://apapsy.ch/AI-recording. Information on FDA policies regarding machine-learning medical devices is posted at http://apapsy.ch/FDA-machine-learning-devices.

Jury Still Out on Digital Therapies for ADHD

Getty Images/iStock/BrianAJackson

Families want to know if the investment of time spent on digital interventions is worth more than time spent on other activities, such as practicing an instrument or playing sports. ***BY NICK ZAGORSKI***

In the three years since the FDA cleared the EndeavorRx video game (developed by Akili) for the treatment of attention-deficit/hyperactivity disorder (ADHD) in youth, research into digital ADHD interventions has diversified, expanded, and matured. So remarked Stephen Faraone, Ph.D., at the 2023 annual meeting of the American Academy of Child and Adolescent Psychiatry (AACAP) in New York.

"I've played some of the new products, and they are compelling on the surface," said Faraone, a distinguished professor and vice chair of research of psychiatry and behavioral sciences at SUNY Upstate Medical University in Syracuse, N.Y. But can use of these tools lead to meaningful changes for young people? Faraone was part of a panel of researchers at an AACAP session that explored this question.

Clinically, the goal of therapeutic video games is to target circuits that are known to be compromised in youth with ADHD (for instance, working memory circuits). While such cognitive training has been shown to improve performance on attention and memory tests, it has not translated to visible improvements in measures such as academic performance. Even Akili's game received FDA clearance based on participants' improvements on a research-focused metric known as TOVA (Test of Variables of Attention) and not clinical improvements in symptoms.

Jennifer Crosbie, Ph.D., an assistant professor of psychiatry at the University of Toronto, noted that developing a therapeutic video game is complicated by the fact that effective cognitive training demands time and attention—which can be off-putting to some kids.

Crosbie has conducted many focus groups with families interested in therapeutic video games and found consistent themes expressed by youth and parents alike: "The parents want something portable that does not require Wi-Fi, so it's accessible anytime. The kids want variety, short run times, and more rewards."

Her lab has been working with game developers on a smartphone game package called Mega Team that tries to balance neuroscience-based training techniques with kid expectations. Mega Team includes four separate reflex-based mini games that target different aspects of executive function. She noted that the game concepts were designed with input from kids.

She presented some findings from a research study that compared youth with ADHD or autism (168 and 61, respectively) who played five weeks of Mega Team (five days a week for 25 minutes a day) with those who played a set of control games. As anticipated, the children who played Mega Team showed greater improvements in laboratory tests of inhibition control after five weeks than those in the control group. The parents of the children who played Mega Team also reported greater improvements in the children's attention and hyperactivity than the parents of those playing the control games.

Crosbie acknowledged that the parents were aware of the interventions that their children were playing, which may have impacted the findings. However, a small sample of teachers who were unaware of the game assignments and completed a follow-up questionnaire after six months reported greater

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symptom improvements in the youth who played Mega Team than those who played the control games.

Passive Monitoring Shows Promise

An attention-monitoring wearable may also provide benefits for youth with ADHD, said Margaret Weiss, M.D., Ph.D., an associate professor of psychiatry at Harvard University and director of the Neurodiversity Center at Cambridge Health Alliance. Weiss helped to develop a device called FokusRx that provides periodic prompts via vibrations or text messages to help children regain focus or stay on task. The AI-guided software initially selects times for prompting based on a child's school schedule, which can be entered by a parent in a mobile app. Over time, the software tracks the child's responses to the prompts as well as passive cues like fidgeting or pacing to develop more personalized prompting.

"Basically, it's the nagging mother or annoying teacher technique of improving attention," Weiss said. "But we let the device do the nagging privately, which raises the child's self-concept."

Weiss conducted an open-label pilot study testing this device in school settings and found that children with ADHD who used the device over four weeks (at least three schooldays a week) showed marked improvements in attention and academic productivity. There were minimal changes to impulsive and/or disruptive behaviors, which she says suggests the device targets attention specifically.

David Coghill, M.D., a professor of developmental mental health at the University of Melbourne in Australia and chair of the session, expressed optimism about the future of digital therapies for ADHD. However, he reiterated that while these may seem like low-risk devices, they need to be used wisely like any other treatment.

Weiss said that future research with digital interventions, particularly ones that require active engagements, should be tested against non-digital approaches to strengthen attention and executive function. "Afterschool time is not unlimited," she said. Families want to know if the investment of time spent on digital interventions is worth more than time spent on other activities, such as practicing an instrument or playing sports, she said. **PN**

More information on Mega Team is posted at https://www.child-bright.ca/megateam. More information on FokusRx is posted at https://www.revibetech.com/our-future-technology.

Trustees

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same rate as in-person care; continuing virtual supervision of trainee physicians when the resident is delivering telehealth; the allowance of Medicare billing practitioners to report their practice location rather than the home address when providing services via telehealth from their homes; and telehealth services delivered by Federally Qualified Health Centers and Rural Health Centers without a prior in-person visit.

Other Actions

Trustees approved Arizona state Rep. Amish Shah as the 2024 recipient of APA's Jacob K. Javits Public Service Award and approved the nomination of Sidney Zisook, M.D., for the Vestermark Psychiatry Educator Award.

Finally, the Board voted to approve the following new or revised position statements:

New Position Statements

- Position Statement on Contingency Management for the Treatment of Stimulant Use Disorder (2023)
- Position Statement on Harm Reduction (2023)
- Position Statement on Housing, Homelessness, and Mental Health (2023)

Revised Position Statements

- Position Statement on Abortion, Family Planning, Legislative Intrusion, and Reproductive Decisions
- Position Statement on Peer Support Services
- Position Statement on the Role of Psychiatrists in Reducing Physical Health Disparities in Patients With Mental Illness
- Position Statement on Firearms Access: Inquiries in Clinical Settings
- Position Statement on Police Interactions With Persons With Mental Illness
- Position Statement on Utilization of Measurement Based Care **PN**

APA position statements are posted at https://www.psychiatry.org/Policy-Finder. APA practice guidelines are posted at https://psychiatryonline.org/guidelines.

Meaning and Medication: Integrating All the Evidence Bases

BY DAVID MINTZ, M.D.

Decades of neuroscientific advances have led to a host of safer and more tolerable treatments in our psychiatric armamentarium. However, despite a major commitment to the evidence-based practice of pharmacotherapy, treatment refractoriness remains a significant problem for those with psychiatric illness, and, for many of the most prevalent psychiatric conditions, there is little evidence that outcomes are substantially better than they were a half-century ago. There are many reasons for this, including the true complexity of many psychiatric illnesses and the current limitations of our treatments. One correctable reason, however, may have to do with a narrow or reductionist understanding of evidence-based psychiatric practice. Typically, when we reference evidence-based practice, we are referring to the matching of *DSM*-defined disorders with biomedical treatments shown in placebo-controlled studies to be effective for those disorders.

There are, however, other evidence bases, too often neglected, that provide guidance not about *what* to prescribe, but rather, how to prescribe to optimize outcomes (see the paper by David Flynn, M.D., and me noted at the end of this article). The evidence base in this regard suggests that the psychosocial dimensions of pharmacotherapy contribute substantially to pharmacotherapy outcomes. Indeed, for some of the most common psychiatric conditions (for example, depression), the evidence suggests that psychosocial factors in prescribing (the person of the patient, the person of the doctor, placebo effects, and the quality of the doctor-patient alliance) contribute more to outcomes than the putative active ingredient of those medications.

For example, a secondary analysis of the data from the Treatment of Depression Collaborative Research Project (TDCRP), which was, before STAR*D, the largest, NIMH-funded, multicenter, placebo-controlled randomized trial that had been conducted, looked at outcomes through the lens of the prescriber. The analysis, published in the June 2006 *Journal of Affective Disorders,* indicated that, if TDCRP prescribers got a good outcome with one patient, they tended to get superior outcomes with all their patients, and prescribers who got poorer outcomes with one patient tended to get poorer outcomes overall. Using linear hierarchical modeling, the researchers were able to stratify the prescribers into highly effective, moderately effective, and relatively ineffective prescribers. Effects were additive, so that patients had the best outcomes when they had an effective prescriber and got the active antidepressant, and patients had the worst outcomes when they had a relatively ineffective prescriber and were administered placebo treatment. Most striking, however, was the finding that the top third of prescribers achieved better antidepressant results with placebo than the bottom third achieved with active drug.

This should perhaps not be so surprising when we consider that effect sizes of antidepressants tend to fall around 0.35, while effect sizes of placebo in antidepressant trials are around 1.05. The placebo effect is a complex phenomenon that is shaped by the set and setting of treatment, including the "how" of medication administration and the quality of the doctor-patient relationship.

The therapeutic relationship is also a powerful tool for enhancing outcomes in pharmacotherapy. Another secondary analysis of the TDCRP data was published by Janice L. Krupnick and colleagues in the April 2006 issue of *Focus.* The researchers explored how the therapeutic alliance contributed to outcomes. While they expected to find the alliance to be central to psychotherapeutic outcomes but only marginally impactful in pharmacotherapy, instead they found that the alliance contributed equally to outcomes in both treatment conditions. Indeed, their analysis found that patients with a positive therapeutic alliance with their prescriber had greater reductions in depression with placebo than patients with a poor alliance achieved with active antidepressant. Further, there is a substantial evidence base that paints a picture of the skills and practices needed to establish a sound pharmacotherapeutic alliance. (See my book *Psychodynamic Psychopharmacology: Caring for the Treatment-Resistant Patient* from APA Publishing.)

Even with the effective use of alliance-promoting behaviors, patients may carry unarticulated concerns into treatment (for example, the residue of traumatic relations with caregivers) that adversely affect treatment outcomes. Multiple psychological variables, such as the patient's expectations, contribute to the placebo response, potentiating treatment response when expectations are positive or undermining it when the patient is ambivalent about treatment and/or expectations are negative. Occasionally, such psychological sources of treatment resistance may be addressed by simple psychoeducation. However, frequently, these resistances are connected to deeper and often unconscious sources. In such cases, it is the psychiatrist's capacity to empathically appreciate those factors and intervene at the level of meaning that may be the factor that turns treatment-resistance into treatment response.

Studies such as those referred to (and there are many more) suggest that, for the benefit of our patients, psychiatric prescribers should be thoroughly versed in the psychosocial evidence bases that guide us in knowing how effectively to prescribe, and not just the biomedical evidence bases that tell us what to prescribe. For a truly evidence-based practice, psychiatrists should develop skills for engaging patients in ways that foster the alliance, engage resistances to the healthy use of medications, and optimize psychological factors (for example, placebo effects) that have been shown to promote good pharmacotherapy outcomes, amplifying the benefits of the medication itself. **PN**

David Mintz, M.D. is director of psychiatric education and associate director of training at the Austen Riggs Center, a psychodynamic therapeutic community in Stockbridge, Mass. He is also the recent past leader of APA's Psychotherapy Caucus.

This is part of a series of articles on the psychosocial dimensions of pharmacotherapy.

The article by Mintz and Flynn, "How (Not What) to Prescribe: Nonpharmacologic Aspects of Psychopharmacology," is posted at https://www.sciencedirect.com/science/article/pii/S0193953X11001171?via%3Dihub. The study by McKay et al., "Psychiatrist Effects in the Psychopharmacological Treatment of Depression," is posted at https://www.sciencedirect.com/science/article/pii/S0165032706000395?via%3Dihub. "The Role of Therapeutic Alliance in Psychotherapy and Pharmacotherapy Outcome: Findings in the National Institute of Mental Health Treatment of Depression Collaborative Research Program" is posted at https://focus.psychiatryonline.org/doi/10.1176/foc.4.2.269. Information on *Psychodynamic Psychopharmacology* is posted at https://www.appi.org/Products/Psychopharmacology/Psychodynamic-Psychopharmacology.

NEW YORK City

MAY 4-8

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Why a Course?

BY DAVID BECKERT, M.D.
Course Subcommittee Chair
APA Scientific Program Committee

Want an option for an intensive learning experience? Don't want to fight the crowds when you head to a popular talk by a national or international expert? Want a chance to ask more than one brief question at the end of one of the many general sessions? Want an opportunity to talk to an expert, learn a new skill, or sharpen your current skills with the latest information?

If you answer "yes" to any of these questions, then consider taking a course at APA's Annual Meeting! These are four-hour, in-depth offerings on a wide variety of subjects including psychotherapy, cannabis, neuropsychiatry, global mental health, technology, forensic psychiatry, transcranial magnetic stimulation, and public speaking.

Want something more? Try a master course, an eight-hour intensive learning experience that will hone your skills in areas such as psychopharmacology, motivation interviewing, suicide assessment, management of first-episode psychosis, and office-based buprenorphine treatment. Each of these includes receipt of an APPI-published book on the course's topic by the experts teaching the master courses.

Due to their popularity, courses fill fast, so don't delay. Register for the Annual Meeting today and be sure to get a seat in your first-choice courses. See box at next page for registration information. **PN**

MASTER COURSES

PART 1: SATURDAY, MAY 4, 2024 | PART 2: SUNDAY, MAY 5, 2024

Course Code: 8140 | Psychiatry Review
Course Director: Vishal Madaan, M.D.
Educational Objectivess: (1) Identify gaps in knowledge in psychiatry as part of an exercise in individual learning; (2) Review core concepts in psychiatry and high-yield subspecialty topic areas; (3) Analyze multiple-choice questions and vignettes pertinent to clinical topics.
Time: 8 a.m. – 5 p.m.; Registration cost: $390

SUNDAY, MAY 5, 2024

Course Code: 8097 | Clinical Psychopharmacology
Course Director: Alan Schatzberg, M.D.
Educational Objectives: (1) Develop an evidence-based treatment plan for depressive disorders, bipolar disorders, anxiety disorders, and psychotic disorders among older adults; (2) have a working knowledge on the status of antidepressants in development—e.g., psychedelics; (3) select optimal treatment approaches for patients with insomnia and other sleep disorders; (4) implement treatment strategies for bipolar disorder, schizophrenia, and childhood and adolescent disorders.
Time: 8 a.m. – 5 p.m.; Registration cost: $390

Course Code: 8130 | Consultation-Liaison Psychiatry
Course Director: Mark Oldham, M.D.
Educational Objectives: (1) Discuss the elements of delirium that invite clinical intervention, including cognitive resilience, delirium causes, unique types of pathophysiology, and specific neuropsychiatric disturbances; (2) Describe evidence-based interventions for addressing behavioral health emergencies in acute medical settings; (3) Explain the diagnostic and treatment implications of detecting catatonia, especially in the general hospital; (4) Describe best practices for screening, assessment, and treatment of perinatal mental health and substance use disorders in perinatal care settings; (5) Describe key examples of substance-related challenges in the transplant center and practical guidance on addressing them as part of an interdisciplinary team.
Time: 8 a.m. – 5 p.m.; Registration cost: $390

MONDAY, MAY 6, 2024

Course Code: 8151 | Child and Adolescent Psychiatry
Course Director: John Walkup, M.D.
Educational Objectives: (1) Critically review and analyze cases to improve outcomes from pharmacotherapy in children and adolescents with autism; (2) Critically review and analyze cases to improve outcomes for children and adolescents with anxiety disorders; (3) Critically review and analyze cases to improve outcomes for children and adolescents with mood disorders; (4) Critically review and analyze cases to improve quality and safety of patient care in management of gender dysphoria; (5) Critically review and analyze cases to improve outcomes for children and adolescents with obsessive-compulsive-related disorders and tic disorders.
Time: 8 a.m. – 5 p.m.; Registration cost: $390

Course Code: 8105 | Update in Reproductive Psychiatry: Clinical, Research, Education, and Advocacy Perspectives
Course Director: Lucy Hutner, M.D.
Educational Objectives: (1) Appreciate clinical advances in the field of reproductive psychiatry, including updates in psychopharmacology; (2) Understand major education and research initiatives underway in the field; (3) Describe methods of developing culturally responsive perinatal mental health care for patients from marginalized populations; (4) Appreciate the importance of optimizing reproductive mental health care for patients across the gender and sexuality spectrum; (5) Discuss the clinical approach for patients with substance use disorders in the perinatal population.
Time: 8 a.m. – 5 p.m.; Registration cost: $390

Course Code: 8136 | Buprenorphine and Office-Based Treatment of Opioid Use Disorder
Course Director: John Renner, M.D.
Educational Objectives: (1) Discuss the rationale and need for medications for opioid use disorder: buprenorphine, methadone, naltrexone, and naloxone; (2) Discuss the pharmacological characteristics of opioids used in clinical practice; (3) Describe buprenorphine protocols for all phases of treatment and for optimal patient/treatment matching; (4) Discuss the management of opioid use disorder in adolescents, pregnant women, and patients with acute and/or chronic pain.
Time: 8 a.m. – 5 p.m.; Registration cost: $74

TUESDAY, MAY 7, 2024

Course Code: 8131 | ECT Clinical Practice Update
Course Director: Keith Rasmussen, M.D.
Educational Objectives: (1) Learn how to select ECT patients; (2) Learn how to supervise a series of ECT treatments; (3) Learn how to conduct ECT treatments.
Time: 8 a.m. – 5 p.m.; Registration cost: $390

Course Code: 8058 | Pharmacotherapy for Complex Substance Use Disorders
Course Director: Thanh Thuy Truong, M.D.
Educational Objectives: (1) Analyze the unique considerations and challenges in treating individuals with multiple substance use disorders, particularly minority populations; (2) Incorporate medications in the management of multiple substance use disorders and its integration with psychosocial interventions; (3) Develop strategies for patient engagement and shared decision-making in the context of pharmacotherapy for substance use disorders; (4) Incorporate medications for pregnant patients with SUD that do not respond to nonpharmacologic interventions.
Time: 8 a.m. – 5 p.m.; Registration cost: $390

HOW TO REGISTER

Because most of the spaces in APA's courses fill early, you are encouraged to enroll in advance to ensure you get a space in the course or courses of your choice. Course enrollment must be completed through the meeting registration form, which can be accessed at **www.psychiatry.org/annualmeeting**. Only registered meeting attendees may purchase course tickets. Take advantage of discounted rates by registering by **April 3**; late advance registration rates (online only) are in effect from **April 4** to **May 3**. On-site registration and course enrollment will be available at Registration in the Javits Center main lobby.

