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# Is Social Media Misuse a Bad Habit or Harmful Addiction?

BY JAMES SHERER, M.D., AND PETROS LEVOUNIS, M.D., M.A.

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# Miskimen Rivera Chosen APA's Next President-Elect

*APA's next president-elect is a former speaker of the APA Assembly and long-time public sector psychiatrist who has focused on improving access and delivery of psychiatric care to bilingual and bicultural communities.* **BY CATHERINE F. BROWN**

APA's voting members have elected Theresa M. Miskimen Rivera, M.D., of Millstone Township, N.J., as APA's next president-elect. She ran against Michele Reid, M.D., of Novi, Mich., who is currently APA's trustee-at-large.

Miskimen Rivera is chair and medical director of the Department of Psychiatry at Hunterdon Medical Center in Flemington, N.J. She has worked for over 30 years in public sector clinical practices that have centered on improving access and delivery of psychiatric care to bilingual and bicultural communities and developing and implementing intercultural clinical programs. She has held appointed positions under the three past governors of the state of New Jersey to address mental health issues spanning the intersection of technology and the delivery of psychiatric care, mental health in university settings, and youth suicide prevention.

Theresa M. Miskimen Rivera, M.D., will become president-elect of APA at the end of APA's Annual Meeting in May, when Ramaswamy Viswanathan, M.D., Dr.Med.Sc., becomes president.

Miskimen Rivera has been active in regional and national leadership roles within APA, including president of the New Jersey Psychiatric Association, speaker of the APA Assembly, member of the APA Executive Committee of the Board of Trustees, and vice chair of the Joint Reference Committee. She chaired the APA Board of Trustees Ad Hoc Workgroup on Insurance and has contributed

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PERIODICALS: TIME SENSITIVE MATERIALS

PSYCHIATRIC NEWS

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FROM THE PRESIDENT

# Advancing Psychiatry by Advocacy

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

APA serves as psychiatry's voice on the national stage. In practice, that means that APA leaders and staff are constantly working with lawmakers in Congress and our coalition partners to advance policies that support the mission, vision, and values of our Association, our patients, and the health and mental health of the general public. APA's advocacy doesn't stop with our efforts in the nation's capital. In fact, it is quite the opposite. Many of the issues on which APA advocates at the federal level originate in local communities that APA members serve, and our individual voices are essential as we work to advance psychiatry throughout the United States and abroad.

Our rapidly changing health care landscape demands that today's psychiatrists be adept at advocacy and skilled in communicating complex psychiatric concepts to members of their community and lawmakers alike. Each of us knows just how essential it is to expand and diversify the psychiatric workforce, why we need to increase the number of residency slots for psychiatry, and why it is crucial that mental health parity is rigorously enforced. The trick of advocacy is communicating these concepts to people who may not understand at first and helping them appreciate how they and their constituents can benefit from our work.

In 2023, I flew to Washington, D.C., to represent APA with our allied organization partners called the "Group of Six" in a series of meetings with members of Congress. The Group of Six is made up of allied organizations that share an interest in seeing that primary care and mental health care are always front and center in the minds of our lawmakers. Joining me on this trip were leaders from the American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American College of Physicians, American Academy of Family Physicians, and the American Osteopathic Association. We advocated in support of specific legislation, such as the Strengthening Medicare for Patients and Providers Act (HR 2474), and other bills that promote access to health care and address physician workforce shortages. Face time with lawmakers is invaluable as it puts a human face on issues that seem esoteric and confusing for people who aren't physicians or health care policy experts.

One recent advocacy success involved APA working with a government agency, the Centers for Medicare & Medicaid Services (CMS), which adopted several quality measures in the CMS Quality Payment Program developed by APA in collaboration with the National Committee on Quality Assurance (NCQA). These outcome measures are focused on assessment of function and suicide, including a measure for suicide safety planning. APA members who collaborated with NCQA members on making these measures clear and effective laid the groundwork for our advocacy work on the Hill.

As psychiatrists, we are experts in the connection between mind, body, and brain. It falls to us to speak up not just for our profession, but for our patients and their families as well. There are many ways to get involved, and we don't have to do it alone. APA and its district branches (DBs) and state associations (SAs) are great sources of likeminded people and support. DBs and SAs often have existing relationships with local community leaders who can be crucial allies in making progress on an issue. Trainings are available from APA staff to help anyone who is interested in getting involved in advocacy but may not know where to begin. To find out how you can get involved in APA advocacy, please visit APA's Advocacy Action Center on Psychiatry.org or contact APA staff at advocacy@psych.org. **PN**

**Information on "How to Meet a Lawmaker Training" is posted at https://www.psychiatry.org/Psychiatrists/Advocacy/Congressional-Advocacy-Network/Resources. APA's Action Center can be accessed at https://votervoice.net/AmericanPsych/home.**

## IN THIS ISSUE




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## DEPARTMENTS

EDITOR'S DESK

# Psychedelic Renaissance: Evidence and Culture

***BY ADRIAN PREDA, M.D.***

The ebb and flow of societal beliefs often resemble a pendulum's swing, oscillating between acceptance and rejection. This phenomenon is not confined to the annals of history but is evident in contemporary debates, such as the one surrounding psychedelics.

Historically, what was once deemed abhorrent, a vice, gradually became acceptable, desirable, and, eventually, a virtue. "Virtuous" peaks are commonly followed by declines and, eventually, flat-out rejection as moral failings. Consider the changing attitudes toward individualism versus collectivism or the dominance of reason versus emotion in different cultures and epochs.

This "pendulum effect" isn't just a historical pattern. In medicine, the nature-nurture debate has swung between biological and environmental models of disease. Psychiatry's pendulum has traveled back and forth between the psychological and biological determinants of mental illness. These dichotomies, while oversimplified, often guide public perception as if they were mutually exclusive truths.

Adrian Preda, M.D., is editor in chief of Psychiatric News and a professor of clinical psychiatry and human behavior at the University of California, Irvine, School of Medicine.

Science faces the constant challenge of dispelling the illusion that pendulum swings result from a cumulative body of empirically validated data. This is a dangerous illusion, as in reality, pendulum trajectories are driven by acceptance and rejection, the right and the wrong, as opposed to a data-driven valid/invalid perspective. Belief-based pendulum trajectories of beliefs commonly reflect a majority-view, socioculturally filtered interpretation of evidence.

While it is difficult to take off our socio-culturally colored glasses, the awareness of such filters should be reason enough, when it comes to rapidly swinging belief-driven pendulums, to take a step back; aim to slow down a pendulum moving at high speed; and critically examine not the beliefs, but the evidence.

Would such a perspective help better understand the contemporary, rapidly "swinging up" movement of psychedelics' benefits?

Psychedelics have been used by humans for thousands of years. For most of this time, the use of these powerful substances has been limited by strict rules and clearly defined, usually initiatory and spiritual goals. In the 1960s, this traditionally restricted view of the use of psychedelics changed to a culturally driven push for wider acceptance. While this change initially rested on data indicating that these substances had transformative mental effects, by the mid-1960s, it is not the research but the psychedelics' popularity with the flower-power counterculture movement that propelled these substances into the limelight. Later, another cultural perspective—concerns about high-profile incidents rather than purely scientific data—led to the relatively sudden demonization of psychedelics as "brain-frying," harmful substances.

The last decade has seen a reemergence of interest in these molecules' therapeutic potential. While our current understanding of psychedelics is mostly data driven, in the last couple of years, articles on psychedelics have been a regular feature of several mainstream newspapers and magazines, indicating a resurgence in public interest, supported, in major part, by a cultural shift toward a general acceptance and legalization of priorly deemed toxic substances.

*see* **Editor's Desk** *on page 6*

This is the first of a two-part series.

# Experts Explore How to Encourage Participation in Public Insurance

*In an effort to improve access to care, experts are investigating why many mental health professionals may not participate in public insurance programs and innovative ways to encourage them to do so.* ***BY KATIE O'CONNOR***

The National Academies of Sciences, Engineering, and Medicine has convened a committee of experts to study the challenges that patients face in accessing high-quality behavioral health care through Medicare, Medicaid, and Marketplace Health Insurance programs.

The committee is focused specifically on workforce issues and what incentivizes or disincentivizes behavioral health professionals from participating in these public insurance programs. The goal is to develop recommendations and innovative strategies that would increase the number of professionals who accept payment from these programs and thus improve access to care. A report detailing the committee's findings and its recommendations is due to be released in September.