If you have already registered for the meeting, you can add a paid course by visiting the Registration Resource Center at http://apapsy.ch/Resource-Center.

Register online at
www.psychiatry.org/annualmeeting
Questions? Call 202-459-9731

SATURDAY, MAY 4, 2024

Course Code: 3054

Motivational Interviewing 4 – Updates in Motivational Interviewing for Behavior Change

Director: Caridad Ponce Martinez, M.D.
Educational Objectives: (1) Define and summarize updated terminology, concepts, and approaches for the recently released motivational interview (MI) textbook; (2) Apply the elements of the spirit of motivational interviewing to clinical interactions with patients; (3) Recognize, respond, and evoke change talk, and know how to respond to sustain talk; (4) Apply the core skills of MI in clinical conversations with patients.

Time: 1 p.m. – 5 p.m.; Registration cost: $190

Course Code: 3032

Bias at the Bedside Train-the-Trainer Program for Psychiatrists: Addressing Bias and Discrimination From Patients and Families

Director: Veronica Faller, M.D.
Educational Objectives: (1) Describe the impact that bias incidents can have on trainees, institutional culture, and patient care; (2) Recognize the different types of bias and mistreatment that might occur in a clinical setting; (3) Use specific strategies to respond to microaggressions and overt derogatory language from patients and families in a professional manner, in real time, and after the event; (4) Conduct Bias at the Bedside workshops to educate colleagues and teams about skills learned in this course; (5) Identify barriers against and strategies for implementing bystander skills training to specific clinical practice settings.

Time: 8 a.m. – Noon; Registration cost: $190

Course Code: 3029

Understanding and Treating Borderline Personality Organization: Transference-Focused Psychotherapy

Director: Frank Yeomans, M.D.
Educational Objectives: (1) Recognize and assess the psychological structures that are the core of borderline personality; (2) Know how to discuss a personality disorder diagnosis with his or her patient; (3) Know the conditions of treatment that need to be agreed to before starting therapy with a borderline patient; (4) Better able to recognize and use emotional reactions to the patient in a therapeutic way; (5) Know the steps of interpreting with borderline patients.

Time: 8 a.m. – Noon; Registration cost: $190

SUNDAY, MAY 5, 2024

Course Code: 3046

Essentials of Telepsychiatry, Digital Mental Health, and Online Practice

Director: Steven Chan, M.D.
Educational Objectives: (1) Understand telepsychiatry laws and regulations for clinical practice; (2) Assess novel technologies—such as artificial intelligence, large language models, and virtual reality/mobile apps—to determine their role in patient care; (3) Monitor and maintain your professional identity, privacy, and security; (4) Integrate online practice management tools in education, communication, documentation, screening, and evaluation; (5) Utilize online resources for lifelong learning, patient care, and collaboration.

Time: 1 p.m. – 5 p.m.; Registration cost: $190

Course Code: 3005

Talking With (and Listening to) Your Patients about Cannabis

Director: Henry Levine, M.D.
Educational Objectives: (1) Be familiar with cannabinoid physiology; (2) Know how to address cannabinoid use with patients; (3) Be familiar with potential medical uses of cannabinoids in psychiatric and in medical, nonpsychiatric conditions; (4) Know the history and current status of laws regarding cannabinoid use in the U.S.; (5) Be familiar with data on hazards and contraindications to patients' cannabinoid use.

Time: 8 a.m. – Noon; Registration cost: $190

Course Code: 3016

Psychiatric Oncology Bootcamp: A Basic Course for the General Psychiatric Practitioner and Other Advanced Practice Clinicians

Director: Antolin Trinidad, M.D.
Educational Objectives: (1) Outline the fundamentals of psychiatric consultation unique to patients in oncology; (2) Be familiar with common and updated psychopharmacological treatments of disorders presenting in oncology patients with a mental health problem; (3) Be familiar with fundamental psychotherapeutic facets of cancer patients and of cancer patients presenting as end stage; (4) Be knowledgeable about the growing need for institutions to serve the mental health care needs of more cancer patients in survivorship.

Time: 8 a.m. – Noon; Registration cost: $190

Course Code: 8125

Neurology Update for the Psychiatrist

Director: Sanjay Singh, M.D.
Educational Objectives: (1) Know the basics of neurological diagnosis; (2) Learn about updates in the diagnosis and treatment of neurological disorders; (3) Be familiar with the current and future state of neurology.

Time: 1 p.m. – 5 p.m.; Registration cost: $190

Course Code: 8148

Neuromodulation of Major Psychiatric Disorders: An Overview

Director: Nicola Cascella, M.D.
Educational Objectives: (1) Learn that major psychiatric disorders are circuit based and amenable to neuromodulation; (2) Learn how TMS is applied to treat depression and OCD; (3) Learn that a magnet-based seizure-induced modulation of depressive disorders; (4) Learn about DBS as a novel treatment for auditory hallucinations in schizophrenia.

Time: 8 a.m. – Noon; Registration cost: $190

Course Code: 8117

MindGames Masters: Subspecialty Review for the General Psychiatrist

Director: Vishal Madaan, M.D.
Educational Objectives: (1) Demonstrate an understanding of basic topics in forensic psychiatry; (2) Demonstrate an understanding of topics in addiction psychiatry; (3) Demonstrate an understanding of topics in child and adolescent psychiatry; (4) Demonstrate an understanding of topics in vonsultation-liaison psychiatry; (5) Demonstrate and understanding of topics in geriatric psychiatry.

Time: 1 p.m. – 5 p.m.; Registration cost: $190

MONDAY, MAY 6, 2024

Course Code: 3019

Breath-Centered Mind-Body Treatment/Prevention for Provider Self-Care, Addiction, and Disasters With Experiential Training

Director: Richard Brown, M.D.
Educational Objectives: (1) Enumerate three ways that simple, effective, evidence-based mind-body programs can be helpful in the prevention and treatment of addictions; (2) Apply Polyvagal Theory to understanding how Voluntarily Regulated Breathing Practices (VRPs) help shift the organism from states of defensive disconnection toward a state of safety and connectedness; (3) Describe initiatives using mind-body techniques to relieve stress and trauma among survivors of war and terrorism in Ukraine and Rwanda; (4) Practice Coherent Breathing and other Voluntarily Regulated Breathing Practices (VRPs) for self-care and to reduce stress, anxiety, insomnia, depression, and symptoms of trauma; (5) Acquire tools and resources to integrate breath and movement techniques experienced in this course into clinical practice.

Time: 1 p.m. – 5 p.m.; Registration cost: $190

Course Code: 3011

Integrative Treatment of Anxiety Disorders

Director: Edward Silberman, M.D.
Educational Objectives: (1) Know the comparative prevalence of primary anxiety disorders vs. primary depressive illness and be able to name four factors distinguishing the former from the latter; (2) Name three appropriate target symptoms for medications and three appropriate target symptoms for psychotherapies in treating anxiety disorders; (3) Name five classes of medications that are effective for anxiety disorders and summarize the evidence about their use; (4) Name three types of psychotherapy that are effective for anxiety disorders and list the major indications for each; (5) Summarize the evidence about benzodiazepine abuse, tolerance, withdrawal, and side effects and list five principles for their safe and effective use.

Time: 8 a.m. – Noon; Registration cost: $190

Course Code: 3010

Essential Skills in Psychiatric Leadership

Director: Tobias Wasser, M.D.
Educational Objectives: (1) Identify various components of leadership in psychiatry; (2) Outline important career dynamics to consider when presented with leadership opportunities in psychiatry; (3) Improve capacity to function as a psychiatric leader; (4) Identify avenues for further career development; (5) Apply physician leadership techniques, including negotiation, quality improvement, financial management, and leadership theory to daily work and future career as a physician in leadership.

Time: 1 p.m. – 5 p.m.; Registration cost: $190

Course Code: 8128

Optimizing Pharmacology for People With SMI: Spotlight on Clozapine and Long-Acting Injectable Antipsychotics

Director: Robert Cotes, M.D.
Educational Objectives: (1) Recall the APA Practice Guideline for the Treatment of Patients With Schizophrenia

statements on clozapine and long-acting injectable antipsychotic medications; (2) Discuss strategies for how to identify persistent positive symptoms of psychosis when one is prescribed a long-acting injectable antipsychotic medication; (3) Apply practical strategies for initiating long-acting injectable (LAI) antipsychotics in patients with schizophrenia, with an emphasis on understanding their pharmacokinetic properties; (4) Develop a comprehensive plan for the practical use of clozapine in treating schizophrenia, including strategies for managing potential hematologic, gastrointestinal, and cardiac side effects; (5) Demonstrate effective communication techniques to engage patients in discussions about the use of clozapine and LAI treatments, aiming to enhance patient understanding and improve treatment outcomes.

Time: 8 a.m. – Noon; Registration cost: $190

Course Code: 8132

Shifting Horizons in Psychiatry: Navigating Challenges to Integration and Implementation of Psychedelic-Assisted Therapies

Director: Franklin King, M.D.

Educational Objectives: (1) Critically appraise the potential role of psychedelic-assisted therapies in addressing treatment-resistant mental health conditions within psychiatric care settings; (2) Utilize neuroscientific knowledge of psychedelics' impact on brain networks to assess potential therapeutic applications in psychiatric care; (3)Evaluate the methodological strengths and weaknesses of clinical trials involving psychedelics, enhancing critical analysis skills for interpreting research outcomes; (4) Employ risk-benefit analysis models to assess the potential advantages, drawbacks, and safety considerations of psychedelic use in psychiatric treatment; (5) Develop communication skills to educate patients and stakeholders about the evolving landscape of psychedelic-assisted therapies in psychiatric care.

Time: 1 p.m. – 5 p.m.; Registration cost: $190

Course Code: 8071

Updates in Geriatric Psychiatry

Director: Rajesh Tampi, M.D., M.S.

Educational Objectives: (1) Discuss the epidemiology of depressive disorders, bipolar disorders, anxiety disorders, and psychotic disorders among older adults; (2) Describe the assessment of depressive disorders, bipolar disorders, anxiety disorders, and psychotic disorders among older adults; (3) Develop an evidence-based treatment plan for depressive disorders, bipolar disorders, anxiety disorders, and psychotic disorders among older adults.

Time: 8 a.m. – Noon; Registration cost: $190

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TUESDAY, MAY 7, 2024

Course Code: 3041

Neuropsychiatric Masquerades

Director: Jose Maldonado, M.D.

Educational Objectives: (1) Recognize the most common clues of presentation suggesting an "organic cause" for psychiatric symptoms; (2) Recognize the most common medical disorders presenting as a mood or anxiety disorder; (3) Understand the incidence, epidemiology, and clinical features of the most common endocrine disorders masquerading as psychiatric illness; (4) Understand the incidence, epidemiology, and clinical features of the most common metabolic disorders masquerading as psychiatric illness; (5) Understand the incidence, epidemiology, and clinical features of the most common infectious disorders masquerading as psychiatric illness.

Time: 1 p.m. – 5 p.m.; Registration cost: $190

Course Code: 3051

Disasters and Mental Health: Building Your Skills to Care for Patients Through Wildfires, Chemical Spills, Pandemics, Climate Change, and Beyond

Director: Joshua Morganstein, M.D.

Educational Objectives: (1) Review the range of behavioral and psychological responses, risk and protective factors, and interventions to protect mental health during disaster response and recovery; (2) Engage in an evolving and case-based disaster tabletop exercise scenario in collaboration with other participants to enhance critical thinking and real-world application; (3) Implement various role-play actions for patients, providers, responders, and community leaders throughout the disaster scenario using evidence-based interventions; (4) Discuss strategies for approaching challenges in patient care delivery and other measures to protect public mental health for individuals and communities during and after disasters.

Time: 1 p.m. – 5 p.m.; Registration cost: $190

Course Code: 3004

Interpersonal Psychotherapy

Director: John Markowitz, M.D.

Educational Objectives: (1) Allow participants to differentiate among different treatment approaches to PTSD; (2) Help clinicians understand the evidence basis for interpersonal psychotherapy for PTSD and when to apply it; (3) Comprehend and apply an interpersonal psychotherapy approach to PTSD.

Time: 1 p.m. – 5 p.m.; Registration cost: $190

Course Code: 3001

Psychodynamic Psychopharmacology: Patient-Centered Techniques to Address Pharmacologic Treatment Resistance

Director: David Mintz, M.D.

Educational Objectives: (1) Describe the evidence base linking meaning factors and medication response; (2) Construct a biopsychosocially integrated and patient-centered treatment frame; (3) Explain how pharmacotherapy and the meanings of medications can either support or interfere with development; (4) Diagnose common psychodynamics underlying pharmacologic treatment resistance; (5) Use basic psychodynamic interventions in pharmacotherapy to ameliorate psychological and interpersonal contributors to inadequate medication response.

Time: 1 p.m. – 5 p.m.; Registration cost: $190

Course Code: 3013

Imminent Suicide Risk Assessment in High-risk Individuals Denying Suicidal Ideation or Intent: Introduction and Training

Director: Igor Galynker, M.D.

Educational Objectives: (1) Appreciate the difference between long-term and imminent suicide risk; (2) Learn the nuts and bolts of NCM- and MARIS-based approaches to the assessment of imminent suicide risk; (3) Apply the NCM- and MARIS-based approaches to assess imminent suicide risk in test cases.

Time: 1 p.m. – 5 p.m.; Registration cost: $190

Course Code: 3024

Diagnosing and Managing Treatment-Resistant Depression (TRD): What's Available and What's on the Horizon?

Director: Manish Jha, M.D.

Educational Objectives: (1) Diagnose treatment-resistant depression (TRD) using systematic collection of prior treatment history and measurement-based care; (2) Review state-of-science regarding biomarkers of TRD and antidepressant treatment response; (3) Explain the role of second-generation antipsychotics in treatment of major depressive disorder; (4) Summarize the use of TRD-specific pharmacological and neuromodulation interventions; (5) Discuss experimental treatments for TRD.

Time: 8 a.m. – Noon; Registration cost: $190

CNN Anchor Anderson Cooper To Participate In 'Fireside Chat' at Opening Session

Since the start of his career in 1992, Cooper has worked in nearly 80 countries and has covered numerous major news events around the world, often reporting from the scene. Cooper has also played a pivotal role in CNN's political and election coverage. **BY MARK MORAN**

Anderson Cooper, anchor of CNN's "Anderson Cooper 360°," will be the featured guest at a "fireside chat" during the Opening Session at APA's 2024 Annual Meeting in New York City.

"Anderson Cooper 360°" is a global newscast that goes beyond the headlines with in-depth reporting and investigations. The show airs weeknights at 8 p.m. ET on CNN and is simulcast to an international audience on CNN International. Since April 2023, Cooper has also anchored "The Whole Story," airing Sundays on CNN, which showcases character-driven stories, special interviews, profiles, and investigative deep dives from CNN anchors and correspondents.

Since the start of his career in 1992, Cooper has worked in nearly 80 countries and has covered nearly all major news events around the world, often reporting from the scene. Cooper has also played a pivotal role in CNN's political and election coverage. He has anchored from political conventions and moderated several presidential primary debates and town halls. In 2016, Cooper was selected by the Committee on Presidential Debates to co-moderate one of the three debates between Donald Trump and Hillary Clinton.

In addition to his shows on CNN, Cooper is also a regular correspondent for CBS's "60 Minutes." He has won a number of major journalism awards. He helped lead CNN's Peabody Award–winning coverage of Hurricane Katrina and duPont Award-winning coverage of the 2004 tsunami in the Indian Ocean. Additionally, he has been awarded 20 Emmy Awards, including two for his coverage of the earthquake in Haiti and an Edward R. Murrow Award.

Cooper's four books—*Astor: The Rise and Fall of an American Fortune; Vanderbilt: The Rise and Fall of an America Dynasty; The Rainbow Comes and Goes: A Mother and Son on Life, Love, and Loss;* and *Dispatches From the Edge: A Memoir of Wars, Disaster, and Survival*—all topped *The New York Times* bestseller list.

Before joining CNN, Cooper was an ABC News correspondent and anchor of the network's reality program "The Mole." Cooper anchored ABC's overnight newscast "World News Now" and was a correspondent for "World News Tonight" as well as "20/20."

Cooper graduated from Yale University in 1989 with a bachelor's degree in political science. He also studied Vietnamese at the University of Hanoi. Cooper is based in New York City. **PN**

The Opening Session will be held Sunday, May 5, from 5:30 p.m. to 7 p.m. at the Javits Center.