The committee is chaired by Daniel Polsky, Ph.D., the Bloomberg Distinguished Professor of Health Economics at John Hopkins University. Among the committee members are two APA members: John Torous, M.D., the director of the Digital Psychiatry Division in the Department of Psychiatry at Beth Israel Deaconess Medical Center, and Rachel Talley, M.D., an assistant professor of clinical psychiatry in the Department of Psychiatry at the University of Pennsylvania.

"We see this study as a critical element in increasing access to the existing behavioral health workforce so we can serve the full range of people with mental illnesses and substance use disorders," said past APA President Anita Everett, M.D., in a statement to *Psychiatric News*.

Everett is the director of the Center for Mental Health Services at the Substance Abuse and Mental Health Services Administration (SAMHSA). SAMHSA is one of the study's sponsors, along with the Centers for Medicare & Medicaid Services.

"The government is very interested in and aware of the national concerns about [access to behavioral health care] and in doing what we can do within our abilities to improve access to and the quality of treatment," Everett said during the committee's first public meeting last August.

One of the benefits of sponsoring such a project is that the National Academies completes the project independently, then makes recommendations to the government, Everett said. Currently, the committee is soliciting input from behavioral health professionals, including psychiatrists, psychologists, advanced practice nurse practitioners, social workers, and peer support specialists. These professionals can complete a survey through which they share their experiences and can explain why they do not participate in Medicare, Medicaid, or Marketplace insurance programs.

Anita Everett, M.D., said that SAMHSA, which is sponsoring the committee's work, is hoping to get concrete, innovative recommendations on how to improve workforce participation in public insurance programs.

Many studies have documented the lack of behavioral health professionals' participation in these insurance programs, often focused on psychiatrists. About 35% of psychiatrists participated in Medicaid in 2014-2015, compared with 71% of primary care providers, according to a 2019 study in *JAMA Psychiatry*. A 2022 study in *JAMA Network Open* found that, in 2019, 55% of psychiatrists billed Medicare for services, a decrease compared with 2013, when 61% of psychiatrists billed Medicare. Further, according to the Kaiser Family Foundation, 7.5% of psychiatrists formally opted out of the Medicare program in 2022, compared with an average of 1% among all physicians.

Similar issues exist among psychologists. The results of a 2021 survey conducted by the American Psychological Association found that 31% of health service psychologists accepted Medicaid and 46% accepted Medicare.

During the August meeting, Everett explained that the committee is charged with exploring three factors that influence behavioral health professionals' participation in these programs:

*see* **Public Insurance** *on page 6*

# Psychiatrists Urge Wider Adoption Of Standardized MH Assessments

*Moving to a nationally standardized tool for patient assessments will result in more objective, transparent, and equitable treatment plans and may make it easier to overcome prior authorizations or denials of care.* **BY LINDA M. RICHMOND**

Two adolescents presented at the hospital after making a suicide attempt. Although both were 12-year-old girls, that's where the similarities end. For one, it was her first attempt, and she was from an intact family who was engaged in her treatment. She was living in a single family home in a safe neighborhood. She had no comorbidities, and her family members were healthy.

The other girl's case was nearly the opposite: It was her fourth suicide attempt that year, and she had alcohol use disorder. She also had asthma, requiring the use of an inhaler. She was being raised by a single parent with mental illness and substance use disorder and had unstable housing, staying with various relatives in crime-ridden neighborhoods for several months.

Yet both girls were deemed to have the same level of need and were granted the same length of hospital stay by their insurance provider, said Joe Parks, M.D., medical director of the National Council for Mental Wellbeing, distinguished research professor of science at Missouri Institute of Mental Health at the University of Missouri, and an outpatient psychiatrist at Family Health Center.

The use of Level of Care Utilization System family of tools (LOCUS FT) will allow clinicians to recommend more objective, accurate, and equitable treatment plans and transitions in care that factor in a more complete view of patients, said Joe Parks, M.D.

"What's clear is that the payor's methodology factored in only the depression and suicidality and their intensity. Needs assessments must look beyond the current symptoms," said Parks, who told *Psychiatric News* he discovered many cases like this while investigating complaints of improper denial of inpatient psychiatric care while serving as director of Medicaid in Missouri. "Historically, services have been decided one at a time, but people have multiple illnesses that interact, which affects the intensity and duration of services that they need."

The National Council is now calling for a nationwide paradigm shift in the way these service intensity assessments are conducted for people experiencing mental illness or substance use, according to a report that the nonprofit co-wrote with the American Association for Community Psychiatry (AACP) and the American Academy of Child and Adolescent Psychiatry (AACAP).

Specifically, the report calls for more widespread adoption of the Level of Care Utilization System family of tools (LOCUS FT), originally developed by AACP in the early 1990s. There are now separate tools for children and adolescents, children 5 years and under,

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"Payors, providers, patients, and the public should have a common language around which to understand how basic behavioral health services are funded," said Michael Flaum, M.D.

and individuals with substance use disorder (the American Society for Addiction Medicine Patient Placement Criteria, or ASAM Criteria).

The tools guide clinicians to objectively score patients on their risk of harm, functional status, comorbidities, recovery environment, prior treatment/response, and the engagement of both the patient and family. Parks said use of these tools will allow clinicians to recommend more objective, accurate, and equitable treatment plans and transitions in care that factor in a more complete view of patients.

*see* **MH Assessments** *on page 12*

# Disparities Remain Obstacles for SUD Treatment In Hispanic/Latinx Communities

*Acculturation, assimilation, discrimination, and social determinants of health all play roles in risk of substance use and access to treatment, experts say.* **BY TERRI D'ARRIGO**

The differing degrees of acculturation and assimilation among the Hispanic/Latinx population of the United States are important factors in the risk of substance use initiation and developing a substance use disorder (SUD), said panelists in a February webinar titled "Addressing Alcohol & Substance Use Disorder in the Hispanic Community: Unpacking Sociocultural Risk and Resilience." The webinar was moderated by Héctor Colón-Rivera, M.D., M.B.A., M.R.O., president of the APA Hispanic Caucus, as part of APA's Looking Beyond Series. This series explores ways of improving mental health in historically marginalized and minoritized communities.

"We're talking about so much diversity not only in country of origin but also immigration history," said Caridad Ponce Martinez, M.D., an assistant professor of psychiatry and the director of the addiction psychiatry fellowship program at the University of Massachusetts Medical School. She explained that youth who were born in another country and moved to the U.S. during a transitional age with their families may still be immersed in the practices from their countries of origin that guide substance use and initiation, whereas youth who were born in the U.S. to parents who are immigrants may try to behave more like their peers.

Karina Aguila, Dr.Ph., M.S.W., an assistant regional director at the Substance Abuse and Mental Health Services Administration, agreed.

"As a young person coming in, you're navigating by cultural identity, and incorporating aspects both from your [native] culture but also from the U.S. culture and the different [experiences] of what's going on in school," she said. "All of those things impact the possibility of the initiation to substance use."

Martinez said that adults in the Hispanic/Latinx community face a different set of challenges. She explained that because a stable income is often crucial to their survival and the survival of their families, anything that could take them away from their ability to work, such as inpatient treatment for SUD, takes a back seat to putting food on the table.

Yale School of Medicine

The Hispanic/Latinx population in the U.S. is not a monolithic group because there are differences in country of origin and immigration history, said Caridad Ponce Martinez, M.D.

"They might be viewing substance use as less problematic as long as they're able to maintain employment," Martinez said. She added that people in the Hispanic/Latinx communities often do not have a backup system or support should they need time off from work, resulting in a loss of family income.

Fabiola Arbelo Cruz, M.D., an assistant professor of psychiatry at Yale School of Medicine, said that health professionals need to avoid assuming that ethnic identity as a social classification equates to increased drinking and substance use, however.

"It is important to understand how [identifying as Hispanic or Latinx] translates to risk factors versus how racial and ethnic inequities in access to housing, medical care, or even spiritual discrimination contribute to [substance use] initiation," Cruz said.

Aguila spoke of the complex, systemic barriers to care that members of Hispanic/Latinx communities often face. These include the following:

- Social, economic, cultural, and policy factors that contribute to treatment disparities.