Clinical Updates to Explore Hoarding, Lithium Underuse, and More

This year's Clinical Updates Track will feature 18 sessions that will provide clinically relevant and immediately usable information for the practicing psychiatrist. **BY NICK ZAGORSKI**

This year's Annual Meeting will once again feature the popular Clinical Updates Track: 18 sessions on clinically relevant topics presented by some of the leading minds in the psychiatry field. As with previous iterations, the Clinical Updates Track provides ready-to-use guidance on a range of common challenges a practicing clinician often encounters, said Ronald Winchel, M.D., chair of the Clinical Updates Track Subcommittee.

Winchel is excited about what he calls "an all-star lineup of speakers, including many world-class psychiatry scholar-teachers, including Charles Nemeroff, Stephen Stahl, Kim Yonkers, Roger McIntyre, Katherine Phillips, John Kane, Maurizio Fava, Lenard Adler, and many more." Winchel believes all 18 are excellent and worth attending, but he shared some thoughts on a few noteworthy ones:

- **Technological Addictions: The New Frontier in Addiction Psychiatry:** While a presentation by the current APA president might be reason enough to attend, Winchel said this talk by Petros Levounis, M.D., M.A., is extremely timely. "This may be *the* topic of 2024, if not the decade," he said, noting the deluge of stories about almost unstoppable tech overuse and overload, "stealing our time and our attention and possibly sabotaging our kids' development."

- **Rethinking Lithium:** One of the goals of this year's Clinical Updates is to reinvigorate awareness, understanding, and use of lithium. Lithium is "an extraordinary medication that has been shockingly underused—and possibly misunderstood—in recent years," said Winchel. Stephen Stahl, M.D., and Jonathan Meyer, M.D., "will address the myths that surround the drug and update us on state-of-the-art clinical use of lithium."

- **Hoarding Disorder: A Comprehensive Clinical Overview and New Research Directions:** "We all have patients who hoard, and often we may not even know years into treatment. It can be a source of enormous shame," Winchel said. "Given that many individuals may find it hard to acknowledge either to their doctors or themselves that their habits constitute a hoarding condition, and given the therapeutic nihilism that clinicians feel about hoarding, many psychiatrists may not have experience in talking to patients about hoarding." Carolyn Rodriguez, M.D., Ph.D., and Randy Frost, Ph.D., who co-authored a book on the subject last year, together with Michael Wheaton, Ph.D., will address the subject.

- **Overweight and Obesity in Persons Living With Mental Illness:** Given the recent surge of interest in medication-assisted weight loss, the ubiquity of weight gain associated with many psychotropic medications, and the growing awareness of a relationship between excess weight and vulnerability to psychiatric morbidity, everyone wants to know "what's the skinny on fat?" said Winchel. Roger McIntyre, M.D., who recently received an award from the Brain and Behavior Research Foundation for his research into the links between obesity and mood disorders, and Joseph Goldberg, M.D., both stellar teachers, will review the evolving science and clinical application of our emerging knowledge.

- **Worry, Worry, Worry: Treatment of Anxiety Disorders and PTSD:** "Anxiety symptoms and disorders are enormously common but often minimized or dismissed as a secondary disorder in comparison to depression or other diagnoses," Winchel said. But disorders such as generalized anxiety disorder and social anxiety disorder can be the sources of considerable—even life compromising—distress and functional impairment; they are also among the most challenging to bring to full, or near, remission. The always engaging Charles Nemeroff, M.D., Ph.D., will draw on his breadth of experience and discuss how psychiatrists can optimize their anxiety treatment.

- **Overview of Antipsychotics:** "Old, new, typical, atypical, first generation, second generation, third generation. The range in this oldest of psychotropic classes is

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Acclaimed Public Interest Lawyer and Best-Selling Author To Present Plenary Address

Renowned public interest lawyer Bryan Stevenson, J.D., M.P.P., has devoted his career to helping the poor, incarcerated, and condemned.

BY KATIE O'CONNOR

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Among the many awards that Bryan Stevenson, J.D., M.P.P., has won is APA's 2012 Chester M. Pierce Human Rights Award for his work on social justice and human rights.

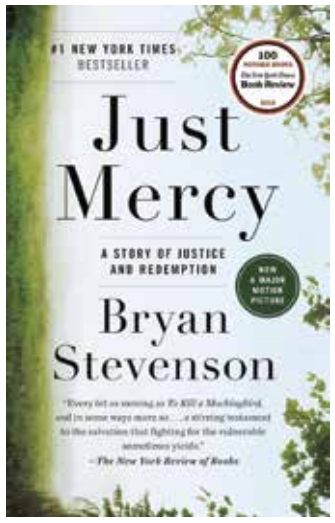
Social justice activist, lawyer, and author Bryan Stevenson, J.D., M.P.P., will be a plenary speaker at the 2024 APA Annual Meeting in New York City. He will present a lecture in the ongoing series titled "Emerging Voices: Diversity, Equity, Inclusion and Belonging."

A world-renowned public interest lawyer, Stevenson has devoted his career to criminal justice reform and defending condemned prisoners, juvenile offenders, and people who were wrongly convicted. He founded the Equal Justice Initiative, a nonprofit law organization that focuses on social justice and human rights. He and his staff have won reversals, relief, or release from prison for over 140 wrongly condemned prisoners on death row. They have also won relief for hundreds of other individuals who were wrongly convicted or unfairly sentenced. He also led the creation of two highly acclaimed cultural sites that opened in 2018: the Legacy Museum and the National Memorial for Peace and Justice. The institutions chronicle the legacy of slavery, lynching, racial segregation, and the connection to mass incarceration and contemporary issues of racial bias.

Stevenson has argued and won multiple cases at the U.S. Supreme Court, including a 2019 ruling protecting condemned prisoners who suffer from dementia and a 2012 ruling that banned mandatory life imprisonment without parole sentences for children 17 and younger. A graduate of Harvard Law School and the Harvard School of Government, he received the MacArthur Fellowship Award Prize in 1995.

He received APA's Chester M. Pierce Human Rights Award in 2012. Some of the additional prestigious awards he's received include the Reebok Human Rights Award; the Olaf Palme Prize in Stockholm, Sweden, for international human rights; and the ACLU National Medal of Liberty after he was nominated by U.S. Supreme Court Justice John Stevens. In 2015, he was named to the *Time* 100, which annually recognizes the world's most influential people.

His 2015 book *Just Mercy* won the Carnegie Medal for Best Nonfiction, the Dayton Literary Peace Prize, and the NAACP Image Award for Best Nonfiction. It was adapted into a major motion picture, and the film won the American Bar Association's 2020 Silver Gavel Award. Stevenson is also the subject of the Emmy Award-winning HBO documentary "True Justice."



The Aronson Family Professor of Criminal Justice at the New York University School of Law, Stevenson has written for numerous publications. In 2015, he contributed an essay to the Brennan Center for Justice's *Solutions: American Leaders Speak Out on Criminal Justice*. In his essay, titled "Mercy, Especially for the Mentally Ill," Stevenson wrote that his clients have often been broken by mental illness, poverty, and racism.

"In their broken state, they were judged and condemned by people whose commitment to fairness had been broken by cynicism, hopelessness, and prejudice," he wrote. "We are supposed to sentence people fairly after fully considering their life circumstances, but instead we exploit the inability of the poor to get the legal assistance they need—all so we can kill them with less resistance."

One powerful way to practice mercy is to change the way individuals with mental illness are treated, he wrote. "We get angry when people fail to recognize the need for thoughtful and compassionate assistance when it comes to the physically disabled, but because mental disabilities aren't visible in the same way, we tend to be dismissive of the needs of the disabled and quick to judge their deficits and failures," he wrote.

There are viable options to accommodate people with mental illness, he explained. Reforms should focus on providing funding so people with mental illness can receive services in the community. Mental health courts could redirect individuals to treatment instead of prison.

"Ultimately, you judge the character of a society, not by how they treat their rich and the powerful and the privileged, but by how they treat the poor, the condemned, the incarcerated," he wrote. "All of our survival is tied to the survival of everyone." **PN**

Stevenson's lecture will be held Monday, May 6, from 10:30 a.m. to noon at the Javits Center.

"Mercy, Especially for the Mentally Ill" is posted at https://www.brennancenter.org/our-work/analysis-opinion/mercy-especially-mentally-ill.

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sometimes beyond perplexing." Winchel said. He pointed out that the large number of choices, complicated by variabilities in neurotransmitter effects, costs, indications, and side effects "can generate a psychiatric crisis in the doctor who is trying to make the best choice for a particular patient." John Kane, M.D., will make use of his outstanding expertise and experience in the field to bring order and clarity to these medications and their application to both mood and psychotic disorders.

Additional sessions and presenters include the following:

- **Suicide Across the Board: Risk Factors, Assessments, and Interventions:** Karen Wagner, M.D., Doug Jacobs, M.D.

- **Irritability and Disruptive Behaviors in Children and Adolescents:** Janet Wozniak, M.D.

- **Clinical Update on Personality Disorders: Diagnosis and Treatment:** Kaz Nelson, M.D., Carla Sharp, M.D.

- **Cardiac Issues in Psychiatry:** Margo Funk, M.D.

- **Autism and Neurodivergent Individuals Across the Lifespan:** Eric Hollander, M.D.

- **Obsessive-Compulsive Spectrum Disorders: Clinical Presentation and Treatments:** Jon Grant, M.D., M.P.H., Katherine Phillips, M.D., Christopher Pittenger, M.D., Ph.D.

- **Psychiatric Update on Reproductive Mood Disorders:** Kim Yonkers, M.D., Gina Savella, M.D.

- **Pharmacological Approaches to Treatment-Resistant Depression:** Maurizio Fava, M.D.

- **Emerging Concepts in Difficult-to-Treat Late-Life Depression:** Jordan Karp, M.D., Eric Lenze, M.D., Olusola Ajilore, M.D., Ph.D., Meryl Butters, Ph.D.

- **Real-World Strategies for BP 2: Recognition and Management Under Conditions of Uncertainty:** Gary Sachs, M.D.

- **Neuromodulation:** Andrew Leuchter, M.D., Linda Carpenter, M.D.

- **Diagnosis, Assessment, and Treatment of ADHD Through the Lifespan:** Leonard Adler, M.D. **PN**

Richard Kogan: 'S Wonderful Once Again

The special lecture and recital by pianist-psychiatrist Richard Kogan, M.D., will mark the 100th anniversary of Gershwin's "Rhapsody in Blue" and include other timeless classics from this "quintessential New Yorker." **BY NICK ZAGORSKI**

It's encore time! After a six-year hiatus, psychiatrist and pianist Richard Kogan, M.D., will return to the APA Annual Meeting to offer one of his standing-room-only musical lectures and demonstrations. As the 2024 meeting will take place in New York, Kogan will discuss the life, music, and mental health of a quintessential New York composer: George Gershwin.

"Not only did he grow up in the city and spend most of his life there, but perhaps his most iconic piece is a perfect encapsulation of New York in the jazz age," Kogan said. That iconic musical number is "Rhapsody in Blue," which is celebrating its 100th birthday this year and will be one of the pieces Kogan will play and discuss.

Kogan is a clinical professor of psychiatry at Weill Cornell Medical College, artistic director of the Weill Cornell Music and Medicine Program, and co-director of the Weill Cornell Human Sexuality Program.

"Rhapsody in Blue" enthralled the audience upon its world premiere on February 12, 1924, at New York's Aeolian Hall, and it quickly became a commercial success. It also led to a meteoric and surprising rise for the young Gershwin, who was only 25 at the time.

"Unlike many of the greats in the composer pantheon, Gershwin grew up in a home without music," Kogan said. He was a typical New York tenement child, running around with friends and getting into trouble. "My perspective is that were he to grow up today, Gershwin might get a diagnosis of conduct disorder and possibly attention-deficit/hyperactivity disorder; he was impulsive and could not sit still in a classroom," Kogan said.

His trajectory changed at age 10 when he stopped by a classmate's violin recital and became captivated by the sounds he heard. His parents had recently bought a piano for Gershwin's brother Ira, but George became the one to use it intently.

"It's a pretty powerful story of music's capacity to heal," Kogan noted. "Most of his conduct and attention problems abated after he began studying music." Gershwin dropped out of school at age 15 and started working as a song plugger (playing sheet music at music houses to promote and sell new songs); he also began working on his own compositions with the help of Ira, who provided lyrics. Gershwin produced several minor hits in musical theater before his breakthrough with "Rhapsody in Blue."

"What may be relevant to our very divisive times is that Gershwin did not believe in rigid distinctions of musical genre," Kogan said. "His popularity grew because he could unite genres that were considered distinct, like the classical and jazz elements of 'Rhapsody.'

see **Richard Kogan** *on page 27*

NIMH Celebrates 75th Anniversary With Special Sessions

Among the presentations will be a panel featuring not one, not two, but three distinguished scientists who have directed the institute over the years: Joshua Gordon, M.D., Ph.D., Thomas Insel, M.D., and Steven Hyman, M.D. **BY NICK ZAGORSKI**

In April 1949, the National Institute of Mental Health (NIMH) was formally established as one of the first components of the National Institutes of Health (NIH). At this year's Annual Meeting in New York, NIMH is sponsoring a special track of eight sessions marking its 75th anniversary and looking ahead to the future.

"NIMH doesn't get enough credit for all the progress we have made in understanding the brain," said Megan Kinnane, Ph.D., senior advisor to the NIMH director who helped organize this year's track of sessions. "We are really excited about where we have come from and where we are going and hope to share some of our stories."

The centerpiece presentation will be a panel talk featuring current NIMH Director Joshua Gordon, M.D., Ph.D., along with two of his predecessors: Steven Hyman, M.D., Ph.D. (1996–2001, currently the director of the Stanley Center for Psychiatric Research at the Broad Institute), and Thomas Insel, M.D. (2002–2015, currently executive chair of Vanna Health, a startup organization that works with community partners to provide for people with serious mental illness).

The trio of past and present leaders will reflect on their time at the helm as well as discuss the history of mental health research more broadly. Kinnane said the session will be frank and discuss not only the institute's many accomplishments but also areas in which it could improve. "We haven't always been in a good space, and it's important to acknowledge that."

The other seven scientific sessions will touch on some of the big programs that NIMH has initiated and/or been involved in over the years; these include the Recovery After an Initial Schizophrenia Episode (RAISE) initiative, which paved the way for specialty coordinated care services for schizophrenia, and the ongoing BRAIN initiative, which is developing innovative tools to study and treat brain disorders.

The track includes the following sessions:

- Rigor, Translation, and Inclusion in NIMH-supported Youth Mental Health Research to Advance Impact: Lessons Learned and Opportunities
- Early Psychosis Care: From RAISE to EPINET and Beyond
- Expanding 988 Suicide and Crisis Services and Research: What Psychiatrists Need to Know
- Brain Behavior Quantification and Synchronization: Multimodal Measurements in the Real World
- Cutting-Edge Mental Health Disparities Research: Current State and Future Directions
- Leveraging the All of Us Research Program Dataset to Support Mental Health Research and Advance Precision Medicine
- Therapeutics Pipeline for the Treatment of Mood and Psychotic Disorders

In addition to the presentations, NIMH will have an exhibit showcasing the institute's history and milestones, so attendees should look for it between sessions.

In the meantime, Kinnane suggested that interested individuals check out the 75th anniversary celebration page on NIMH's website. The page includes a downloadable history booklet, a digital toolkit, podcasts, and a schedule of related events. On March 18, for example, NIMH will host a live and virtual symposium at the National Archives in Washington, D.C., on NIMH's interaction with society over the years. The symposium will bring together researchers and people living with mental illness who will discuss the challenges of clinical mental health research and how it can be made more inclusive. **PN**

NIMH's 75th Anniversary webpage is posted at https://www.nimh.nih.gov/75years.

Future of California's 'Millionaire Tax' Up for Vote in March

BY NEIL S. ABIDI, D.O., AND WILLIAM ARROYO, M.D.

President George W. Bush's New Freedom Commission on Mental Health reported in 2002 that the mental health systems across the country were in shambles. Many attempts to change the system in California have failed. The ballot initiative, the Mental Health Services Act (MHSA) or millionaire's mental health tax, passed in 2004. The MHSA imposed a state individual 1% tax surcharge on annual incomes exceeding $1 million. It sought to achieve its aims by local planning, community-based care, prevention, early intervention, and innovation primarily through the local county administration; the target were those individuals with severe mental disorders. The tax generates approximately one-third of the financing of California's public mental health system, generating $3.8 billion in 2022.

Local and state elected officials have been stymied by an accelerating lack of affordable housing, housing shortages, homelessness, and the opioid crisis, among other obstacles. Numerous public media reports, including a state audit in 2018, have further fueled concerns that the MHSA has not achieved its original goals. A statewide comprehensive evaluation of the MHSA did not occur. In response to the urgency of the situation, Gov. Gavin Newsom has decided to tackle both homelessness and a "shambled" mental health system by way of a politically expedient option. This option is framed in the form of a new ballot initiative, Proposition No. 1: Behavioral Health Services Program and Bond Measure, which comprises two bills. The first is SB 326, also known as The Behavioral Health Services Act, and the second is AB 531, also known as The Behavioral Health Infrastructure Bond Act of 2023.

According to the governor, new challenges have emerged since the passage of the MHSA, which require a renewed vision of how to address the burdens of the behavioral health and homelessness crises in California. The announcement of this proposal was abruptly introduced in March 2023 and startled the mental health community. Nonetheless, the governor is determined to have the initiative placed on the March ballot instead of the November one—timing that historically does not favor such initiatives.

The controversies related to the proposed initiative include limiting scrutiny by the legislature and general public; limiting input by the broad community of behavioral health stakeholders, including consumers, statewide bodies, and organized psychiatry; expanding the target population to individuals with substance use disorders and veterans with behavioral health problems without commensurate tax rates; diverting funds from ongoing prevention and early intervention programs and voluntary services; shifting funding from children's mental health services; reversing the initial decision to exclude the use of funds from locked settings; the shift from county to state oversight; deprioritizing historically underserved minoritized communities; shifting of 30% of revenue to housing intervention programs; and abrupt defunding of ongoing local programs. Similarly, the state Legislative Analyst's Office was dissatisfied with the rationale for restructuring the MHSA and lack of a fiscal analysis on its potential impact on current programs.

Neil S. Abidi, D.O., is a child and adolescent and adult psychiatrist at Northeast Mental Health Center, a community-based mental health clinic of the Los Angeles County Department of Mental Health. William Arroyo, M.D., is an adjunct clinical assistant professor of psychiatry and behavioral health sciences at the Keck USC School of Medicine. Additionally, he is a member of APA's Council on Advocacy and Government Relations and serves as an advisor to the California Department of Health and Human Services, the Department of Healthcare Services, and the Department of Corrections and Rehabilitation.

SB 326 will modernize the MHSA by expanding services to include treatment for substance use disorders, provide bridge housing, prioritize those with severe mental illness, and diversify the state oversight commission. It will shift 30% of the newly renamed fund, Behavioral Health Services Act (BHSA) Fund, to housing interventions. Expansion of 24/7 services and supports, early intervention programs, outreach, and workforce education are included, but local flexibility for use of funds will be curbed. The companion bill, AB 531, proposes 10,000 new treatment beds and supportive housing units, including acute and subacute beds, funded by establishing a $6.4 billion general obligation bond. Other housing interventions include subsidies, shared housing, and family housing options. Greater state oversight, transparency, and accountability elements are added.

see **Millionaire Tax** *on page 32*

What Can You Do to Decrease Homelessness in the U.S.?

BY KATHERINE WU, M.D.

Have you ever tried to get eight hours of tranquil sleep while contending with constant threats to your physical safety or the possibility of having your belongings stolen?

Every psychiatrist knows about the importance of good sleep, so I ask all my patients about their sleep patterns. Disrupted circadian rhythm contributes to decompensations in almost every mental illness. Inadequate sleep increases cortisol levels, which makes patients more irritable, anxious, dysphoric, manic, and even delirious. I provide information on behavioral modifications and prescribe medications to make sleep more restful. For patients without a permanent place to call home, my efforts fall short, as the unpredictability of homelessness makes it hard to form a "normal sleep routine" (for example, going to sleep at the same time every night, putting away electronics before bed, and participating in quiet activities to promote sleepiness). For patients with substance use disorders and homelessness, it is difficult to stay away from drug paraphernalia and other triggers for usage.

Katherine Wu, M.D., is an APA/APA Foundation Leadership Fellow and a PGY-3 psychiatry resident at the University of Virginia.

To achieve the APA Foundation's goal of a mentally healthy nation, we need to do our part to ensure that every person is safely housed. In Charlottesville, Va., alone, where I live, there has been about a 40% increase in homeless individuals from 2020 to 2022. Homeless individuals include the number of people who are in emergency shelters, transitional housing, or unsheltered on a given day, according to the Blue Ridge Area Coalition for the Homeless.

If you want to do your part in addressing homelessness and provide meaningful support to homeless individuals, here are some helpful advocacy points to address at the local and state levels:

- **Advocate against local and state-managed curfews.** Stringent curfews force people in homelessness to seek shelter, but in cities that do not have capacity to shelter people for the night, this increases the risk of unsheltered people being incarcerated. Criminal charges may make it even more difficult to obtain permanent, safe housing in the future.

- **Support housing-first programs.** Numerous institutions have argued that housing is a human right. Providing housing without requiring potential tenants to "work a program" and prove themselves "worthy of housing" is not only the right thing to do but it is also cost-effective—for example, it decreases the number of emergency room visits and hospitalizations and the burden on the criminal justice system. After obtaining secure housing, people are able to make incremental changes toward getting a job, obtaining an education, or participating in substance use treatment programs. As mental health professionals have witnessed firsthand, people who voluntarily engage in mental health services without mandates are more likely to stay in treatment.

- **Support expansion of the Housing Choice Voucher Program, Mainstream Vouchers, and project-based rental assistance programs.** The Housing Choice Voucher Program provides financial assistance for families in the private market, whereas Mainstream Vouchers provide financial assistance to families whose head of household, spouse, or sole inhabitant is a person with disabilities. Project-based rental programs provide

see **Homelessness** *on page 28*

ADHD Meds Linked to Cardiovascular Risk

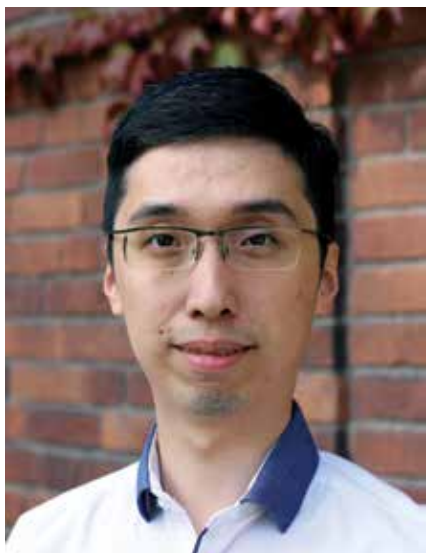
The increase in risk is dose-dependent, and largely attributable to stimulant medications. **BY TERRI D'ARRIGO**

Long-term use of medications for attention-deficit/hyperactivity disorder (ADHD) is associated with a small but statistically significant increase in risk for cardiovascular disease (CVD), notably hypertension and arterial disease, according to a study in *JAMA Psychiatry*.

Zheng Chang, Ph.D., principal researcher in the Department of Medical Epidemiology and Biostatistics at the Karolinska Institutet in Stockholm, and colleagues examined data from 278,027 Swedish individuals aged 6 to 64 years who had an incident ADHD diagnosis or ADHD medication dispensation between 2007 and 2020. They identified 10,388 patients with CVD and matched them to 51,672 controls without CVD. The researchers followed the patients, who were a median age of 35 years, for up to 14 years, with a median length of follow-up of 4.1 years.

Overall, individuals who took ADHD medication for more than five years had a 23% higher risk of CVD compared with those who did not take the medication. The increased risk appeared to peak at 27% between three and five years of medication use.

Those who took ADHD medications for three to five years and more than five years had 72% and 80% increased risk of hypertension, respectively. Those who took ADHD medications for three to five years and more than five years had 65% increased risk and 49% increased risk of arterial disease, respectively. However, risk did not appear to increase for arrhythmias, cerebrovascular disease, heart failure, ischemic heart disease, or thromboembolic disease.



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The increased cardiovascular risk of ADHD medications should be weighed on a case-by-case basis, said Zheng Chang, Ph.D.

Compared with taking no ADHD medications, taking methylphenidate for three to five years or more than five years was associated with 20% increased risk and 19% increased risk of CVD, respectively. Taking lisdexamfetamine for three to five years or more than five years was associated with 23% increased risk and 17% increased risk of CVD, respectively. However, those who took atomoxetine had only 7% increased risk of CVD, and only for the first year of use. The increased risk for CVD occurred only above an average daily dose of 45 mg for either methylphenidate and lisdexamfetamine and 120 mg for atomoxetine.

"The use of ADHD medications has increased substantially in many countries during the past decades. Cardiovascular safety is one of the most important safety concerns of these drugs," Chang told *Psychiatric News*.

"The increased cardiovascular risk, together with other safety concerns [such as the individual's risk profile and family history of cardiovascular diseases], should be carefully weighed against the established benefits, on a case-by-case basis," Chang added, noting that ADHD itself is associated with a higher risk of CVD.

In an accompanying editorial, Samuele Cortese, M.D., Ph.D., a professor of child and adolescent psychiatry at the University of Southampton, United Kingdom, and Cristiano Fava, M.D., Ph.D., an associate professor in the Department of Medicine, General Medicine and Hypertension Unit at the University of Verona, Italy, stressed the importance of considering clinical guidelines while also weighing the risk-benefit ratios of ADHD medications for different patients.

"[S]everal guidelines recommend stimulants as first-line treatment over nonstimulants, considering the balance between efficacy and overall tolerability and safety. Therefore, recommending nonstimulants as first-line treatment solely based on cardiovascular risk would not reflect the full body of evidence on ADHD medications," they wrote.

They added that the risk-benefit ratio may be lower in individuals with preexisting cardiovascular conditions, but that more evidence and precise recommendations are needed in relation to the treatment of individuals with those conditions and ADHD.

"In summary, the study … should remind us that clinical decision-making is often based on tricky trade-offs that should be considered at the individual patient level, rather than straightforward one-size-fits-all recommendations," they wrote.

The study was supported by the Swedish Research Council for Health, Working Life, and Welfare and the European Union's Horizon 2020 research and innovation program. **PN**

"Attention-Deficit/Hyperactivity Disorder Medications and Long-Term Risk of Cardiovascular Diseases" is posted at http://apapsy.ch/ADHD-CVD. "Long-Term Cardiovascular Effects of Medications for Attention-Deficit/Hyperactivity Disorder—Balancing Benefits and Risks of Treatment" is posted at http://apapsy.ch/editorial-ADHD-CVD.

As Psychedelic Research Advances, Can Youth Benefit?

A session at the American Academy of Child and Adolescent Psychiatry's annual meeting explored the research landscape of psychedelics as therapeutics for mental illnesses among youth, encouraging both clinicians and the public to approach the topic with caution and balanced enthusiasm. **BY KATIE O'CONNOR**

As research on psychedelics has accelerated, the drugs have increasingly been spotlighted in the media. "There's a lot of excitement and enthusiasm about the potential for psychedelics to transform the treatment of psychiatric and substance use disorders, or even just to improve overall well-being," said Tiffany Farchione, M.D., director of the Division of Psychiatry in the Office of Neuroscience at the Food and Drug Administration (FDA).

Yet the problem with a lot of the news coverage is that it generally suggests that psychedelics are miracle drugs, Farchione continued. "That's really putting the cart before the horse," she said.

Farchione spoke at a session at the American Academy of Child and Adolescent Psychiatry's annual meeting. She and David Hellerstein, M.D., addressed the therapeutic potential of psychedelics for treating mental illnesses, specifically within child and adolescent psychiatry. Hellerstein is the director of the Depression Evaluation Service at the New York State Psychiatric Institute. The session was co-chaired by Kevin Gray, M.D., and Paul Croarkin, D.O., M.S.

"As a clinician, I'm excited about this area because like many others, I've been frustrated that we haven't had a lot of new treatment breakthroughs," said Gray, assistant vice president for advancing research partnerships at the Medical University of South Carolina. "We're seeing patients every day who are struggling, and we are looking for new therapeutics.

"But as somebody who is cautious by nature," he continued, "I really appreciate when clinicians and regulatory authorities work together to develop these new therapeutics in ways that can be leveraged appropriately."

Hellerstein outlined the current state of research on psychedelics as therapeutics. He pointed out some of the difficulties in conducting studies in this area, such as the difficulty of blinding in psychedelic trials. Participants in these trials often have high expectations and are highly educated on the effects of psychedelics. Many of them have used psychedelics before, so they know what a trip feels like and can tell if they've been given a placebo.

"Child and adolescent research in psychedelics poses complex challenges and a variety of potential risks."

—David Hellerstein, M.D.

There are still many questions to be answered about how psychedelics can best be used among the adult population, Hellerstein said. "I think the biggest question for child and adolescent populations is: Should research in this area be pursued?"

see **Psychedelic Research** *on page 30*

PSYCHIATRIC NEWS
Special Report

Psychiatrists Critical in Screening, Treatment of Alcohol Use Disorder

Despite the wide prevalence of alcohol misuse and the existence of evidence-based treatments, including three FDA-approved medications, only a small percentage of people with alcohol use disorder receive treatment.

BY SEAN LYNCH, M.D., AND JEREMY KIDD, M.D.

Alcohol remains the most commonly used and misused substance in the United States. In 2021, there were nearly 174.3 million people aged 12 and up who reported past-year alcohol consumption, 2 million emergency department visits related primarily to alcohol, and over 140,000 alcohol-related deaths, according to the U.S. National Survey on Drug Use and Health (NSDUH). This makes excessive alcohol consumption the fourth-leading preventable cause of death in the United States.

Alcohol use has significant consequences—among them are impairment across major areas of functioning; disrupted academic/work performance; interference with interpersonal relationships; and increased risk of violence, suicide, and overall accidents, including motor vehicle accidents.

Alcohol-related medical complications are significant and include alcohol-associated liver disease, which can involve steatosis (fatty liver), steatohepatitis, fibrosis, cirrhosis, and alcohol-associated hepatitis. Alcohol-associated liver disease is responsible for 80% of liver-disease deaths and is the most common indication for liver transplantation.

Alcohol affects the entire body, not just the liver, including the brain, gastrointestinal tract, cardiovascular system, and immune system. Alcohol is a carcinogen associated with multiple forms of cancer. Chronic heavy alcohol consumption is the leading cause of chronic pancreatitis and can lead to nutritional deficits and subsequent neurological syndromes, such as the Wernicke-Korsakoff syndrome.

Alcohol interacts with many medications, including those commonly prescribed by psychiatrists. Patients with depression who are taking antidepressant medications may have reduced treatment response and adherence, even with low levels of drinking. Sedative and anxiolytic medications can have synergistic effects with alcohol, increasing the risk of accidental overdose. Alcohol has also been found to contribute to over 20% of opioid overdose deaths.

Sean Lynch, M.D., is a PGY-3 psychiatry resident at Mount Sinai Beth Israel in New York City. He is an APA Leadership Fellow and is co-chair of the Addiction Committee of the New York County Psychiatric Society. Jeremy Kidd, M.D., is an assistant professor of clinical psychiatry in the Division on Substance Use Disorders at Columbia University Irving Medical Center. He is a member of APA's Council on Addiction Psychiatry.

In addition to the individual-level impacts, hazardous drinking has significant effects on families, communities, and the population at large. According to the U.S. surgeon general, the annual economic

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impact of alcohol misuse costs the United States economy $249 billion annually.

Spectrum of Drinking: From Alcohol Use to Alcohol Use Disorder

Prevalence

According to the 2021 NSDUH, nearly 30 million Americans met past-year *DSM-5* criteria for alcohol use disorder (AUD). Lifetime prevalence of AUD was estimated to be 29% (8.6% mild, 6.6% moderate, and 13.9% severe). In addition, there were significant racial/ethnic differences in heavy alcohol use among Americans 12 years and older, with White Americans having the highest rate (6.7%) and Asian Americans having the lowest rate (1.9%).

Various risk factors for developing AUD have been identified, including environmental risk factors such as poverty, discrimination, structural inequalities, cultural attitudes, and stress levels. There is also a significant genetic risk, as those who have a close relative with AUD have a three to four times higher risk of developing AUD themselves. Patients who have specific psychiatric diagnoses, particularly schizophrenia or bipolar spectrum disorders, are also at an increased risk.

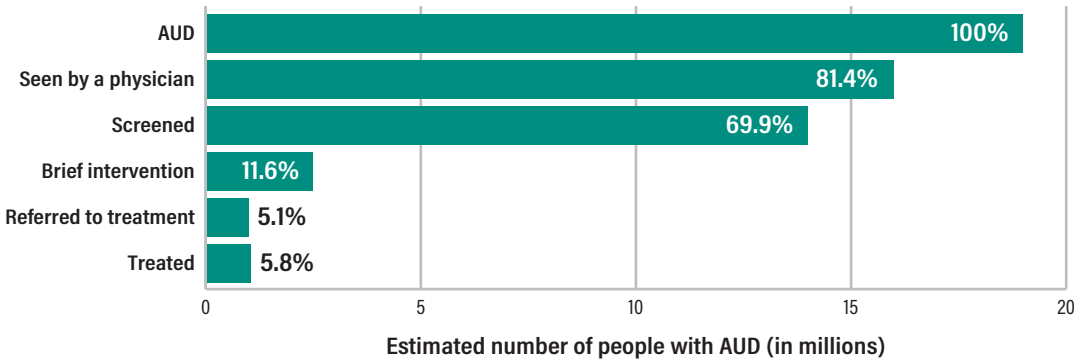
Neurobiology

Acute and chronic alcohol use impacts multiple neurotransmitters, including serotonin, dopamine, gamma-aminobutyric acid, glutamine, acetylcholine, and the endogenous opioid systems. This disruption can affect normal brain activity and lead to dysregulation in the natural reward system.

Addiction to alcohol occurs in three phases involving different brain regions. First is the "preoccupation and anticipation stage" involving the prefrontal cortex. Second is the "binge and intoxication stage," primarily involving the basal ganglia.

Most People With AUD Are Screened but Few Receive Any Treatment

Data from the 2015–2019 National Survey on Drug Use and Health shows that most people with AUD visited a doctor and were screened about alcohol use during the past year, but few received intervention. These results suggest there is a missed opportunity in health care settings to engage people with AUD in care and point to the need for improved implementation of evidence-based AUD treatments.