*see* **Disparities** *on page 7*

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# In Addressing Maternal Mortality, Mental Health Often Left Out

*Mental health conditions are the leading underlying cause of maternal mortality, yet mental health is often left out of national initiatives to improve maternal outcomes. Experts say much more needs to be done, including gathering data to better understand the significance of the problem.* **BY KATIE O'CONNOR**

In 2022, the Centers for Disease Control and Prevention (CDC) published data from 36 maternal mortality review committees (MMRCs). Deaths by suicide, overdoses, and other deaths determined by the MMRCs to be related to suicide, substance use disorders, or other deaths related to mental health conditions were far and away the leading underlying cause of pregnancy-related deaths (deaths that occur during pregnancy or within one year postpartum). Mental health conditions were the underlying cause of 23% of pregnancy-related deaths from 2017 to 2019. Hemorrhage was the second leading cause of death, at about 14%.

"The inclusion of mental conditions in maternal mortality statistics was long overdue," wrote Katherine Wisner, M.D., M.S., and colleagues in *JAMA Psychiatry* in February. Research has long pointed to the significant link between mental health and maternal mortality, the authors wrote. They referenced a 2003 article published in the *British Confidential Enquiry*. In it, the authors reported that suicide accounted for 28% of maternal deaths in 1997-1999, and additional deaths were associated with substance use. Yet despite this research, Wisner and her colleagues noted that maternal mental health is often left out of efforts to combat maternal mortality.

"Mental health conditions remain stigmatized in our society," Wisner told *Psychiatric News*. Wisner is the associate chief for perinatal mental health at the Developing Brain Institute at Children's National Hospital. She pointed to a 2019 paper published in the *American Journal of Obstetrics and Gynecology*, which reviewed numerous studies that identified self-harm, including suicide or opioid overdose, as the leading cause of death in the perinatal period. "These self-harm deaths remain under the public radar," the authors wrote.

## Trauma's Impact on Perinatal Outcomes

The myth that pregnancy somehow protects women from mental illness is persistent among the public, but research has consistently debunked it.

"The process of having a baby itself can be traumatic for some patients," said Nancy Byatt, D.O., M.S., M.B.A. Byatt is the executive director of the Lifeline for Families Center and Lifeline for Moms program at UMass Chan Medical School, the founding medical director of the Massachusetts Child Psychiatry Access Program (MCPAP) for Moms, and a member of APA's Committee on Women's Mental Health.

Some studies estimate that between 34% and 45% of women experience childbirth as traumatic, regardless of their need for medical interventions. Byatt and her colleagues conducted a qualitative study among 32 individuals, most of whom were White and privately insured, who reported experiencing a traumatic birth. Participants reported that their labor experiences were traumatic for a variety of reasons, such as fetal complications or poor communication with staff. Among the participants, 34% screened positive for posttraumatic stress disorder (PTSD), 19% for depression, and 34% for anxiety. The findings were published in *General Hospital Psychiatry* in 2021.

"We need to support perinatal individuals, because then we can actually prevent some of the downstream effects of trauma and stressors families are experiencing," said Nancy Byatt, D.O., M.S., M.B.A. "I think that's the best chance we have of addressing this mental health crisis, because we're not going to do it by reacting only when we see the illness."

Most participants felt that they did not receive adequate mental health support while they were in the hospital following their deliveries. Others did not feel comfortable discussing mental health symptoms with their clinicians due to stigma surrounding mental health care.

Byatt noted that births can especially feel traumatic for patients if they are entering the perinatal period with histories of sexual trauma or other kinds of trauma. Adverse social determinants of health, such as lack of housing or food insecurity, are also considered traumas or stressors that can negatively impact a patient's birthing experience.

## Maternal Mental Health in the VA

The impact that trauma has on birthing outcomes was noted in a January report by the Government Accountability Office (GAO) on maternal health within the Department of Veterans Affairs (VA). Research indicates that pregnant veterans are more likely to have experienced PTSD or military sexual trauma, which can increase their risk of adverse pregnancy outcomes, the report stated.

The trauma burden among women veterans is significant, said Amanda Johnson, M.D., director of women's reproductive health in the VA's Office of Women's Health. About 40% of women veterans who use the VA for their health care have at least one mental health diagnosis, she said. "We also know that [women veterans] may actually have a higher trauma burden when

*see* **Maternal Mortality** *on page 34*

# Federal Government Issues New Rule on SUD Records

*The changes to 42 CFR Part 2, many of which APA supported, will better align the rule with HIPAA, improve care coordination between health professionals, and help eliminate the stigma patients experience.* **BY KATIE O'CONNOR**

Over a year since proposing changes to the rule that regulates the confidentiality of substance use disorder (SUD) records, the Department of Health and Human Services (HHS) released its final rule, which better aligns the rule with the Health Insurance Portability and Accountability Act (HIPAA).

The final rule—known as 42 CFR Part 2 and commonly referred to as Part 2—was released by HHS through the Office of Civil Rights and in coordination with the Substance Abuse and Mental Health Services Administration (SAMHSA). While HIPAA is intended to protect patient health information broadly, Part 2 pertains specifically to the confidentiality of patient records that are maintained in relation to SUD prevention, training, education, treatment, rehabilitation, or research.

Previously, there were key differences between Part 2 and HIPAA that could impede care coordination, explained Smita Das, M.D., Ph.D., M.P.H., chair of APA's Council on Addiction Psychiatry. "For example, under HIPAA, health information could be shared without consent, with certain limitations, for the purposes of TPO—or treatment, payment, and healthcare operations—while Part 2 required patient consent for each disclosure," Das explained. "[W]hile intended to protect confidentiality, this was often a barrier for Part 2 providers attempting to bill or coordinate care."

The new rule includes several provisions for which APA advocated that would both improve care coordination for patients with SUDs and help eliminate the stigma and discrimination that these patients often experience. Some of the new rule's provisions include the following:

- Part 2 now allows patients to sign a single consent form for all future uses and disclosures for SUD treatment, payment, and other health care operations. APA supported this provision to help with care coordination, and it may reduce patients' paperwork burden as well, Das pointed out.

- The new rule allows HIPAA-covered entities and business associates that receive records under this single consent to redisclose the records in accordance with the HIPAA regulations without requiring patients to re-consent.

- The new rule expands prohibitions on the use and disclosure of Part 2 records in civil, criminal, administrative, or legislative proceedings conducted against a patient unless the patient provides consent or a court order is issued. APA advocated for this provision to help eliminate stigma against seeking care.

- When agencies investigate or prosecute Part 2 programs or individuals providing care under Part 2, they may unknowingly receive confidential, protected records before obtaining a court order. The updated rule creates new, stronger diligence steps that investigational agencies must follow before they are eligible for a safe harbor (a protection from civil or criminal liability) under Part 2. Investigational agencies must look for a health professional in SAMHSA's online treatment facility locator and check a professional's patient notice or HIPAA notice of privacy practices to determine whether the health professional is subject to Part 2.

"It is important that information about substance use disorders be confidential so that patients feel comfortable getting treatment," said Smita Das, M.D., Ph.D., M.P.H.

- Previously, health professionals were required to track and segregate records that are subject to Part 2 from those that are subject to HIPAA. For example, if a clinic provided general medical services along with services on a unit specializing in SUD treatment, the clinic had to segregate its SUD records and medical records for the same patient. Now, if consent is provided, SUD records that are shared with other general medicine units do not have to be segregated once received.

- The new rule creates a new definition for an SUD clinician's notes that are analogous to HIPAA's protections for psychotherapy notes. Notes analyzing conversations during SUD counseling sessions that the clinician voluntarily maintains separately from the rest of the patient's SUD treatment and medical records cannot be used or disclosed based on a broad treatment, payment, and health care operations consent. Instead, the patient must provide additional consent before these notes can be disclosed.

- Records can be disclosed without patient consent to public health authorities, provided that the records are de-identified according to the standards of HIPAA's privacy rule.

In terms of enhancing patient collaboration, the final rule represents a step in the right direction, Das said. "People with SUDs are unfortunately subject to increased stigma and discrimination from many systems, including the health care, legal, and financial systems," she said, adding that these burdens are worse for marginalized and vulnerable populations.

"We have evidence-based treatments for SUDs that are often underutilized out of fear of lack of confidentiality," she continued. "Ensuring protections for our communities while enhancing the effectiveness of care—through care coordination, for example—will result in more people accessing care and will lead to better outcomes." **PN**

**More information on the final rule is posted at http://APAPsy.ch/Part-2-Fact-Sheet.**

## Public Insurance

*continued from page 3*

- Current perceptions and/or experiences among these professionals, especially among trainees, that may challenge or impede participation.

- Administrative processes and policies that produced perceived or experienced burdens and the ways in which those processes may be clarified, simplified, or streamlined.