Source: Carrie Mintz, M.D., et. al., *Journal of Alcohol Clinical and Experimental Research,* May 16, 2021.

And third is the "withdrawal and negative affect stage," linked to changes in the amygdala and other limbic structures. At each stage, clinicians can effectively intervene (see figure on facing page).

Alcohol use versus alcohol use disorder

The majority of people who use alcohol do not meet the criteria for AUD. In contrast to alcohol use, AUD is characterized by an inability to control alcohol consumption despite negative health, social, and/or occupational consequences. The criteria for diagnosing AUD have changed somewhat over the years, with *DSM-5* moving AUD from a binary diagnosis (alcohol abuse versus alcohol dependence) to a spectrum of illness, with the severity of AUD now defined by the number of individual symptoms that someone experiences. Notably, in *DSM-5* craving for alcohol was added as a criterion, while having legal problems was removed. Also removed was the requirement to experience withdrawal symptoms when consumption stops, which is particularly notable because many people with AUD are not physiologically dependent on alcohol.

Impact of COVID-19 pandemic

In the first year of the COVID-19 pandemic, alcohol sales increased by almost 3%. Twenty-five percent of people reported drinking more than usual, and deaths related to alcohol-linked liver disease increased by over 22%. One meta-analysis sought to identify predictors of increased alcohol use and found that the mean change in alcohol consumption was nonsignificant. However, 23% of individuals significantly increased their consumption, which has been interpreted to mean that there was an increase in heavy alcohol consumption among some individuals, while people who typically drank

Table 1. Medications Used to Treat AUD

Medication	FDA Approval	Mechanism	Dosing	Contraindications	Pros	Cons
Naltrexone (Revia, Vivitrol)	Yes	Naltrexone is an opioid antagonist that blocks the reinforcing effects of alcohol	Oral: 50 mg initially, normal range 50-100 mg daily Intramuscular: 380 mg IM every 4 weeks	Current opioid use Hepatic failure Liver enzymes > 3 times normal limit	Naltrexone is available in a long-acting injectable formulation; patients may begin taking the medication while still drinking.	Liver enzyme monitoring is recommended within several weeks of initiation, and then biannually during treatment. Naltrexone has a black-box warning for liver damage at excessive doses
Acamprosate (Campral)	Yes	Acamprosate is an NMDA receptor antagonist that alleviates emotional discomfort as the brain adjusts to abstinence	666 mg TID	Severe renal insufficiency	Acamprosate is not metabolized by the liver.	Acamprosate requires a burdensome dosing schedule that may be difficult for patients to comply with
Disulfiram (Antabuse)	Yes	Disulfiram operates on the principle of negative reinforcement. It blocks a key enzyme in ethanol metabolism (acetaldehyde dehydrogenase) producing unpleasant symptoms if alcohol is consumed	250-500 mg/day for 1-2 weeks, then usually 250 mg daily	Cardiac disease, psychosis, ongoing alcohol use	Multiple clinical trials support the effectiveness of this medication, especially when voluntary adherence is monitored (e.g., by a family member)	This medication carries a high risk of pharmacological interactions. Liver enzymes should be monitored when initiating treatment and biannually during treatment. There is no option for harm reduction, and efficacy is dependent on adherence
Topiramate (Topamax)	No	Topiramate is a GABA and glutamate modulator.	25 mg once daily, range of 50-300 mg/day in split doses.	Renal disease	Topiramate prevents seizure and does not cause weight gain; it may cause some weight loss	Topiramate may impact memory/cognition and carries a risk for metabolic acidosis
Gabapentin (Neurontin)	No	Gabapentin inhibits calcium influx and subsequent release of excitatory neurotransmitters	300 mg/day, with target dose of 600 mg TID	Myasthenia gravis or myoclonus	Gabapentin may offer some seizure prevention. Evidence supports adjunctive use of this drug with naltrexone; there is no need for hepatic dose adjustment	Gabapentin carries a risk for misuse. Dose adjustment may be required for patients with renal impairment

only socially may have consumed less. Predictors of increased drinking included contextual changes (such as income loss, remote work and resulting isolation and anxiety, children at home) as well as factors related to mental illness (such as worsening depression or anxiety).

AUD Prevention and Screening

Despite the high prevalence of AUD in this country, many patients go undiagnosed, and even fewer receive any treatment: less than 10% receive any treatment, and less than 2% receive one of the three FDA-approved medications—naltrexone, acamprosate, and disulfiram. The APA Practice Guideline on the Pharmacological Treatment of Patients With Alcohol Use Disorder recommends that all patients with suspected AUD be assessed for use of all substances.

Intervening early in the course of AUD can lead to better outcomes. For example, individuals who engage in heavy drinking are at increased risk of developing AUD. According to the National Institute on Alcohol Abuse and Alcoholism, "heavy drinking" is defined as four or more drinks in one day (or eight or more a week) for women, and five or more drinks in one day (or 15 or more a week) in men. Additional research is needed to create a definition that is inclusive of nonbinary and other gender-diverse populations.

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based paradigm for prevention and early detection of AUD. In the SBIRT model, all patients complete a validated screening instrument (for example, the Alcohol Use Disorder Identification Test for adults or the CRAFFT for adolescents; CRAFFT stands for Car, Relax, Alone, Forget, Friends, Trouble). Those who meet *DSM*-5 criteria for AUD are referred for full evaluation and formal evidence-based AUD treatment.

AUD remains a clinical diagnosis, with no definitive diagnostic instrument or laboratory test. However, in addition to the screening tools mentioned above, there are assessments such as the 11-item Alcohol Symptom Checklist, adapted from the diagnostic criteria in *DSM*-5, which can help make the diagnosis as well as establish the severity of AUD.

Laboratory tests can be helpful in detecting heavy alcohol use and monitoring treatment response. Alcohol biomarkers include gamma-glutamyltransferase, carbohydrate-deficient transferrin, and ethylglucuronide. Other indirect biomarkers (such as liver function tests, mean corpuscular volume, uric acid, and lipid profile) can help measure the impact of alcohol on the body. Presenting patients with such objective evidence of bodily harm can sometimes overcome ambivalence about starting AUD treatment. For more information on alcohol biomarkers, including their relative strengths and limitations, see the APA Practice Guideline on the Pharmacological Treatment of Alcohol Use Disorder.

Treatment Goals and Treatment

Collaboratively establishing treatment goals with patients should include a personalized discussion of the alcohol-related harms they are experiencing (for example, relationship and job problems, medical problems, psychological impact) and the risks of continued alcohol use. Historically, abstinence was viewed as the only effective way to recover from AUD and was the primary endpoint of much AUD treatment research. However, for many patients, researchers and clinicians have found that moderation goals (reducing heavy alcohol consumption or reducing drinking in high-risk situations) can improve health outcomes and mitigate the impact of AUD. While abstinence may remain the safest course for specific subgroups of patients, nonabstinence-based treatment that embraces a harm-reduction philosophy allows clinicians to reach a wider segment of the population with AUD.

For individuals who screen positive for potential AUD, clinicians deliver a 5- to 10-minute brief intervention based on principles of motivational interviewing. The goal is to help patients identify ways that alcohol may be negatively impacting their lives and to collaboratively set short-term goals to reduce alcohol-related harms.

Most AUD treatment occurs in the outpatient setting and involves regular office visits. The preferred approach to treating patients with AUD outside of the acute intoxication and withdrawal stages is a combination of pharmacological and nonpharmacological interventions. Continued care across settings (inpatient and outpatient) is recommended to achieve long-term recovery.

Evidence-based AUD psychotherapies include cognitive-behavioral therapy to identify and manage cues that lead to heavy drinking, motivational enhancement therapy to overcome ambivalence about reducing or stopping drinking, and 12-step facilitation to help patients make optimal use of mutual self-help groups like Alcoholics Anonymous. Community-based mutual self-help groups (Alcoholics Anonymous, Smart Recovery, Moderation Management) may also be helpful for patients, particularly because they reduce social isolation and provide interaction with others in recovery.

Commonly used pharmacological interventions are described in the table on the facing page. Pharmacotherapies are significantly underutilized; in 2022, only 2.1% of adults with AUD received medication treatment, according to the National Institute

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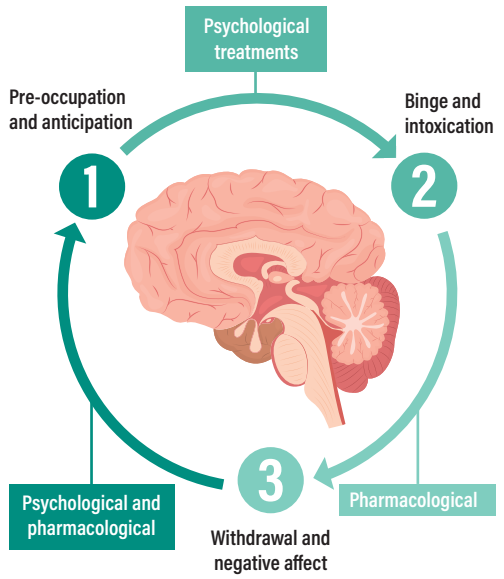
Alcohol Cycle

This figure depicts the typical cycle of alcohol use disorder, which includes anticipation (involving the prefrontal cortex), intoxication (involving the basal ganglia), and withdrawal (involving the amygdala and other limbic structures). Each stage in this cycle is an opportunity for clinical intervention (psychosocial, pharmacological, or both).



General Psychiatrists Can and Should Treat AUD: A Case Study

Ms. A, a 28-year-old woman with no formal medical or psychiatric history, presents to your outpatient psychiatric practice for "anxiety and insomnia." She reports several years of sleep-initiation insomnia, as well as intermittent feelings of anxiety. A few months ago, her primary care physician prescribed escitalopram 10 mg daily for symptoms of anxiety, which Ms. A did not find helpful and subsequently discontinued. This prompted a referral to your office. While initially hesitant, Ms. A was convinced to attend the appointment by her partner, who felt that Ms. A "needed help" because of increasing irritability and seeming to be more "on edge." On further interview, Ms. A discloses consuming three to four glasses of wine each night after returning home from her job as an accountant and five to six drinks on Saturdays.

Given this history, you administer the Alcohol Use Disorders Identification Test (AUDIT) to screen for alcohol use disorder (AUD). Ms. A receives a score of 21, indicating a high likelihood of moderate to severe AUD. On discussing these findings with Ms. A, she discloses significantly increased alcohol consumption over the past several years. She has tried to cut back on drinking because of arguments with her partner when she is intoxicated and because she hates feeling "hungover" at work. However, cutting back has been extremely difficult.

You are initially hesitant to treat Ms. A because your outpatient practice is not primarily focused on substance use disorders. However, you know there is a shortage of specialist addiction psychiatrists. Additionally, APA advocates for general psychiatrists to treat patients with co-occurring substance use disorders and provides resources like the APA Practice Guideline for the Pharmacological Treatment of Patients With Alcohol Use Disorder. (The guideline is expected to be updated this year.)

When discussing treatment goals with Ms. A, she reports being highly motivated to decrease her alcohol consumption but is not interested in complete abstinence. She sets an initial goal to decrease her daily alcohol consumption from three to four glasses to one to two glasses. After discussing risks and benefits of the FDA-approved medications for AUD and obtaining routine baseline laboratory tests, Ms. A provides informed consent to start naltrexone 50 mg daily. She also accepts a referral for weekly cognitive-behavioral therapy to help her identify triggers for drinking and alternate coping strategies for stress and anxiety. She declines information about Alcoholics Anonymous, citing her personal religious beliefs and nonabstinence treatment goals. However, she accepts a brochure about Smart Recovery (a non-faith-based, mutual self-help program for AUD).

Over the course of the next year in treatment, Ms. A significantly decreases her alcohol consumption. She also reports improvements in sleep quality, anxiety, mood, and energy. For convenience, she elects to transition from oral naltrexone to monthly intramuscular depot naltrexone and continues to benefit from weekly therapy and occasional Smart Recovery meetings.

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on Alcohol Abuse and Alcoholism. Physicians may not be familiar with the FDA-approved medication treatments for AUD or they may feel inadequately trained about AUD. Additionally, some providers and patients may have misconceptions about medication treatments for AUD, despite the robust evidence base for their efficacy.

In addition to treating patients for AUD, it is important to assess and manage alcohol withdrawal in patients who drink alcohol on a regular basis. The Clinical Institute Withdrawal Assessment (CIWA) is a commonly used method for assessing and quantifying alcohol withdrawal symptoms. Mild symptoms can include insomnia, gastrointestinal upset, headache, and diaphoresis. More severe withdrawal can involve electrolyte abnormalities, seizures, hallucinosis, and cognitive impairment (delirium tremens). Often, mild withdrawal symptoms can be managed in the outpatient setting. Patients who have severe withdrawal symptoms or are medically compromised may require inpatient, medically managed treatment.

Benzodiazepines remain the standard of care for treating acute alcohol withdrawal. The most frequently used benzodiazepines are diazepam (Valium), lorazepam (Ativan), and chlordiazepoxide (Librium). A symptom-triggered approach (rather than a standing taper), using standardized measures such as the CIWA is preferable.

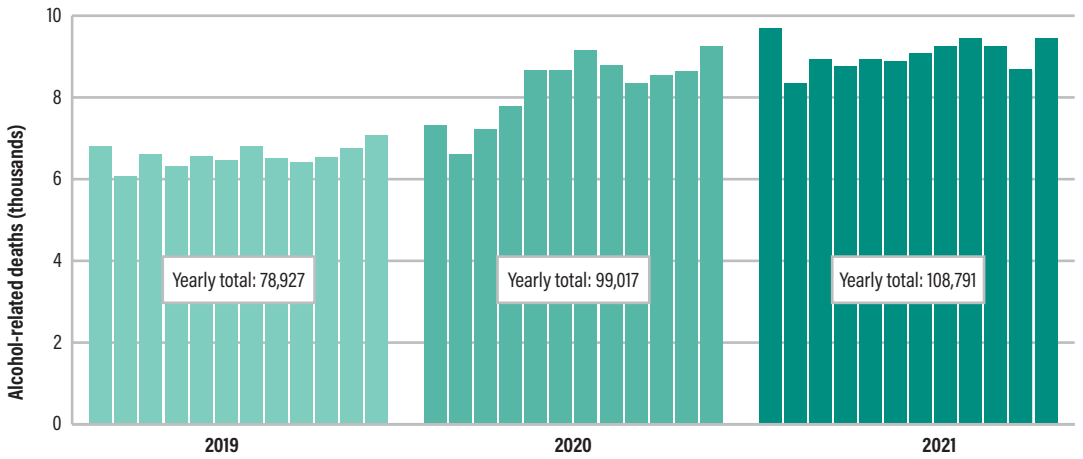
Table 2. *DSM-5* Diagnostic Criteria for Alcohol Use Disorder

1. Drinking in larger amounts or over a longer period than intended.
2. A persistent desire or unsuccessful efforts to cut down or control alcohol use.
3. A great deal of time spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects.
4. Craving, or a strong desire or urge to use alcohol.
5. Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.
7. Important social, occupational, or recreational activities given up or reduced because of alcohol use.
8. Recurrent alcohol use in situations in which it is physically hazardous.
9. Continued drinking despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol.
10. Tolerance, as defined by either of the following:
    - A need for markedly increased amounts of alcohol to achieve intoxication or desired effect.
    - A markedly diminished effect with continued use of the same amount of alcohol.
11. Withdrawal, as manifested by either of the following:
    - The characteristic withdrawal syndrome for alcohol.
    - Alcohol (or a closely related substance, such as a benzodiazepine) is taken to relieve or avoid withdrawal symptoms.

Source: *DSM-5-TR*, APA Publishing, 2022.

Alcohol-Related Deaths Rose During Pandemic

The figure below shows the number of alcohol-related deaths in 2019 (before the pandemic) and in 2020 and 2021. The annual total number of deaths increased 25% between 2019 and 2020 and increased 10% between 2020 and 2021. A death was considered alcohol-related if alcohol was listed in a death certificate as the primary cause (such as alcohol-associated liver disease) or a contributing factor (such as death from a fall while intoxicated).



Source: National Institute on Alcohol Abuse and Alcoholism based on CDC Data

Implications for Psychiatric Practice

AUD often co-occurs with other mental disorders, including depressive disorders, anxiety disorders, trauma-related disorders, sleep disorders, and other substance use disorders. As previously mentioned, individuals with schizophrenia, bipolar disorder, and ADHD are at elevated risk for developing a substance use disorder. In fact, pre-existing psychiatric disorders more broadly can increase the risk of developing AUD, likely due in part to people using alcohol to cope with psychiatric symptoms. Heavy and hazardous drinking may also be a consequence of impulsivity in individuals with schizoaffective disorder, bipolar disorder, ADHD, or borderline personality disorder. Therefore, it is important to screen all patients for the presence of AUD and other substance use disorders. The likelihood of recovery from AUD and a co-occurring psychiatric condition is highest when patients are treated for both simultaneously.

Despite the high morbidity and mortality associated with AUD, recovery is possible with access to evidence-based psychotherapy and medication treatments. Unfortunately, there are fewer than 2,000 physicians nationwide certified in addiction medicine, and fewer than 1,300 physicians certified in addiction psychiatry. Therefore, primary care providers and general psychiatrists are critical to addressing the public health burden of AUD. APA and its partner organizations offer multiple opportunities for education and training on evidence-based AUD treatment. Together, we can meet the needs of our patients with AUD and other substance use disorders to have a truly meaningful impact on their health and well-being. **PN**

APA Resources

- Resources for patients and families, including an explainer video and the NIAAA Alcohol Treatment Navigator, are posted on APA's website at https://www.psychiatry.org/Patients-Families/Alcohol-Use-Disorder.
- Top Ten Things Everyone Should Know About Addiction is posted at http://apapsy.ch/facts-for-public.
- Top Ten Things Every Physician Should Know About Addiction is posted at http://apapsy.ch/facts-for-physicians.

References

- The Surgeon General's reports on addiction and substance use are posted at https://www.hhs.gov/surgeongeneral/reports-and-publications/addiction-and-substance-misuse/index.html.
- "Alcohol Use Disorder: Neurobiology and Therapeutics" is posted at https://www.mdpi.com/2227-9059/10/5/1192.
- The *Psychiatric News* article "NIAAA Definition of Recovery Provides Measurable Endpoints for AUD Researchers" is posted at https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2022.07.7.22.
- Information about 12-Step Facilitation is posted at https://www.recoveryanswers.org/resource/twelve-step-facilitation-tsf.
- The APA Treatment Guideline on Pharmacologic Treatment of Patients With Alcohol Use Disorder is posted at https://www.psychiatry.org/psychiatrists/practice/clinical-practice-guidelines. (The guideline is expected to be updated later this year.)
- "A Cascade of Care for Alcohol Use Disorder: Using 2015-2019 National Survey on Drug Use and Health Data to Identify Gaps in 12-month Care" is posted at https://onlinelibrary.wiley.com/doi/10.1111/acer.14609.
- Information on the 2021 National Survey on Drug Use and Health is posted at https://www.samhsa.gov/data/release/2021-national-survey-drug-use-and-health-nsduh-releases.

Long COVID May Be Linked to Serotonin Levels

Getty Images/iStock/VioletaStoimenova

In some patients infected with COVID-19, the virus triggers a process that leads to depletion of circulating serotonin, with disrupted vagus nerve signaling causing clinical symptoms. ***BY SANDRA A. JACOBSON, M.D.***

Sandra A. Jacobson, M.D., is an associate faculty member at the University of Arizona College of Medicine in Phoenix. She is the author of *Clinical Laboratory Medicine for Mental Health Professionals* and *Clinical Manual of Laboratory Medicine in Psychiatry and Behavioral Science, Second Edition* from APA Publishing.

According to the Centers for Disease Control and Prevention and the Department of Health and Human Services, long COVID is defined by multisystemic signs, symptoms, and conditions that continue or develop four or more weeks after initial infection with SARS-CoV-2. Symptoms can persist from weeks to years, and in some cases they are totally disabling. Overall, about 20% of patients develop long COVID after recovery from infection; the incidence is higher in those who had severe infection, but even patients who were asymptomatic with the primary infection are at risk.

Extreme fatigue and cognitive impairment are prominent issues for many of those afflicted. Cognitive problems include inattention; poor concentration; impaired frontal/executive function; memory difficulties; and "brain fog," which is a commonly used lay term without formal definition. Sensorimotor symptoms include not only anosmia, dysgeusia, and hearing loss, but also neuropathic pain, peripheral neuropathy, paresthesias, myalgias, and weakness (see box).

Psychiatrists who have worked with patients suffering from myalgic encephalomyelitis/chronic fatigue syndrome (CFS) might find this constellation of symptoms somewhat familiar (although a history of COVID-19 would preclude the additional diagnosis of CFS). In addition to extreme fatigue, patients with CFS experience similar patterns of neuropsychological impairment. Like long COVID, CFS often develops following a viral illness.

As little is known about the pathogenesis of CFS, investigators in this area are hopeful that the intense research efforts directed at COVID-19 might shed light on mechanisms involved in CFS. It is hoped that if a biomarker for long COVID is developed, it would also help to advance CFS research. Recently, the report of a study posted in the journal *Cell* last October—building on the findings of other recent studies—raised hopes in relation to a surprising candidate biomarker: circulating serotonin levels.

The researchers, from the Perelman School of Medicine at the University of Pennsylvania, used data from patients attending a post-COVID clinic as well as small animal models to construct a hypothesis regarding long COVID's development. Their findings can be outlined as follows:

- Some patients with long COVID show viral components of SARS-CoV-2 in stool samples long after initial infection.

- This viral reservoir in the gut continuously triggers an immune response in the form of RNA-induced type I interferons.

- These interferons cause inflammation that reduces absorption of gut tryptophan and disrupts serotonin signaling.

- These processes lead to depletion of circulating serotonin, with disrupted vagus nerve signaling causing clinical symptoms.

Taken together, the findings of Wong and colleagues suggest that alterations of the gut microbiome may cause or contribute to persistent symptoms after SARS-CoV-2 infection. Moreover, the investigators found in small animal models that dietary supplementation with tryptophan or administration of the selective serotonin reuptake inhibitor (SSRI) fluoxetine reversed impairments.

These findings suggest a significant opportunity for psychiatrists treating patients with long COVID (and CFS) to systematize clinical diagnostic and treatment data to address questions such as the following:

- What are the characteristics of long COVID patients who benefit from treatment with tryptophan or SSRIs?

- Is the time course of improvement in symptoms the same as for SSRI treatment generally?

- Is the course of illness for CFS patients who contract COVID-19 the same as for patients without CFS?

- Are some SSRIs—such as fluvoxamine and sertraline, which have stronger affinity for sigma-1 receptors—better than others such as paroxetine in the treatment of long COVID symptoms?

- Is vagal nerve stimulation helpful in reducing neuropsychiatric symptoms in patients with long COVID? **PN**

"Serotonin Reduction in Post-Acute Sequelae of Viral Infection" is posted at https://www.cell.com/cell/fulltext/S0092-8674(23)01034-6.f1.

Long COVID: Neuropsychiatric Symptoms

Anxiety
Cognitive impairment
Delirium
Depression
Fatigue
Headache
Insomnia
Mood swings
Pain disorder
Posttraumatic stress disorder
Psychosis
Sensorimotor symptoms

Richard Kogan

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For him, it was just music."

Another amazing trait of Gershwin that Kogan will discuss is Gershwin's capability of extracting music from noise. "He would frequently open the windows of his house to use the city noise as stimulation. On a trip to Paris, for example, he became fascinated by the sound of Parisian taxi horns, which were different from New York horns." Kogan said that Gershwin returned to the states with four of those taxi horns and used them in his 1928 composition "An American in Paris."

Though he continued to be successful into the 1930s, some of his psychiatric issues resurfaced in the form of anxiety and depression, which led him to seek psychiatric treatment. "I think this phase of his career offers a fascinating look into how mental health impacts creativity," Kogan said. For as Gershwin was receiving psychotherapy, he also began writing an opera based on DuBose and Dorothy Heyward's play "Porgy," a love story set amid an impoverished African American fishing community.

Though "Porgy and Bess" contained Gershwin's signature style—seamlessly blending classical opera with folk music—it was also quite different from his previous works, Kogan noted. "It was an extraordinary act of imagination and empathy," he said, resulting in a score full of poignancy, sorrow, and anguish.

Though many today consider "Porgy and Bess" to be the finest opera ever composed by an American, the show was a critical and commercial failure in its day. Kogan believes the negative reception contributed to a worsening of Gershwin's depression, though his increasing mental and physical struggles (such as headaches and coordination problems) were also furthered by an undiagnosed brain tumor.

After collapsing at a friend's house in July 1937, Gershwin was rushed to the hospital, and the tumor was discovered. After emergency surgery, he did not regain consciousness and died at just 38 years of age.

Gershwin's timeless classics live on, memorialized on stage, film, and marketing. Over the course of an evening, Kogan will share some of these classics, and the stories behind them, with APA. **PN**

"Rhapsody in Blue at 100: The Mind and Music of George Gershwin" will be presented Sunday, May 5, from noon to 1:30 p.m.

More information on Kogan, including performance videos, is posted at https://richardkogan.com/home.

Brain Imaging Holds Clues to Causes, Treatment Of Pediatric PTSD

Childhood trauma has been found to cause brain changes that severely impact children's neurodevelopment, but effective treatments are available. **BY LINDA M. RICHMOND**

There is mounting evidence from brain imaging studies that post-traumatic stress disorder (PTSD) in children and adolescents is a neurodevelopmental disorder.

As such, effective recovery from pediatric PTSD may involve helping youth restore their brain's threat circuitry and executive function, Ryan Herringa, M.D., Ph.D., director of the Division of Child and Adolescent Psychiatry at the University of Wisconsin School of Medicine and Public Health, said at a webinar hosted by the Brain & Behavior Research Foundation (BBRF). BBRF is the world's largest private funder of mental health research.

Brain scans of girls who had suffered abuse showed delayed maturity in the emotion circuitry of their brains, which was associated with increased hyperarousal symptoms, one of the hallmarks of PTSD, according to a study by Herringa and colleagues in *The American Journal of Psychiatry* in 2021. In fact, researchers found that the brains of girls exposed to abuse may habitually utilize threat-related circuitry, even when they're in a safe setting.

Other brain imaging research by Herringa and others that followed youth aged 8 to 18 has uncovered other differences: Over time youth with PTSD experience regression in normal brain development, namely decreased hippocampal volume, increased amygdala activation, and decreasing prefrontal-amygdala connectivity. That connectivity is critical in helping regulate emotional responses and allowing youth to benefit from exposure therapy, he added.

Put together, recent imaging studies show a "fairly consistent pattern of developmental decline in adaptive or healthy functioning in the brain, particularly in the emotional regulatory and threat response systems," Herringa said, adding that more study is needed.

PTSD Risk Factors

Data reported by the National Institute of Mental Health indicate that an estimated 5.0% of adolescents have PTSD, and an estimated 1.5% have severe impairment. Direct exposure to interpersonal violence creates by far the highest risk, with rape topping the risk factors for development of the disorder. The prevalence of PTSD among female adolescents is more than three times higher than that of adolescent males. Black and Hispanic youth are far more likely to experience trauma than White or Asian youth.

Various studies suggest that other risk factors include prior internalizing disorders, such as anxiety or depression, as well as a prior episode of PTSD or trauma, high IQ, and being female, Herringa said.

Courtesy of UW Health Media Center

Ryan Herringa, M.D., Ph.D., said that recent imaging studies of children exposed to trauma show a "fairly consistent pattern of developmental decline in adaptive or healthy functioning in the brain, particularly in the emotional regulatory and threat response systems."

Evolution of Pediatric PTSD Diagnosis

It was a school bus kidnapping in Chowchilla, Calif., in 1976 that changed the long-held notion that children were resilient to trauma, Herringa said. Three men hijacked a school bus at gunpoint, drove it 100 miles away, and forced the bus driver and 26 children down a hole into an old trailer that had been buried 12 feet underground. The bus driver and an older student worked frantically during the night to dig their way out and move a heavy manhole cover blocking their exit, as the trailer roof began to cave in. Miraculously all the students reached the surface safely and were reunited with their families several hours later.

"Experts at the time thought there would be no lasting effects from this type of trauma," Herringa said. In fact, the children suffered from what is now known as typical PTSD symptoms: panic attacks, nightmares involving kidnappings and death, and personality changes. Many developed fears of such things as cars, the dark, and the wind and continued to report trauma symptoms even 25 years later. Survivors also reported substance abuse and depression; several have since been imprisoned for violence against others.

Since that time the PTSD diagnosis has gradually evolved, and in 1980 *DSM-III* finally made the illness diagnosable in children. Herringa said brain imaging research has led to a greater understanding of how children experience PTSD very differently than adults; now the *DSM-5-TR* provides separate diagnostic criteria for children under 7. For more than two decades, there has been discussion of creating a new diagnosis, developmental trauma disorder, that is related to multiple and chronic childhood trauma. However, evidence was not deemed strong enough for its addition to *DSM-5*.

Trauma-focused psychotherapy remains the first-line treatment for PTSD in youth and can effectively reduce depressive and anxiety symptoms, Herringa said. Parents or caregivers are often included, and one important piece involves challenging distorted cognition, including the feelings of guilt about the trauma and that the youth is somehow at fault, Herringa said. The strongest evidence base is for trauma-focused cognitive-behavioral therapy; eye movement desensitization and reprocessing are also effective.

Unfortunately, there are no evidence-based medications for pediatric PTSD, but medications for comorbid disorders may still be helpful.

More than two-thirds of youth with PTSD have a comorbid psychiatric condition (68%), with attention-deficit/hyperactivity disorder the most common, followed by social phobia or other anxiety disorders, and then mood disorders. Research shows that PTSD carries the highest risk of any mental illness of a first-time suicide attempt in young people, so clinicians and family members should stay vigilant to that risk as well as to the risk for self-harm, Herringa said.

To best help children with PTSD, Herringa said it is important to consider the entire family dynamic, as well as their friends and support network. "When key caregivers are in stress or in pain or perhaps suffering with their own PTSD, that can trickle down easily to their child or adolescent and heighten their risk."

One experimental treatment being studied for use in pediatric PTSD is DEEP VR, Herringa said. It is a biofeedback-based virtual reality game that allows users to navigate through a serene and poetic underwater world. Users wear a belt that measures their breathing; the creatures, plants, and patterns on screen mirror the user's breath, reinforcing their awareness of their body and mental state.

Users progress through the world by engaging in controlled, slow, and deep diaphragmatic breathing. Ultimately it is hoped that participants will learn to use deep breathing to regulate anxiety and alleviate hyperarousal. **PN**

"Differential Patterns of Delayed Emotion Circuit Maturation in Abused Girls With and Without Internalizing Psychopathology" is posted at https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.2021.20081192. More information about DEEP VR is posted at https://www.exploredeep.com. "Psychic Trauma in Children: Observations Following the Chowchilla School-Bus Kidnapping" is posted at https://ajp.psychiatryonline.org/doi/epdf/10.1176/ajp.138.1.14.

Homelessness

continued from page 21

financial assistance for inhabitants of privately owned rental units, but once inhabitants move, the rental assistance does not follow them. While these housing vouchers may be life-changing, it can take years on a waiting list to quality for one.

I am treating a single mother who is 240-something on the waiting list for a Housing Choice Voucher for herself and her daughter. She left her old apartment unit due to possible predatory rental practices, which made it difficult to afford other basic necessities. Medication and psychotherapy cannot alleviate this social determinant of health. To have a mentally healthy nation, we must treat housing as a right itself. **PN**

Information on the Housing Choice (formerly Section 8) Voucher Program is posted at https://www.hud.gov/topics/housing_choice_voucher_program_section_8. Information about Mainstream Vouchers is posted at https://www.hud.gov/program_offices/public_indian_housing/programs/hcv/mainstream. Information on homelessness in the Charlottesville, Va., region is posted at http://apapsy.ch/homelessness-report.

Mortality Risk Mixed for Youth Taking Antipsychotics

Higher antipsychotic doses were associated with increased risk of death in youth, especially among young adults aged 18 to 24 years. **BY TERRI D'ARRIGO**

Physically healthy children and adolescents aged 5 to 17 years who begin taking second-generation antipsychotics such as aripiprazole, olanzapine, or risperidone for conditions that do not involve psychosis appear to be at no greater risk of death than those initiating other psychiatric medications, according to a study in *JAMA Psychiatry*. However, young adults aged 18 to 24 years who took high doses of antipsychotics (greater than 100 mg chlorpromazine equivalents) had an increased risk of death.

"The findings emphasize the importance of following existing guidelines: use other therapeutic approaches when possible, including those that are nonpharmacological; carefully evaluate patients before initiating treatment; use the lowest effective dose; and monitor during treatment," lead author Wayne A. Ray, Ph.D., a professor of health policy at Vanderbilt University School of Medicine, told *Psychiatric News*.

Ray and colleagues used the Medicaid Analytic Extract, a national repository of data from Medicaid and the Children's Health Insurance Program, to identify all individuals aged 5 to 24 without psychosis who initiated antipsychotic treatment between January 2004 and September 2013. Individuals diagnosed with a serious medical illness in the past year were excluded from the analysis. The researchers divided these patients into low- and high-dose antipsychotic groups, using 100 mg daily of chlorpromazine or its equivalent as the cutoff.

The researchers also identified a control group of similarly aged patients who began taking alternatives to antipsychotics for such conditions as attention-deficit/hyperactivity disorder, depression, or disruptive behaviors, including antidepressants or lithium. A total of 2,067,507 children and young adults who filled nearly 22 million prescriptions (about 8.3 million antipsychotic prescriptions and 13.5 million control prescriptions) were included in the analysis.

Overall, the researchers found that patients in the study who took doses up to 100 mg chlorpromazine equivalents a day were no more likely to die than those who took control medications; however, those who took high-dose antipsychotics had a 37% increased risk of death compared with those who took the control medications. Those who took more than 100 mg chlorpromazine equivalents per day had a 57% increased risk of dying either by overdose or by nonoverdose unintentional injury. However, taking a dose of more than 100 mg chlorpromazine equivalents a day was not associated with nonoverdose suicide deaths, cardiovascular or metabolic deaths, or deaths from other causes.

"A novel contribution of our study is that health care professionals might be more cautious about initiating antipsychotic treatment in patients taking opioids or benzodiazepines or with substance use disorder, as this group is highly vulnerable to overdose death," Ray said.