- Infrastructure requirements that are necessary for these professionals to participate, such as electronic health records, third-party billing systems, and/or data collection.

"We would like some really deep thinking about what models we might pursue that might help more providers participate in these public payer systems," Everett said during the meeting. "We're looking for very concrete recommendations." **PN**

**More information on the Committee on Strategies to Improve Access to Behavioral Health Care Services through Medicare and Medicaid is posted at http://apapsy.ch/access-to-care.**

## Editor's Desk

*continued from page 3*

Where are we now? As a clinician and clinical researcher, I hold the "first do not harm" principle as the most important value informing my practice. As such, I found the preclinical data mapping psychedelic-induced neuroplasticity and neuroregeneration invaluable in helping me better understand the risk/benefit of these interventions. I am less enthusiastic about the human studies testing the potential clinical uses of psilocybin and LSD.

To illustrate some of my concerns, let me propose a thought experiment. Consider any of the psychedelic clinical trials recently published by *The Lancet, JAMA Psychiatry,* or *The New England Journal of Medicine*. Edit the text to replace the active substance (psilocybin/LSD/psychedelic drug) with "drug x". Read the edited "drug x" paper, a paper reporting on a "drug x" effect on a given outcome of interest: depression/PTSD/studied clinical indication. Finally, on a scale of 1 to 10, rate your confidence about your "drug x" clinical trial likelihood for publication by a first-tier medical journal. For me, this thought experiment results in pretty low confidence rates, which in turn, accurately reflects my view of the strength of evidence underlying this psychedelic revival.

My reading of the recently completed psychedelics clinical trials is that there is a lot of hope, which is good, and there is also a lot of hype, which is not good. The fact is that we are seeing a rapidly building momentum.

Consider this: On the one hand, this momentum, when carefully managed, could speed up the rate of discovery. On the other hand, strong momentum could be destabilizing to the point of swiftly running into the ground a fragile and far from established body of knowledge.

What can we do? In future editorials, we will focus on potential solutions: ways to ensure that we maintain the momentum while avoiding the temptations and danger of a high-speed chase. **PN**

# Leading and Advocating 38,900 Members Strong

*Don't wait for other APA members to advocate for psychiatry and its patients—get off the sidelines now and make your voice heard.* **BY DIONNE HART, M.D.**

APA's mission is to promote universal and equitable access to the highest quality care for people affected by mental illness, including substance use disorders, as well as to promote psychiatric education and research, advance and represent the profession of psychiatry, and serve the professional needs of its membership.

Advocacy is an integral and essential part of APA's leadership responsibilities. The Board of Trustees discusses and sets broad advocacy policies and determines budgets for advocacy activities. APA's Council on Advocacy and Government Relations advocates at the state and federal levels on issues important to APA and the field of psychiatry and creates programs to encourage members to become advocates as well. APA's Assembly advocates for policy and positions that will advance psychiatry and support psychiatric physicians and patients. APA's district branches advocate at the local and state levels; many issues relevant to psychiatry specifically and medicine more generally involve state laws and regulations.

Dionne Hart, M.D., is an adjunct assistant professor of psychiatry at the Mayo Clinic Alix School of Medicine and provides clinical care services in multiple community settings. She is a member of APA's Council on Advocacy and Government Relations (CAGR) and the incoming Area 4 trustee. She can be reached on X (formerly known as Twitter) at @lildocd. This article is part of a series by CAGR.

Each part of APA's governance structure plays an important and supportive role in forwarding our mission. However, advocacy is not just the task of our elected and appointed leaders—it is also the responsibility of each of us as members. Take the time to contact your APA leadership and let your thoughts be known. When APA's next election rolls around next year, be sure to learn about the candidates and cast an informed vote. Also, remain informed on issues impacting your patients and practice and actively participate in amplifying APA's efforts by engaging in social media, responding to APA's Action Alerts, and joining the Congressional Advocacy Network. I want you to hold me and my fellow Board members accountable to do our best to advocate on your behalf. Let's work together to lead and advocate as 38,900 members strong.

Visit https://www.psychiatry.org/psychiatrists/advocacy to become involved now or donate to APAPAC. The staff of APA's Division of Advocacy, Policy, and Practice Advancement is eager to provide information and connect you to your members of Congress. While constant advocacy efforts are always needed, this election year makes your involvement that much more crucial. **PN**

## APA'S GOVERNMENT, POLICY, AND ADVOCACY UPDATE

### APA Staff Urge CMS to Make Telehealth Flexibilities Permanent

Recently, APA staff spoke with the Centers for Medicare & Medicaid Services (CMS) staff to request that they make the telehealth flexibilities introduced during the COVID-19 public health emergency permanent.

On January 29, APA staff joined 11 other organizations on a call with CMS. Participants from APA, the American College of Physicians, the American Academy of Neurology, and the American Geriatrics Society expressed their support for payment parity for telehealth services. They cited parity as a top priority for their organizations to ensure that physician practices can continue providing vital care via telemedicine in 2025 and beyond.

APA staff also met with CMS individually on February 5 to reinforce this message about telehealth payment parity. They requested that CMS allow physicians to continue using the same payment codes as they do when seeing patients in person. Further, they asked CMS to make permanent virtual supervision of residents and underscored the value of such flexibility when a resident is providing virtual or in-person care.

APA followed up on these meetings with a letter in support of these and other priorities for CMS to consider as the agency begins to write its proposed rule on the 2025 Medicare Physician Fee Schedule.

### APA Provides Comments to SAMHSA On Improving Maternal Mental Health

The Office on Women's Mental Health n the Substance Abuse and Mental Health Services Administration (SAMHSA) issued a request for comments on behalf of its Task Force on Maternal Mental Health on questions related to the prevention and treatment of maternal mental health conditions. In its response, APA emphasized that perinatal women often go without care for their mental health conditions and that equitable care must be prioritized in the effort to curb maternal mortality.

"For the first time in 2021, the leading cause of pregnancy-related death in the United States was underlying mental health conditions," stated APA's letter, which was signed by APA CEO and Medical Director Saul Levin, M.D., M.P.A.

APA supported increased screening during pregnancy and postpartum, as well as connecting pregnant and postpartum people to safe treatment spaces. "An example of a safe treatment center is the Salvation Army in Honolulu, which has residential treatment for pregnant people with addiction, where moms can keep children with them, and an outpatient facility where pregnant persons can get support and supportive services, including prenatal care," the letter stated.

APA noted that the maternal mortality rate is twice as high for Black women compared with White women. Research shows that women from marginalized backgrounds are distrustful of health care professionals and may choose not to disclose important information. APA pointed to the need to provide culturally appropriate care, which could be done by employing those with lived experience who represent the communities in which they reside.

Further, APA pointed out some evidence-based interventions that could improve maternal mental health, such as the Massachusetts Child Psychiatry Access Program for Moms. The program provides real-time behavioral health consultations for health professionals caring for perinatal patients.

APA's letter is posted at http://APAPsy.ch/maternal-task-force-response.

## Disparities

*continued from page 4*

- Language barriers and the limited availability of treatment programs in Spanish.

- A lack of bilingual and culturally competent health professionals and educational materials.

Yale School of Medicine

Health professionals who share the same language, life experiences, and racial and ethnic heritage of a community are critical to successful treatment, said Fabiola Arbelo Cruz, M.D.

- Cultural stigma that affects an individual's ability and willingness to seek mental health and substance use treatment.

- Religious or traditional beliefs that may discourage individuals from disclosing certain things to people outside of their family or home.

- Limited financial resources to afford treatment.

Cruz added that mental illnesses such as depression and anxiety are independently linked to substance use and that people in the Hispanic/Latinx population are at greater risk of these illnesses because of discrimination and disparities related to social determinants of health. To that end, it's crucial that each community has health professionals who belong to the community.

"[P]eople who share the racial and ethnic heritage of the community, the language, the socioeconomic status, the life experiences [are often] more effective for ... our underserved communities. They are found to be more accessible than traditional clinical behavioral health services and workers," she said.

"Treatment does not happen in isolation and ideally should not happen in a single instance of care but [rather through] developing a relationship with communities and with individuals." **PN**

**APA's Looking Beyond Series is posted at https://www.psychiatry.org/psychiatrists/diversity/mental-health-equity-fireside-chat.**

# APA's Resident/Fellow Census Captures Snapshot Of Current Class, Future Workforce

*A significant percentage of positions in subspecialty fellowships go unfilled each year, with occupancy rates for addiction, consultation-liaison, forensic, and geriatric psychiatry all averaging less than 65%.* **BY MARK MORAN**

The number of available match positions in psychiatry continues to increase, with nearly all positions consistently filled over the past five years, according to APA's 2022 resident/fellow census. At the same time, although the number of residents pursuing subspecialty fellowships has increased over the years, a large number of subspecialty slots continue to go unfilled.