"Psychiatrists and other health professionals should follow existing guidelines when prescribing antipsychotic medications."
—Wayne A. Ray, Ph.D.

When breaking down the data by age groups, Ray and colleagues found no increased risk of death among 5- to 17-year-olds taking high-dose antipsychotics. Eighteen- to 24-year-olds taking high-dose antipsychotics had a 68% increased risk of death overall.

Ray said that the research was prompted by both the number of youth who take antipsychotic medications—roughly 1.3 million as of 2010—and the known risk of adverse events in adults who take antipsychotic medications, such as weight gain and other metabolic effects; prolongation of the QT-interval, which could increase arrhythmia-related deaths; and respiratory-sedative effects, which could increase the risk of overdose, particularly in combination with opioids.

"Although death is very infrequent in children and youth, we wondered about the consequences of widespread antipsychotics in this population," Ray said. "Several of our group conducted a study in Tennessee that had the provocative finding of increased risk of overdose and cardiovascular deaths in patients 5 to 24 years of age. However, there were several limitations, particularly the inclusion of the first-generation antipsychotics, the generalizability of the experience in a single state, and small numbers of deaths."

Ray summarized the major takeaways from the study as follows: "No increased risk for children younger than 18 years old and for doses up to 100 mg chlorpromazine equivalents, no increased risk for cardiovascular deaths, and an increased risk of overdose deaths."

This study was funded by the National Institute for Child Health and Human Development. **PN**

"Antipsychotic Medications and Mortality in Children and Young Adults" is posted at http://apapsy.ch/antipsychotics-youth.

Family Involvement in Patient Care One Key to Success

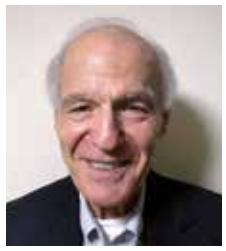
Meeting with the family members of people with mental illness provides valuable information to both the therapist and the family and should be a routine part of psychiatric care. Here are some tips to make it informative and efficient. **BY GABOR I. KEITNER, M.D.**

A prime source of valuable information about psychiatric patients is their family members, and psychiatrists should make meeting with them a priority. Families exert a powerful influence on the health and mental health of its members, and such influence can be leveraged in a positive way to support treatment and help ensure its success.

There is extensive research highlighting how family and relational factors interact with biological systems to produce and modify disease. Risk factors for adverse outcomes include relational conflicts, rigidity, blame, and high levels of criticism. However, good communication, support, clear roles, adaptability, and problem-solving skills provide protection from the negative effects of illness. Meeting with families to assess their ways of dealing with a family member who has a mental illness and enlist their participation as collaborators in the treatment process should be a routine part of psychiatric care.

While some families of psychiatric patients are dysfunctional, many deal effectively with recurring, chronic, and severe illnesses. All families, however, can benefit from receiving information about the illness, validation of effective ways of coping, and reinforcement of resilience in the face of major stress.

Family meetings can be focused, time efficient, and structured to minimize disruptions. The primary goal of a family meeting is to provide a safe place for all participants to express their concerns without being blamed, invalidated, or criticized. It is a place for them to listen to each other and find ways to work together. The task of the therapist is to create that safe space.



Gabor I. Keitner, M.D., is a professor of psychiatry at the Warren Alpert School of Medicine at Brown University.

The therapist should orient family members about what to expect during the meeting and lay out the ground rules for working together. They should be told the following: Such meetings are part of routine care; no one is being singled out as problematic or judged to be right or wrong; the purpose is to identify the family's concerns; people should take turns talking; and everyone will have the opportunity to ask questions and be involved in treatment decisions. If the family members do not follow the agreed-upon process, the meeting may be terminated. They should then be asked for permission to proceed with the meeting. This introductory discussion takes only a few minutes but saves time in the long run.

The duration of the meeting can be kept reasonable by limiting the amount of time each person is given to outline his or her concerns. As each person describes a problem, the therapist can reflect back what was said and, if it is correct, move on to the next problem. This also gives family members a chance to correct any misconceptions. There are usually a finite number of problems, so the process does not take very long. Once all the problems have been identified, it is useful to evaluate how the family is coping with them, including how they communicate with each other, solve problems, connect emotionally, divide responsibilities for managing their household, and set rules and expectations of each other.

see **Family Involvement** *on page 34*

DBT Found Effective in Treating Suicidal Youth With Bipolar Disorder

Improvement in emotional regulation among youth who received dialectical behavior therapy (DBT) was associated with decreased suicide risk, particularly among those with high baseline emotion dysregulation. **BY MARK MORAN**

Young people with bipolar spectrum disorder who received dialectical behavior therapy (DBT) had significantly fewer suicide attempts compared with young people who received standard psychotherapy, according to a report published last September in *JAMA Psychiatry*. DBT is an evidence-based treatment that focuses on emotional regulation, and one of its uses is for suicidal behavior.

"Up to 50% of youth with bipolar spectrum disorder attempt suicide," wrote Tina Goldstein, Ph.D., an associate professor of psychiatry at the University of Pittsburgh who studies early onset mood disorders, and colleagues. For up to 60% of individuals, their first suicide attempt is lethal, and for those who survive, the risk of death increases with each successive attempt. "Thus, the capacity to predict first attempt among youth with [bipolar spectrum disorder] and provide a potentially preventive intervention like DBT offers a compelling future direction."

The study involved adolescents aged 12 to 18 years diagnosed with bipolar spectrum disorder who were recruited from a specialty outpatient psychiatric clinic at the University of Pittsburgh Medical Center between November 2014 and September 2019. Forty-seven were randomized to receive 37 sessions of DBT over one year, and 53 were randomized to receive standard psychotherapy (for example, sessions focused on cognitive strategies and behavioral approaches). All youth received medication from study psychiatrists according to a treatment algorithm. By the study's end, 28 youth had withdrawn from the study, and eight were lost to follow-up.

Primary outcomes included suicide attempts over one year and mood symptoms and episodes of depression and hypomania/mania. Suicide attempts were assessed using the Columbia Suicide Severity Rating Scale and the ALIFE Self-Injurious/Suicidal Behavior Scale. The researchers also assessed emotional regulation using the self-reported Difficulties With Emotion Regulation Scale.

Over the year-long study, youth who had received DBT reported significantly fewer suicide attempts compared with those who had received standard psychotherapy.

"[S]uicide attempts declined to a greater extent over time among those receiving DBT compared with those receiving [standard] psychotherapy, particularly among participants with a recent and/or lifetime history of suicide attempt," the authors noted.

While the groups displayed similar improvements in symptoms of depression and episodes of hypomania and mania, those who received DBT experienced greater improvement in emotional regulation. Improvement in emotional regulation was associated with decreased suicide risk, particularly among those with high baseline emotion dysregulation.

The authors concluded, "Adolescents with bipolar disorder at elevated risk of suicidal behavior and those exhibiting high emotion dysregulation stand to benefit most from DBT's effects on decreasing suicide attempt risk through enhancing emotion regulation."

Child and adolescent psychiatrist Blaise Aguirre, M.D., who reviewed the report for *Psychiatric News,* said that it is not surprising that the benefits of DBT can be extended to youth with bipolar disorder. He is an assistant professor of psychiatry at Harvard Medical School and the Michael Hollander, Ph.D., Endowed Director of 3East Continuum, a DBT treatment program for teenagers and young adults at McLean Hospital.

"We have treated more than 5,000 adolescents with severe suicidality, and some have comorbid bipolar," he said. "I have not done research on bipolar specifically, but anecdotally the skills taught in DBT have a degree of universality that includes benefiting patients with bipolar disorder."

Aguirre wondered, however, whether some of the study cohort may have had comorbid borderline personality disorder; on inpatient units, up to 40% of patients with bipolar disorder also have a diagnosis of borderline personality disorder, he said.

He pointed out that DBT therapy can help patients identify, label, and better manage triggers that may lead to depression, anxiety, and suicidal thinking. "Where DBT has its greatest impact is with people with disorders of emotional regulation," he told *Psychiatric News*. "But the core skill of DBT is mindfulness. It's impossible to regulate anger or sadness if you don't pay attention to what it is. What DBT does is to insist on targeting, naming, and labeling those emotions."

Aguirre recently returned from Singapore where he taught mental health professionals the principles of DBT.

"Although DBT was well known to the psychologists, it was not well known to the psychiatrists," he said. "Once I had completed the training, the psychiatrists concluded that they were less afraid to treat suicidal adolescents and that the skills and application of DBT would make their lives easier because they could rely on an evidence-based methodology that specifically targets suicidal behavior."

More information about DBT can be found in "The Medical Mind" podcast episode titled "The Science and Experience of Dialectical Behavior Therapy." The podcast is co-hosted by SMI Adviser, APA's clinical support system for serious mental illness, and NAMI. **PN**

"Dialectical Behavior Therapy With Adolescents for Bipolar Disorder: A Randomized Clinical Trial" is posted at https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2809647. "The Science and Experience of Dialectical Behavior Therapy" is posted at http://apapsy.ch/DBT-podcast.

Psychedelic Research

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In some cases, Hellerstein said, they can be intensely disappointed that they didn't have a trip, which can happen even when a participant has received an active drug.

"Difficulty blinding could really lead us to go down the wrong path for determining true efficacy," Hellerstein pointed out. "We might not know our actual mechanism of action, and [it could lead to] unnecessary risks, especially for populations like children and adolescents."

Some researchers have posited that psychedelics could have useful applications among adolescents with severe PTSD, treatment-resistant depression, and social anxiety caused by autism as well as in pediatric palliative care, Hellerstein said. Yet there has been very little research on psychedelic use among youth, with many researchers urging caution, especially regarding how psychedelics could impact the developing brain. Much of the research that is available on psychedelics and youth dates back decades, to the 1960s-1970s, and Hellerstein explained that many of the methods used then would not be ethically sound today.

Yet with the United States potentially on the verge of approving psychedelics for the treatment of mental illnesses among adults, pharmaceutical companies may soon be interested in starting trials involving adolescents.

"What we've been trying to do is encourage investigators to have equipoise as much as possible, treat [psychedelics] like they would any other drug, and take it seriously."
—Tiffany Farchione, M.D.

Farchione pointed out that the FDA has the authority to require pediatric studies when new drugs are approved for the adult population. "We actually do require companies to provide a plan for pediatric drug development no later than 60 days after their end-of-phase-2 meetings," she said, though she added that there are certain circumstances in which companies can delay the development of those plans. But generally, she continued, companies should be planning their pediatric programs even before starting their phase 3 studies. "At the FDA, we've started to think about what those pediatric programs might look like for these products because some of these [psychedelic drug] programs are actually in phase 3 already," she said.

She explained that it's not enough to recognize that psychedelics have therapeutic potential. "We need to take a really cautious approach in terms of study design and inclusion and exclusion criteria, such as definitely not including anyone with a family history of psychosis or bipolar disorder," she said. "Those are the kinds of things that we would consider as we're looking at the study designs. We want to do our best … to make the studies as safe as possible while still being able to answer meaningful questions." **PN**

MED CHECK

BY TERRI D'ARRIGO

NDA Submitted for MDMA-Assisted Therapy For PTSD

In December the Multidisciplinary Association for Psychedelic Studies submitted a New Drug Application (NDA) to the Food and Drug Administration (FDA) for ***3,4-methylenedioxymethamphetamine (MDMA)-assisted therapy for posttraumatic stress disorder (PTSD)***, the organization announced.

In a phase 3 randomized, double-blind, placebo-controlled study of MDMA-assisted therapy, participants with severe PTSD were assigned to receive either manualized therapy with MDMA (n=46) or with placebo (n=44) at one of 15 study sites across the United States, Canada, and Israel. Participants underwent three eight-hour experimental sessions spaced four weeks apart with a single divided dose of 80 to 180 mg MDMA or placebo, in addition to three preparatory and nine integrative therapy sessions. In the first experimental session, participants received an initial dose of 80 mg followed by a supplemental half-dose of 40 mg, 1.5 to 2.5 hours later. In the second and third experimental sessions, participants received an initial dose of 120 mg followed by a supplemental half-dose of 60 mg. Each experimental session was followed by three 90-minute integrative therapy sessions spaced one week apart to allow participants to incorporate their experiences.

At 18 weeks, participants in the MDMA group showed a significant reduction in PTSD symptoms, as assessed by the Clinician-Administered PTSD Scale for *DSM-5* (CAPS-5). Total scores dropped by a mean of 24.4 points for those who took MDMA compared with 13.9 points in those in the placebo group. In addition, at 18 weeks, 67% of participants in the MDMA group no longer met diagnostic criteria for PTSD, compared with 32% of participants in the placebo group.

Karuna Publishes Phase 3 Results on KarXT

In December Karuna Therapeutics published the results of its phase 3 EMERGENT-2 trial of ***KarXT (xanomeline-trospium)*** in adults with schizophrenia in *The Lancet*.

The phase 3 EMERGENT-2 trial was a double-blind, placebo-controlled, five-week inpatient trial that enrolled 252 adults with schizophrenia in the United States. Participants took either a twice-daily, flexible dose of KarXT or placebo. Schizophrenia symptoms were measured by the Positive and Negative Syndrome Scale (PANSS). At week 5, total PANSS scores were an average of 9.6 points lower in patients who took KarXT compared with those who took placebo.

Results published in *The Lancet* also include data for all the pre-specified secondary outcome measures: change in PANSS positive subscale, PANSS negative subscale, PANSS Marder negative factor, Clinical Global Impression-Severity score, and percentage of participants achieving a ≥30% reduction from baseline to week 5 in PANSS total score.

The most common adverse events with KarXT versus placebo were constipation (21% versus 10%), dyspepsia (19% versus 8%), nausea (19% versus 6%), and vomiting (14% versus 1%).

"Efficacy and Safety of the Muscarinic Receptor Agonist KarXT (Xanomeline-Trospium) in Schizophrenia (EMERGENT-2) In the USA: Results From a Randomised, Double-Blind, Placebo-Controlled, Flexible-Dose Phase 3 Trial" is posted at https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(23)02190-6/fulltext.

Fremanezumab Promising For Migraines With Comorbid Obesity

In December Teva Pharmaceuticals announced that ***Ajovy (fremanezumab injection)*** reduced migraine attacks in patients with migraine and comorbid obesity in two clinical trials.

A post hoc analysis of the HALO-LTS and FOCUS phase 3 studies examined the safety and efficacy of fremanezumab migraine preventive treatment in people with a history of migraines who had a body mass index (BMI) of at least 30 kg/m2 (the cutoff for obesity) compared with those of lower BMI over a six-month period. There were 578 people in the BMI-high group and 1,859 in the BMI-normal group.

The analysis showed that the efficacy of fremanezumab was the same in migraine patients with BMI-high compared with BMI-normal patients. At baseline, there were 13.7 and 13.6 monthly migraine days in BMI-high and BMI-normal patients, respectively. After six months of treatment with fremanezumab, there were 6.8 monthly migraine days in BMI-high patients compared with 7.2 in BMI-normal patients. Adverse events were similar in both groups.

FDA to Review ALPHA-1062 For Treating Alzheimer's Disease

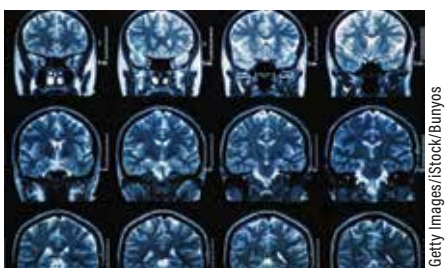
The FDA has accepted for review an NDA for ***ALPHA-1062***, a prodrug of the acetylcholinesterase inhibitor galantamine, Alpha Cognition announced in December.

The NDA submission includes data from studies that demonstrated bioequivalence for ALPHA-1062 to galantamine and galantamine extended-release (ER). A bioequivalence study, designed to compare ALPHA-1062 to galantamine hydrobromide (a standard treatment for patients with mild to moderate Alzheimer's disease), showed ALPHA-1062 achieved amounts of medication in the body similar to the immediate-release formulation of galantamine.

Another study compared 5 mg ALPHA-1062 delayed-release tablets with 8 mg galantamine hydrobromide ER capsules, with similar results. **PN**

JOURNAL DIGEST

BY NICK ZAGORSKI



Getty Images/iStock/Bunyos

Fetal Alcohol Spectrum Disorders Do Not Accelerate Brain Aging

A brain-imaging study appearing in *JAMA Network Open* has found that people with a fetal alcohol spectrum disorder (FASD) are no more likely to experience accelerated brain aging in middle age than those without FASD.

Researchers at Stanford University School of Medicine and colleagues recruited adults (average age, 42 years) who had participated in a prior FASD study two decades prior. As part of the original study, participants received a thorough clinical assessment for FASD as well as an MRI brain scan. The participants represented three groups:

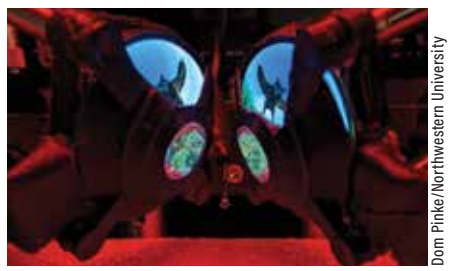
- 22 adults with fetal alcohol syndrome—defined as the presence of central nervous system dysfunction, growth deficits, and sentinel facial features of prenatal alcohol exposure.
- 18 adults with fetal alcohol effects—defined as the presence of some, but not all, characteristics of fetal alcohol syndrome.
- 26 adults with no history of prenatal alcohol exposure.

The researchers performed another MRI scan and found the same pattern of brain volume differences as had been observed previously: Average total intracranial brain volume as well as the volume of specific regions such as the cerebellum were much larger in the control group than the group with fetal alcohol syndrome; the brain volumes of those with fetal alcohol effects were in between the control group and fetal alcohol syndrome group.

The researchers found no evidence of any accelerated brain aging or reversal of brain volume deficits in the two groups with prenatal alcohol exposure over the two time points.

"There is a critical need to extend the longitudinal assessment of this cohort into older ages when clearer signs of accelerated aging might manifest morphologically to track whether the FASD population is at heightened risk for premature or exacerbated dementia or other disorders of aging," the researchers wrote.

Pfefferbaum A, Sullivan EV, Pohl KM, et al. Brain Volume in Fetal Alcohol Spectrum Disorders Over a 20-Year Span. *JAMA Netw Open*. 2023; 6(11): e2343618. http://apapsy.ch/FASD



Dom Pinke/Northwestern University

Researchers Develop Mouse VR Goggles to Aid Brain Research

Investigators at Northwestern University and colleagues have designed a set of virtual reality (VR) goggles for mice. As detailed in *Neuron*, the researchers hope these goggles can

see **Journal Digest** *on page 32*

Journal Digest

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recreate the animal's natural environments and enhance the study of the brain circuits underlying behaviors such as fear and anxiety.

Current methods of creating virtual environments for mice involve placing mice on treadmills surrounded by computer monitors or projection screens. Such approaches do not fully encompass the large field of view that mice possess.

Like human VR systems, the Miniature Rodent Stereo Illumination VR (iMRSIV) system provide a 180-degree field of view, removing all external content. (The goggles do not wrap around the mouse but rather sit over the eyes when the mouse is fixed on the treadmill.)

The investigators found that mice that used the iMRSIV system learned and mastered virtual tasks (for example, running down a linear track to get water) more quickly than mice using a monitor-based VR system. In addition, the investigators were able to induce intrinsic freezing and fleeing behaviors in iMRSIV mice by creating overhead shadows, something traditional VR systems cannot do.

Finally, the iMRSIV setup enabled the investigators to position a photon microscope over the mouse's head while they performed tasks. By injecting the mice with a marker that made neurons in the hippocampus fluorescent, they were able to see which hippocampal neurons became activated as the mice navigated and entered new environments.

The investigators noted several limitations of the iMRSIV system, including the contact between the goggles and the animal's whiskers (which affects their behavior).

"[W]ith future miniaturization, goggles small and light enough to be carried by a freely moving mouse might be achievable," the authors wrote. "Such a system could be used for augmented visual reality paradigms in which the other senses, including self-motion cues, are preserved."

Pinke D, Issa JB, Dara GAet al. Full Field-of-View Virtual Reality Goggles for Mice. *Neuron*. 2023; 111(24): 3941-3952.e6. http://apapsy.ch/mouse-vr

Getty Images/iStock/Vladyslav Horoshevych

E-Cigarette Dependence May Increase Risk of Depression

Youth and young adults who are dependent on e-cigarettes may be more likely to develop depressive symptoms than those who are not dependent on e-cigarettes, reports a study in the *American Journal of Preventative Medicine*.

"Notably, the results were not bidirectional, that is, depression scores, after controlling for potential covariates, and depressive symptoms did not predict changes in vaping dependence," wrote the researchers from the University of Toronto and colleagues.

The study involved 1,226 Canadian youth aged 16 to 25 (81.7% female) who had never smoked cigarettes but who reported using e-cigarettes. At the start of the study and every three months for a year, the participants were asked to answer questionnaires about how often they used e-cigarettes and their dependency on e-cigarettes (using the Penn State E-Cigarette Dependence Index). They were also asked about their use of other substances and symptoms of depression.

The researchers found a strong association between the vaping dependence score at any given time point and depressive symptom score three months later—that is, someone with vaping dependence at three months was likely to have elevated depressive symptoms at six months. The analysis also found that higher vaping frequency was associated with future vaping dependence, but it did not find any association between vaping frequency and future depression.

"These results are consistent with the diathesis-stress model of substance use and depression," the researchers wrote. "People who are already vulnerable (i.e., a diathesis) to mental illness would have their psychological state triggered or made worse through smoking (a stressor)." The researchers suggested that the cycles of nicotine withdrawal and relief through vaping exacerbate depressive symptoms in people who are nicotine dependent.

Chaiton M, Fan J, Bondy SJ, et al. E-Cigarette Dependence and Depressive Symptoms Among Youth. *Am J Prev Med*. 2024; 66(1):104-111. https://www.ajpmonline.org/article/S0749-3797(23)00381-1/fulltext

OnTrackNY

Videos Humanizing Mental Illness by Actors Found Effective

Brief educational videos aimed at reducing stigma toward people with psychosis appear equally effective regardless of whether the protagonist in the video is a person with lived experience or an actor, a report in *Psychiatric Services* has found.

"A video posted online creates a digital footprint that can expose the presenter to undesired outcomes," wrote the researchers at Columbia University and colleagues. "Providing people with lived experience the autonomy to choose between presenting their story directly or through a professional actor might empower those who feel uncomfortable with public self-disclosure."

This research team has conducted several studies evaluating people's attitudes toward people with serious mental illness after watching one- to two-minute videos in which a speaker describes the experience of living with schizophrenia. For this newest analysis, the team developed a pair of two-minute videos, both featuring a Black man in his mid-20s. One video featured a man with lived experience describing what it's like to live with schizophrenia. The other featured a professional actor describing living with schizophrenia (based on the help of a focus group and direct quotes from people with schizophrenia).

The team then recruited 1,216 adults aged 18 to 30 to one of three groups: one group watched the lived experience video, one watched the actor video, and one group watched neither video. The participants filled out surveys prior to watching, after watching, and 30 days later. The surveys included questions on stigma and how emotionally engaging the videos were.

Both videos significantly reduced viewers' stigma toward people with schizophrenia immediately after watching (with an effect size up to 0.65) and 30 days later (with an effect size up to 0.57) relative to the control condition.

Additional analysis comparing changes in stigma and engagement scores from baseline to postintervention and from baseline to the 30-day follow-up across stigma domains revealed that the actor video was not inferior to the lived experience video.

Amsalem D, Jankowski SE, Pagdon S, et al. Stigma Reduction Via Brief Video Interventions: Comparing Presentations by an Actor Versus a Person With Lived Experience. *Psychiatr Serv*. December 13, 2023. Online ahead of print. http://apapsy.ch/stigma-video

Getty Images/iStock/Olivier Le Moal

Personality Traits May Offer Clues About Dementia Risk

Individuals who have high neuroticism and/or low conscientiousness are at higher risk of being diagnosed with dementia, suggests a meta-analysis published in *Alzheimer's & Dementia*.

Researchers at the University of California, Davis, and colleagues examined data from eight longitudinal studies of cognition and dementia that included personality traits as possible dementia predictors. The sample included 44,531 people from four countries (United States, Germany, Sweden, and the Netherlands). They explored the impact of the "Big Five" personality traits (agreeableness,

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Millionaire Tax

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The BHSA would provide the first major structural reform of the MHSA in two decades. While the debate on the effectiveness of the MHSA continues, an emerging consensus among the general public is that new strategies are desperately needed to address the overwhelming homelessness crisis and the needs of those individuals with severe behavioral health problems in California. This proposal must complement ongoing and future initiatives considering the complexity of factors strongly associated with these humanitarian crises. Additionally, it would seem prudent, should the Yes on Proposition No. 1 campaign prevail in March, that an evaluation of this initiative by an independent entity be launched from the outset.

The favorable political forces for the "Yes on No. 1" campaign include the recently completed expedient public review, a supermajority of Democrats in the state legislature, a Democratic governor, and the waning opposition by the mental health community. Relief of suffering and recovery by those individuals who have severe mental illness and are unhoused would be a great achievement indeed. **PN**

The text of Proposition No. 1: Behavioral Health Services Program and Bond Measure is posted at https://ballotpedia.org/California_Proposition_1,_Behavioral_Health_Services_Program_and_Bond_Measure_(March_2024).

Gene Sequencing

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genetic material.

In the *AJP* article "Single-Nucleus Transcriptome Profiling of Dorsolateral Prefrontal Cortex: Mechanistic Roles for Neuronal Gene Expression, Including the 17q21.31 Locus, in PTSD Stress Response," Nikolaos Daskalakis, M.D., Ph.D., the director of the Neurogenomics and Translational Bioinformatics Laboratory at McLean Hospital, and colleagues used this technique to analyze postmortem brain tissue of people with posttraumatic stress disorder (PTSD). The findings offered new details into how the stress response is altered in people with PTSD.

The analysis focused on 32 postmortem samples of the prefrontal cortex from 11 individuals who had PTSD, 10 who had major depressive disorder, and 11 who had neither disorder. To complete snRNAseq, individual cell nuclei were extracted and individually encased in tiny gel droplets containing barcodes. These barcoded droplets were then fed into a machine that reads the barcode and sequences the RNA inside each nucleus. (RNA is used to make proteins and thus is a measure of gene expression.)

In total, about 415,000 nuclei were analyzed. Daskalakis said this is an immense amount of data, but by looking for the presence of genes that are known to be conserved across the dataset (called "anchor genes"), the gene expression data can be easily sorted. In the *AJP* study, his team identified data from eight different cell types and 22 cell subtypes.

The analysis revealed some notable differences in gene expression in PTSD and depression samples in multiple types of neurons, particularly genes related to the activity of stress-related steroid hormones known as glucocorticoids (for example, cortisol). A follow-up sequencing of 15 different brain samples (five each from people with PTSD, depression, or control) produced similar results. To support their snRNAseq data, Daskalakis' team created neurons (from the stem cells of people who did not have PTSD or depression) and stressed them with the corticosteroid dexamethasone. They found that dexamethasone altered the expression of several glucocorticoid receptors in a similar pattern as was seen in the cells from people with PTSD.

"This paper gives a taste of the power of single cell resolution analysis," wrote *AJP* Assistant Editor Elisabeth Binder, M.D., Ph.D., who selected this study as her favorite of 2023. "While previous large-scale RNA sequencing studies in postmortem brain have indicated the relevance of inhibitory neurons in the biology of PTSD, this manuscript can

now pinpoint that excitatory and inhibitory neurons show most changes in gene expression, as well as differentiate which transcripts and pathways are regulated in which cell type." Binder is the director of the Department of Genes and Environment at the Max Planck Institute of Psychiatry in Munich.

"What really amazed us was that in our small sample of 30 brains, we could see signs of how genetic risk influences PTSD biology," Daskalakis said. A previously conducted genomewide analysis involving hundreds of thousands of DNA samples had suggested that a region on chromosome 17 was associated with PTSD risk. In this study, Daskalakis' team found altered gene expression in four genes that are in the chromosome 17 region.

"It's wonderful that the editors recognized our efforts. Our team put all our heart and resources into this study," Daskalakis said. He expressed enthusiasm about next steps in this research, including studies to compare the changes in gene expression in tissue from people with PTSD who were exposed to different kinds of trauma.

Additionally, Daskalakis noted the importance of analyzing gene expression from other brain regions, such as the amygdala and hippocampus.

"I hope projects like this will help our field develop a larger appetite for complex studies," Daskalakis said. "We have to be more lateral thinkers to fast-track progress; when we come to a scientific problem, we should ask ourselves 'How many different ways can we attack this?'"

Childhood Trauma, OCD Among Other Studies of Import and Impact

Another study that stood out to the journal editors in 2023 was "A Comprehensive Multilevel Analysis of the Bucharest Early Intervention Project: Causal Effects on Recovery From Early Severe Deprivation."

The landmark Bucharest Early Intervention Project (BEIP, initiated in 2001) took advantage of Romania's dramatic societal changes following the fall of communism to examine the developmental differences in children receiving institutional care versus foster care.

While numerous studies using BEIP data have shown the benefits of quality foster care on measures such as IQ or social behavior, the *AJP* study combined over 7,000 clinical observations of 136 children, taken from infancy to late adolescence. The results showed that children placed in high-quality foster families had better physical, behavioral, and cognitive outcomes than those who continued to receive institutional care that continued across the children's lifespan.

"This study is remarkable," *AJP* Editor in Chief Ned Kalin, M.D., wrote in his summary of the study. "It is likely the first scientific demonstration of an intervention that promotes healthy physical and brain development in neglected children, and the data from this study were used to support public policy changes [in Romania] related to the care of orphaned children. This is a great demonstration of how effective science can promote societal change."

Brain Imaging to Predict Response

Deputy Editor Carolyn Rodriguez, M.D., Ph.D., selected an article reflecting how brain imaging can help inform clinical data: "Resting-State Connectivity and Response to Psychotherapy Treatment in Adolescents and Adults With OCD: A Randomized Clinical Trial."

In this trial, 54 adolescents and 62 adults with obsessive-compulsive disorder (OCD) received an MRI scan prior to 12 weeks of either exposure and response prevention (ERP) or stress management therapy to see if there were any patterns of brain connectivity that might predict treatment response. The researchers found baseline brain connections between regions in the frontal cortex and deeper areas of the brain that signaled a general tendency to respond to psychotherapy, but also uncovered a couple of connections that were specific to people who improved with ERP. These ERP-specific connectivity patterns also differed with age.

"Taken together, the findings indicate that it may be possible to improve the effectiveness of ERP via novel cognitive training or neuromodulation interventions targeting baseline connectivity between cognitive control and subcortical regions," Rodriguez wrote.

Daskalakis' study and the OCD study were supported by grants from the National Institute of Mental Health; the BEIP study was supported by the National Institutes of Health, the John D. and Catherine T. MacArthur Foundation, the Palix Foundation, and the Jacobs Foundation. **PN**

AJP's 2023 Articles of Import and Impact

- A Comprehensive Multilevel Analysis of the Bucharest Early Intervention Project: Causal Effects on Recovery From Early Severe Deprivation. Lucy S. King et al.
- Single-Nucleus Transcriptome Profiling of Dorsolateral Prefrontal Cortex: Mechanistic Roles for Neuronal Gene Expression, Including the 17q21.31 Locus, in PTSD Stress Response. Chris Chatzinakos et al.
- Racial and Ethnic Bias in the Diagnosis of Alcohol Use Disorder in Veterans. Rachel Vickers-Smith et al.
- Inequalities in the Incidence of Psychotic Disorders Among Racial and Ethnic Groups. Winston Chung et al.
- Functional Connectivity Mapping for rTMS Target Selection in Depression. Immanuel G. Elbau et al.
- Shared and Unique Changes in Brain Connectivity Among Depressed Patients After Remission With Pharmacotherapy Versus Psychotherapy. Boadie W. Dunlop et al.
- Resting-State Connectivity and Response to Psychotherapy Treatment in Adolescents and Adults With OCD: A Randomized Clinical Trial. Stefanie Russman Block et al.
- Visual Media: An Aperture Into the Past and Future of Psychiatry. Can Misel Kilciksiz et al.

"2023 Articles of Import and Impact" is posted at http://apapsy.ch/2023-import-impact. "Single-Nucleus Transcriptome Profiling of Dorsolateral Prefrontal Cortex: Mechanistic Roles for Neuronal Gene Expression, Including the 17q21.31 Locus, in PTSD Stress Response" is posted at http://apapsy.ch/nuclei-sequencing. "A Comprehensive Multilevel Analysis of the Bucharest Early Intervention Project: Causal Effects on Recovery From Early Severe Deprivation" is posted at http://apapsy.ch/Bucharest. "Resting-State Connectivity and Response to Psychotherapy Treatment in Adolescents and Adults With OCD: A Randomized Clinical Trial" is posted at http://apapsy.ch/OCD-psychotherapy.

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conscientiousness, extraversion, neuroticism, and openness) as well as three measures of subjective well-being (positive affect, negative affect, and life satisfaction).

The researchers found that higher neuroticism and negative affect were associated with increased dementia risk, whereas higher conscientiousness, extraversion, and positive affect were associated with reduced dementia risk. Neuroticism and conscientiousness appeared to have the strongest link with dementia across multiple models tested.

In contrast, the researchers found no association between any personality measures and dementia-related pathology, such as atherosclerosis in the brain or amyloid protein accumulation.

"Although the Big Five and aspects of [subjective well-being] were not associated with neuropathology at autopsy, moderator analyses reveal some evidence that these psychological factors may also act as predispositions that influence neuropathology," the researchers wrote. "Future work is needed to build upon these key findings, focusing on more nuanced, time-varying questions to determine the temporal ordering of these associations and mechanisms underlying them." **PN**

Beck ED, Yoneda T, James BD, et al. Personality Predictors of Dementia Diagnosis and Neuropathological Burden: An Individual Participant Data Meta-analysis. *Alzheimers Dement*. November 29, 2023. Online ahead of print. http://apapsy.ch/personality-types-alz

Family Involvement

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The final step is for the therapist to reflect back his or her understanding of family members' concerns and ways of dealing with them and ask what, if anything, they would like to do about the problems and what help they may want or need.

Most families are grateful for the opportunity to meet with their loved one's psychiatrist, to be listened to, to hear each other's concerns, and to be actively involved in the treatment process. In turn, the psychiatrist is in a position to harness the family's energy to benefit their loved one and provide improved care. **PN**

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