Those are among the takeaway messages from the census, a richly detailed portrait of the 2021 group of psychiatry trainees and the future of the psychiatric workforce.

The census is a product of the APA Division of Education and supported by the APA Division of Membership; it was compiled by Meghan Hophing, M.D., a fellow in the geriatric psychiatry program at New York Presbyterian Hospital, and Karuna Thomas, M.D., a first-year resident at the University of Massachusetts. They were mentored by Sanya Virani, M.D., an assistant professor and associate program director of the addiction psychiatry fellowship at the University of Massachusetts; Tanner Bommersbach, M.D., M.P.H., a child and adolescent psychiatry fellow at the Mayo Clinic; and APA Deputy Medical Director and Chief of Education Vishal Madaan, M.D.

Karuna Thomas, M.D., said that the census should be read with interest by program directors and others who care about the composition of the current group of trainees.

The census compares 2021 data with the previous four years beginning with 2017.

A total of 1,907 psychiatry slots were offered in 2021, three of which went unfilled. That figure is up from 1,495 slots offered and 1,491 filled in 2017. The rising number of filled positions reflects the increasing popularity—and competitiveness—of psychiatry as a field. This trend has been accompanied by a decreasing percentage of positions filled by international medical graduates (IMGs). These physicians have traditionally worked in rural and underserved areas of this country.

"The APA resident/fellow census is an important resource that provides critical information related to the psychiatric workforce and helps guide our training programs with their recruitment and retention efforts," said Madaan. "The report provides a range of useful demographics—age and gender, subspecialty-specific information, and recruitment trends over time.

"A heartening trend is the sustained fill rate of greater than 99% over several years and the growing number of women joining the psychiatric workforce," he continued. "A clear challenge, however, is a lower percentage of international medical graduates that match into psychiatry."

Of the 1,904 positions filled in 2021, 309 (16.3%) were filled by IMGs, down from 20.3% in 2017. The majority were filled by U.S. allopathic graduates (1,205, or 63.2%), osteopathic graduates (332, or 17.4%), and others (58, or 3%).

Racial and ethnic diversity among psychiatry trainees has remained largely unchanged over the past five years, but the number of non-U.S. citizen and Hispanic/Latino residents did increase in 2021. Among first-year general psychiatry trainees in 2021, 10.5% were Hispanic compared with 8.4% in 2020; 15.86% reported being non-U.S. citizens, up from 11.8% in 2020.

The number of residents pursuing subspecialty fellowships has marginally increased since 2017, with the greatest percentage increase in addiction psychiatry (20.7%). Still, a significant percentage of positions in subspecialty fellowships go unfilled each year. The occupancy rate for addiction, consultation-liaison, and forensic psychiatry fellowships averaged 64%, 60%, and 64%, respectively, over the last five years. Geriatric psychiatry had the lowest average enrollment rate of 33.5% from 2017 to 2021.

Other findings from the census include the following:

- Among general psychiatry trainees reporting gender, the percentages reporting male or female has been nearly equal since 2017, with 50.2% female in 2021, up slightly from 48.9% in 2017. (In 2020, the Accreditation Council for Graduate Medical Education began reporting on a "nonbinary" category; to date, no trainees have identified as nonbinary.)

Meghan Hophing, M.D., said the census offers "important information on the recruitment and retention of psychiatry residents and fellows, as well as areas in need of greater [recruitment]."

- Among subspecialty fellows, the gender breakdown has been more variable: 41.6% reporting female for addiction psychiatry, 58% female for child and adolescent psychiatry, 46% female for forensic psychiatry, 56.9% female for geriatric psychiatry, and 58.4% female for consultation-liaison psychiatry.

*see* **Census** *on page 10*

RESIDENTS' FORUM

# Investing in Residents' Mental Health Vital To Psychiatry's Own Health

**BY JACOB CROSS, M.D.**

Working in psychiatry exposes you to the extremes of the human condition: rage, shame, panic, fear, melancholy, and grief. Part of our role as psychiatrists is to sit with our patients through these intense feelings and create a space in which they are allowed to explore these parts of themselves while feeling safe and heard. We regularly help patients develop curiosity about a wide range of affects, identify their feelings, and understand themselves better. Although this work can be incredibly rewarding, it is important to remember that being a consistent, calm, safe, and thoughtful clinician takes a significant amount of mental and emotional energy. For mental health professionals to function well and create a holding space for our patients' intense emotions, it is paramount that we have access to psychiatric care. The benefits that we provide to our patients are the same ones we sometimes desperately need to receive in order to continue doing our essential work.

Jacob Cross, M.D., is a fourth-year psychiatry resident at Rush University Medical Center, an APA/APAF public psychiatry fellow, a certified medical interpreter in Spanish, and rising Hispanic psychiatry fellow for the 2024-2025 academic year at Yale School of Medicine. He is passionate about immigrant mental health with a focus on the Spanish-speaking community.

In addition to this, it is crucial to understand that being a resident physician is itself a risk factor for depression. Residency requirements create conditions that normalize poor work-life balance and sleep deprivation, both of which negatively impact mental health. Additionally, social isolation is commonplace as residents' waking hours are consumed by working. More than 1 in 4 residents report suffering with depression, which is significantly higher than average when compared with the rates of the general population, according to a 2015 report in *JAMA*. Furthermore, being a resident shortens one's telomeres, the protective

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# Canada Honors APA Member for Groundbreaking Work

*Bruce G. Pollock, M.D., Ph.D., was among those appointed to the Order of Canada last December. He was honored for his pioneering contributions to geriatric psychopharmacology.* **BY KATIE O'CONNOR**

When Bruce G. Pollock, M.D., Ph.D., was a resident in Toronto at what is now the Centre for Addiction and Mental Health (CAMH), the psychoanalytic model of care was predominant. One of his patients at the time was a young woman who was not responding to desipramine. Even at the smallest doses, she complained that she was experiencing intense side effects. Pollock's supervisor labeled the patient "hysterical," but Pollock sent a sample of the patient's blood to the United States for testing. It turned out that, even at the smallest doses, the patient's blood had very high levels of the medication.

This case, Pollock said, heavily influenced his research career, which he has devoted to clinical psychopharmacology. He has been internationally recognized for his work related to geriatric psychopharmacology in particular. Most recently, Pollock's list of accolades has grown to include one of the highest civilian honors available to any Canadian. In December, Canada's Governor General, Mary Simon, named Pollock a member of the Order of Canada. The honor recognizes individuals whose achievements and service have had an impact on communities both within Canada and beyond. Pollock was honored "for his pioneering contributions to geriatric psychopharmacology as a researcher, builder, and educator," according to the Governor General's website.

Past APA President Dilip Jeste, M.D., has known Pollock for over 25 years and is also a geriatric psychiatrist. "He is unquestionably a major international leader in geriatric psychiatry specifically, but also within psychiatry as a whole," he said. "For governments to recognize the importance of psychiatry and mental health is critical, and to have his leadership recognized is great for our field."

Pollock is now a senior scientist with the Adult Neurodevelopmental and Geriatric Psychiatry Division at CAMH. He previously served as director of CAMH's Campbell Family Mental Health Research Institute and was the Peter & Shelagh Godsoe Endowed Chair in Late-Life Mental Health. He has received numerous prestigious awards during his career, including APA's Jack Weinberg Memorial Award for Excellence in Geriatric Psychiatry, APA's Mrazek Award in Psychiatric Pharmacogenetics, the Abrams Award in Geriatric Clinical Pharmacology from the American Society for Clinical Pharmacology and Therapeutics, and the Distinguished Investigator Award from the American Association for Geriatric Psychiatry (AAGP). He was also the first Canadian to serve as president of AAGP.

After completing residency, Pollock began applying clinical pharmacology to geriatric psychiatry while completing his Ph.D. at the University of Pittsburgh. "I would get frustrated because when I was looking at newer psychiatric medications, only lip service was paid to geriatric dosing and trials," he told *Psychiatric News*. "No patients were included in the trials who were over the age of 65." Those that did include people over age 65 included patients who Pollock described as "geriatric astronauts." They had no other medical problems except the index psychiatric illness, while many patients in the general geriatric population have comorbid illnesses that may complicate how a drug affects them.

CAMH Public Affairs

Bruce G. Pollock, M.D., Ph.D., devoted his career to improving the understanding of how psychiatric medications impact older adults.

Early in his research career, as he and his colleagues were trying to optimize pharmacologic treatment, he said he became very interested in drug metabolism in the elderly. His work has shed important light on how drug clearance changes with age, which has influenced the ways in which older adults with psychiatric illnesses or dementia are treated in clinical practice. He has led numerous studies that have both resulted in new treatments for older adults and ensured the safety and efficacy of existing treatments.

His career has focused on treating depression in older adults, as well as treating the agitation that can accompany dementia. "I have long believed that the most common treatable illness in older people is caused, frankly, by us," he said. "Medication has a significant impact on the elderly, both for good and ill."

Jeste pointed out that ageism is a significant problem, but older people bring important strengths to society. "That is why research and clinical work that focus on how to help people live healthier and promote positive views of older people is critically needed," he said. "That is what Bruce has been doing from the very beginning of his career." **PN**

**More information on the Order of Canada and other recent awardees is posted at https://www.gg.ca/en/order-canada-appointees-december-2023.**

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structure at the ends of chromosomes. According to a 2019 study in *Biological Psychiatry,* a resident's DNA during the intern year ages six times faster than that of the average person.

Working as a resident has very real emotional and physical consequences. After accidents, suicide is the number one cause of death for residents. According to a 2015 study in *JAMA Psychiatry,* as many as 22% of interns had suicidal thoughts, and only about half of these thoughts were adequately addressed with psychotherapy. The suicide rate among male physicians is 1.41 times higher than the general male population. And among female physicians, the rate is even higher—2.27 times greater than the general female population, according to a meta-analysis in *The American Journal of Psychiatry.* We need to prioritize the mental health of residents and encourage them to get treatment, as untreated mood disorders are a risk factor for suicide.

Even though psychiatrists report having less clinical work demands, they report higher work-related emotional exhaustion and severe depression than other physicians. One explanation for this is that psychiatrists are exposed to occupational hazards that worsen burnout. For example, one concern in mental health treatment is violence perpetrated by patients. Another unfortunate reality is that psychiatry residents may have patients who die by suicide, which can be a particularly destabilizing aspect of the job. The last few years have been even more challenging than usual. A 2023 paper in *Psychiatric Research* reported individuals who were infected with COVID-19 (importantly, many resident physicians acquired COVID-19 at some point during the pandemic) demonstrated a 200% increased rate in suicide attempts. On top of this baseline increase of suicidal thoughts, stressors at the height of the pandemic affected psychiatry residents as well, with about half reporting symptoms of depression and anxiety.

Unfortunately, health institutions across the nation are cutting department funding, including taking away funding for psychiatric services for residents. This means that the care that was previously paid for by the hospital system was disrupted because many resident doctors, who live paycheck to paycheck, cannot afford this extra expense.

This is a call for every psychiatry residency program to provide free psychiatric services for their residents and create a culture where seeking care is supported. The decision not to cover these services for psychiatry residents is a dangerous one. **PN**

*The author thanks Cadence Trapini, M.D., for her contributions to this article. Trapini is a third-year psychiatry resident at Rush University.*

**"Prevalence of Depression and Depressive Symptoms Among Resident Physicians" is posted at https://jamanetwork.com/journals/jama/fullarticle/2474424. "Physician-Training Stress and Accelerated Cellular Aging" is posted at http://apapsy.ch/training-stress. "Suicide Rates Among Physicians: A Quantitative and Gender Assessment" is posted at http://apapsy.ch/physician-suicide-rates. "Increased Suicidal Ideation and Suicide Attempts in COVID-19 Patients in the United States: Statistics From a Large National Insurance Billing Database" is posted at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10008142/. "Burnout, Depression, Anxiety, and Stress Among Resident Physicians 18 Months Into the COVID-19 Pandemic: A Cross-Sectional Study" is posted at https://journals.ku.edu/kjm/article/view/18420.**

# SMI Adviser Offers Care Guide for Veterans With Serious Mental Illness

*A tailored, trauma-informed approach that considers military culture, the impact of service-related trauma, and the importance of camaraderie is essential to effectively care for veterans with SMI.* **BY MARK MORAN**

SMI Adviser, APA's clinical support system for serious mental illness, has developed a new guide, "Critical Components for Understanding Veterans With Serious Mental Illness."

"Given the demanding nature of military service and the early age at which many veterans begin their careers, there is a heightened vulnerability to serious mental illness (SMI), which includes major depression, schizophrenia, and bipolar disorder," according to the guide. "These challenges are exacerbated by the unique stressors that veterans face, such as combat-related trauma, the complexities of multiple deployment tours, and the intricacies of transitioning from military to civilian life."

SMI Adviser is funded by the Substance Abuse and Mental Health Services Administration and administered by APA. The guide was developed in collaboration with Jason Phillips, L.C.S.W., a therapist with extensive experience working with veterans and active duty military personnel. Phillips worked as a clinical director for an embedded behavioral health clinic at Fort Liberty (formerly Fort Bragg) from 2017 to 2021.

Phillips told *Psychiatric News*, "The guide will help mental health professionals, patients, and family members better understand what veterans with SMI are experiencing, how their mental illness may have progressed from early adulthood through later years in life, and how life experiences—including those in the military— may impact how veterans experience their illness and their care and treatment.

The guide notes that there is a significant need for specialized and culturally competent care for veterans, stating, "A tailored, trauma-informed approach that considers the military culture, the impact of service-related trauma, and the importance of camaraderie is essential to effectively care for veterans who have SMI."

Included in the guide are the following components of care for veterans with SMI:

- **Understanding symptom and treatment history:** In the military, service members may not acknowledge experiencing symptoms of mental illness, often prioritizing the mission over their own needs. Consequently, service members frequently decline or delay care to avoid diverting time from their unit or jeopardizing their military careers.

Resilience, a trait fostered in military training, may be a positive asset veterans can bring to the management of their serious mental illness, said Jason Phillips, L.C.S.W.

- **Understanding stressors and supports:** After discharge from the military, veterans may encounter distinct challenges. This transition from active duty to civilian life involves a significant readjustment period, in which military rank no longer has the same importance or impact on daily life.

- **Awareness of suicide rates and weapon expertise:** Veterans exhibit higher suicide rates than their civilian counterparts and are more likely to die from self-inflicted firearm injuries, according to the 2022 National Veteran Suicide Prevention Report.

- **Communicating with primary care team:** Active duty takes a physical toll on the body. Collaborative care, involving primary care providers and mental health clinicians, employs a holistic approach by addressing mental illness symptoms and physical health concerns simultaneously.

- **Recognizing stigma:** Approximately 60% of military personnel who face mental health problems choose not to seek professional help because of associated stigma, according to a 2015 report in the journal *Epidemiologic Reviews* on stigma as a barrier to seeking care among military personnel.

- **Considering treatment:** Mental health professionals can support veterans in seeking care by fostering open communication and engaging veterans in shared decision-making.

- **Strengthening self-care and coping strategies:** Veterans may try to cope by using maladaptive strategies they have learned related to combat experience and avoiding certain experiences that are associated with heightened psychological distress and suicidal ideation.

- **Recognizing spirituality:** Veterans who are managing SMI often turn to religion and spirituality as sources of support, which are associated with improved health-related quality of life and reduced depression levels.

- **Leveraging physical activity as coping:** In response to mental health challenges after deployment, veterans often adopt exercise to address the impact of exposure to violence. These activities serve as effective coping mechanisms and contribute to enhanced cardiovascular health.

- **Building resilience resources:** Resilience plays a crucial role in enhancing the well-being of veterans who are managing SMI. Research consistently underscores its significance as a protective factor against the adverse effects of SMI, leading to improved relationship building, social skills, and overall quality of life.

Phillips noted that resilience, a trait that is often fostered in military training, is an asset that veterans may bring to their care. And he emphasized the crucial importance of encouraging veterans to advocate for themselves.

SMI Adviser offers free continuing education credit, expert consultations, and resources to help frontline clinicians and staff—including physicians, nurses, pharmacists, psychologists, social workers, counselors, and peer recovery specialists—provide evidence-based care to individuals with SMI. The latter include those living with schizophrenia, bipolar disorder, or major depressive disorder. **PN**

**"Critical Components for Understanding Veterans With Serious Mental Illness" is posted at http://apapsy.ch/SMI-Adviser-Veterans. Information about SMI Adviser is posted at https://smiadviser.org/. The smartphone app can be downloaded at https://smiadviser.org/getapp.**

## Census

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- The median educational debt for psychiatry trainees was $200,000, similar to that of residents in other specialties.

Thomas and Hophing said that the census should be read by anyone interested in the composition of the current trainees and the future of the psychiatric workforce. "The resident/fellow census provides a yearly snapshot of the psychiatry trainee population and also summarizes trends over the past five years pertaining to the National Residency Matching Program," Hophing said. "It shows us important information on the recruitment and retention of psychiatry residents and fellows, as well as areas in need of greater [recruitment]."

APA first reported the demographics of psychiatry residents in 1969 through a survey of all psychiatry residency and fellowship programs and continued to survey programs annually until 1998. In 1999, APA collaborated with the AMA and used the AMA database of psychiatry residents to produce the 1999-2000 census report. Starting with the 2001-2002 report, APA's data came from the National GME Survey or GME Track, an online survey conducted by the Association of American Medical Colleges in collaboration with the AMA. Additional data were gathered from the Accreditation Council for Graduate Medical Education Data Book and the National Residency Matching Program Data Resource. **PN**

**The 2022 Resident/Fellow Census is posted at https://www.psychiatry.org/residents-medical-students/medical-students/resident-fellow-census.**

APAF

"Where We Play: Nashville" featured a panel session about persevering through adversity in sports. From left: Former NFL player Kevin Dyson, sports medicine specialist Colin Looney, M.D., former MLB World Series MVP and current APA Foundation board member Ben Zobrist, Belmont student athlete Sam Kirkpatrick, and former NFL player Eric Decker.

# 'Where We Play: Nashville' Kicks Off Movement For Better Mental Health for Athletes and Musicians

*A new program by the APA Foundation aims to create a culture that values mental wellness for professional, collegiate, and young athletes and musicians.* **BY ABIGAIL PALAZZO**

Earlier this year, the movement for better mental health outcomes for athletes and entertainers took flight. "Where We Play: Nashville," held at Belmont University's Fisher Center, was an exploration of the mental health challenges associated with performing in the public eye hosted by the APA Foundation. It featured talent such as world champion swimmers Michael Phelps and Allison Schmitt, Grammy-nominated singers/songwriters Blessing Offor and Ashley Gorley, two-time MLB World Series champion and APA Foundation Board of Directors member Ben Zobrist, and more.

Athletes are commonly seen as less likely to struggle with mental health issues, but the opposite is often true. In fact, according to event sponsor Athletes for Hope, about 33% of elite athletes report mental health challenges, yet less than 10% seek help, and performers are twice as likely to experience depression as the general population.

Abigail Palazzo is a communications specialist for the APA Foundation within APA's Division of Communications.

Eric Decker, a former college athlete and NFL player, told an audience of about 200 people, "After I transitioned out of football and started trying to find purpose, I think that was the hardest time of my life. I hit rock bottom and realized that my identity was so tied to sports [that] I didn't know who I was. … The biggest answer for me was connection. Being able to share your story, share your failure, share when stuff is hard. You have to find someone to share that with."

Altha Stewart, M.D., a former APA president and, among other positions, director of the Center for Youth Advocacy and Well-Being at the University of Tennessee Health Science Center, kicked off the event by moderating a session with Schmitt and Phelps, who shared their mental health struggles and approaches to self-care. Offor, Drew Baldridge, Sarah Kroger, and Britt Nicole were among the musicians who combined performances for the audience with their individual approaches to balancing their public and personal lives. Yoga instructor Chelsea Young led stretch breaks with attendees throughout the daylong event to underscore the close relationship between physical and mental health.

The APA Foundation presented a grant in the amount of $7,500 to The Refuge Center, which offers affordable, professional counseling services to those in need in the greater Nashville area. Refuge Center counselor Pike Williams, L.M.F.T., joined the incoming president of the Tennessee Psychiatric Association, Michelle Cochran, M.D., for a panel discussion about the challenges faced by athletes and musicians (such as performance anxiety, substance use, the decision to compete after recovering from an injury, social media, and burnout). They discussed self-care techniques and offered guidance on when to seek professional help, given that there is no health without mental health.

"Where We Play: Nashville" is the first of several events to be held across the country by the APA Foundation, targeting young people aged 18 to 25 with messages from elite entertainers and athletes about their mental health problems and how they have overcome them, with the goal of referring young people to the APA Foundation's Mental Health Care Works public awareness campaign. One key takeaway of the event for young athletes and performers was to recognize oneself as being a complex, multidimensional person instead of limiting one's identity to solely being an athlete or an entertainer.

Zobrist commented, "We are so much more than just the performance on the field. Other people might show love to you when you're performing well, and that's great, but you need to see that you're loved when nothing is going well. It doesn't matter whether you win a World Series championship or you're SEC Player of the Year. It's not going to fulfill, at the end of the day, that level of human need that you have to feel loved. It can't come from the field; it has to come from within." **PN**

*A special thanks to APAF Board of Directors members Maureen Sayres Van Niel, M.D., and Ben Zobrist for their strategic vision and leadership in planning this event.*

**The website for Athletes for Hope is https://www.athletesforhope.org/2019/05/mental-health-and-athletes/. More information about the work of the APA Foundation and its vision to create a mentally healthy nation is posted at https://apafdn.org/wwp. Contributions may also be made at this site.**

# Library Exhibit Celebrates APA's Black Psychiatrists

*Among the psychiatrists featured are those who played a role in the Black Caucus resolutions presented to APA's Board of Trustees in 1969. The exhibit will be open for in-person viewing until August.* **BY KATIE O'CONNOR**


Deena Gorland, M.S.L.I.S.

The exhibit in the Melvin Sabshin, M.D. Library & Archives features prominent figures in APA's history, including (clockwise from top) Ezra Griffith, M.D., Donna Norris, M.D., Altha Stewart, M.D., and Jeanne Spurlock, M.D.

A new exhibit in the APA Foundation's (APAF) Melvin Sabshin, M.D. Library & Archives honors the contributions that Black psychiatrists have made to APA's history.

The exhibit, titled "Voices of Progress: A Historical Journey of Black Psychiatrists in the APA," highlights the Black psychiatrists who played a role in the Black Caucus Resolution presented to APA's Board of Trustees at the 1969 Annual Meeting in Miami Beach, Fla. (*Psychiatric News*, https://psychnews.psychiatryonline.org/doi/pdf/10.1176/pn.1969.4.issue-6.) It also features the history of the Black Psychiatrists of America (BPA), APA's Caucus of Black Psychiatrists, and previous recipients of the Solomon Carter Fuller Award.

"It's hugely important that we showcase this history because of the significant impact that Black psychiatrists have made to both APA and the field of psychiatry as a whole," said Jonathan Shepherd, M.D., president of APA's Caucus of Black Psychiatrists. "We need to make sure we are teaching history truthfully so that the workforce of the future know that they stand on the shoulders of people who worked and made sacrifices so they could be part of this organization."

"Part of the role of the Melvin Sabshin, M.D. Library & Archives is to preserve and examine psychiatry's history so we can reflect on and learn from our past," said APAF Executive Director Rawle Andrews Jr., Esq. "Thank you to these physician psychiatrists who continue to move us toward mental health equity."

The psychiatrists honored in the gallery were those who challenged APA to adopt progressive advocacy stances toward anti-discrimination policies, said Librarian and Archivist Deena Gorland, M.S.L.I.S.

At APA's 1969 Annual Meeting, the Ad Hoc Committee of the BPA presented APA trustees with a list of demands. One result was the creation of the Minority Group Program Development Project. In 1974, it was replaced by the Office of Minority and National Affairs, and Jeanne Spurlock, M.D., was appointed director and APA deputy medical director. Spurlock, who is featured in the exhibit, spent 17 years with APA and championed workforce diversity in the field of psychiatry; she was presented with APA's Solomon Carter Fuller Award in 1988. APAF established the Jeanne Spurlock Congressional Fellowship in honor of her work as a child and minority mental health advocate.

Other psychiatrists featured in the gallery include Solomon Carter Fuller, M.D., the first Black member of APA; Charles Prudhomme, M.D., APA's first Black vice president; Chester Pierce,

*see* **Exhibit** *on page 27*

## MH Assessments

*continued from page 4*

"This report moves us toward a national standard," said Michael Flaum, M.D., emeritus professor of psychiatry at the University of Iowa Carver College of Medicine and report co-author. "Payors, providers, patients, and the public should have a common language around which to understand how basic behavioral health services are funded."

"The standard won't call for specific services such as an SSRI or ECT, but would describe broad categories of service intensity need for a given patient at a given time," he told *Psychiatric News*.

California passed landmark legislation (SB 855) that took effect in 2021, requiring all insurers in the state to use clinical practice guidelines from nonprofit associations, namely LOCUS FT and ASAM Criteria, when making medical necessity determinations around behavioral health. Now, these guidelines must be used by payors when determining service intensity, level of care placement, continued stay, and transfer or discharge.

Oregon and Illinois have followed suit with similar legislation, and the New York State Office of Mental Health has approved similar regulations. "The goal, the North Star, is to get federal legislation passed that requires all payors to use these standards," Flaum said. "Using LOCUS FT and ASAM Criteria allows the level of services devoted to each patient to be determined by consistent and transparent set of criteria, rather than factors such as where they live, or which insurance they have."

A landmark class action ruling in *Wit v. United Behavioral Health (UBH)* in February 2019 paved the way for more widespread use of LOCUS FT and ASAM Criteria. That's when a U.S. district court found that UBH breached its fiduciary duty by refusing coverage for 50,000 people in need of behavioral health care by using its own standards focused on cost containment rather than on a set of "generally accepted standards" of care. The original *Wit* decision, which is still being litigated, set forth the following eight generally accepted standards of mental health and substance use care that are spelled out in National Council's report:

- Target the underlying condition, not just its symptoms.
- Treat comorbidities (medical, psychiatric, substance use, and developmental disabilities) in a coordinated way.
- Provide care in the least intensive and restrictive level that is safe and effective.
- Choose a higher level of care when there is ambiguity.
- Include services to maintain functioning as well as to prevent deterioration.
- Meet individual patient needs on duration of care without predetermined limits.
- Take into account the unique needs of children and adolescents.
- Base treatment on a multidimensional assessment that considers a wide variety of information.

Although the Ninth Circuit eventually reversed the original *Wit* decision, plaintiffs requested another rehearing, arguing that allowing insurers to use guidelines that deviate from the medical standards would have "an enormous and devastating impact." In 2022, a coalition of medical associations, health advocates, and attorneys general from 15 states filed amicus briefs in support of the plaintiffs' petition for a rehearing. In August 2023, the Ninth Circuit released a third ruling vacating its earlier findings, leaving the door open for some plaintiff claims to be reprocessed.

Using the principles of the *Wit* decision, a separate National Council report provides clinicians and patients with practical advice, strategies, and templates to overcome prior authorizations or appeal denials of behavioral health care, Parks said.

Gaining more widespread adoption of the LOCUS FT tools may be an uphill battle. Clinicians report being overburdened with EHR and other paperwork responsibilities, and additional training on the tools would be required. Parks sees these tools as taking the place of other, less value-added documentation.

"We're up against one of the most powerful industries in the world," Flaum said. "There's a lot of momentum against this. Right now, every payor and every system can have its own criteria for needs assessment, and who knows who wrote it, how to decipher it, and who's benefiting from it. ... The use of a common-sense standard approach that can be shared and understood by all stakeholders is long overdue." **PN**

**"Toward a National Standard for Service Intensity Assessment and Planning for Mental Health Care" is posted at https://www.thenationalcouncil.org/wp-content/uploads/2023/12/23.11.13_MDI_LOCUS-White-Paper.pdf. "A Compelling Argument for Facilitating the Equitable Use of Generally Accepted Standards of Care: Strategies for Mental Health and Substance Use Disorder Providers" is posted at https://www.thenationalcouncil.org/wp-content/uploads/2022/02/021020_NCBH_WitParityToolkit_v8.pdf. The original decision in the *Wit v. UBH* case is posted at https://cand.uscourts.gov/filelibrary/3631/C14-2346-JCS_Redacted-FF-and-CL.pdf. The third ruling in the case is posted at https://cdn.ca9.uscourts.gov/datastore/opinions/2023/08/22/20-17363.pdf.**

# Ensuring a Smooth Termination Process Reduces Risk of Abandonment Claims

*Terminating a treatment relationship with a patient can be difficult, but following the guidance in this article should mitigate liability risk.* **BY CARA STAUS, C.P.H.R.M., F.A.S.H.R.M.**

Throughout their careers of treating many patients, psychiatrists will encounter some patients who may need to be discharged from care. There may be hesitancy to terminate the patient care relationship for fear of being accused of abandonment.

Abandonment of duty is defined as the unilateral termination of a physician-patient relationship. It occurs when a physician terminates a patient's care without giving notice and without the patient's having the opportunity to seek alternative medical care. In such cases, the physician may be held liable for patient abandonment.

Ending treatment should be done carefully to avoid any risk to the patient's safety. This is especially important when treatment has reached a breaking point or the therapeutic relationship is strained. The physician must ensure the patient is stable and not experiencing a crisis prior to termination.

Some factors involved in the termination of the doctor-patient relationship are the following:

- The patient no longer requires treatment or treatment is no longer beneficial.
- The patient and/or family disagree with the treatment plan.
- Treatment falls outside the physician's scope or area of expertise.
- The patient does not adhere to the treatment plan.
- The patient frequently misses or cancels appointments.
- The patient does not pay for services.
- The patient relocates to a state where the physician is not licensed to practice.
- The physician closes his or her office, retires, or experiences another type of transition or departure.

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The situations below provide examples of when termination may happen immediately. In such cases, a traditional notification period is not required.

- Threats made by the patient, family, or decision-maker to the safety of the physician or staff.
- Inappropriate conduct by patient (behavior/sexual misconduct).
- Criminal conduct implicating the practice (drug diversion, destruction of property).
- Patient termination of care.

If you need to terminate a patient or a patient terminates treatment, here is some guidance on how to proceed. Document the key elements of the decision to discharge the patient and the next steps to be taken in the patient's medical record. Also document conversations about discharge with the patient and other providers involved in the patient's care. Capture the patient's understanding of the termination and other objective and relevant details.

Every attempt should be made to resolve issues prior to discharge. Be aware of statutory requirements for patient termination. Most states require that a written notification of at least 30 days be sent by both regular and certified mail with a return receipt or secure email portal with read receipt. If appropriate, include the reason why you are no longer able to continue to provide treatment, along with the effective date of termination, referrals, emergency resources, release of information request form, and prescription information. In addition to

*see* **Termination** *on page 25*

ETHICS CORNER

# As Another Election Looms, the Goldwater Rule Remains Relevant as Ever

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

The 2016 U.S. presidential election unleashed strongly felt sentiments in a way that was similar to the response to the 1964 election between then-President Lyndon Johnson and Arizona Sen. Barry Goldwater. Preceding that election, 1,189 psychiatrists responded to a survey published in *FACT* magazine (now defunct) saying that Sen. Goldwater was psychologically unfit to be president. Without having examined the senator, some of these psychiatrists also gave a narrative explanation justifying their opinion. This incident is what prompted the APA Ethics Committee to promulgate Annotation 7.3 of the "Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry," also known as the Goldwater Rule, in 1973. This rule prohibits APA members from offering a professional opinion on the mental health of individuals in the public light unless they have conducted a psychiatric examination and obtained authorization to disclose the information.

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.

In the lead-up to the 2016 election, the cautionary injunction embedded in the Goldwater Rule was not only discarded by some psychiatrists, but also vigorously and persistently attacked. Some psychiatrists, who received prominent attention in the media, asserted that ethics rules are not rules per se as they are not absolute and criticized APA because the rule curtails freedom of speech and scholarship (as in the case of scholarly psychobiography, political psychology, and psychohistory). They argued that the rule impairs a critical national security function by interfering with a psychiatrist's duty to warn the public about a dangerous politician running for president. Additionally, they argued that only APA has such a stifling injunction against free speech. In their expressed opinion, a psychiatrist describing public individuals in psychological terms is appropriate if a diagnosis is not presented.

As promulgated in 1973, the Goldwater Rule makes no mention of diagnosis, but rather urges psychiatrists to desist from publicly offering a "professional opinion" regarding an individual they have not examined and for which they have not been granted proper authorization. What constituted a professional opinion came into such heated debate that the APA Ethics Committee provided more detail in 2017 (see Ethics Opinion Q.3 in "Opinions of the Ethics Committee on the Principles of Medical Ethics").

As the arguments persisted, the AMA, in 2017, addressed the acceptable ethical conduct of physicians providing medical information in the media (see AMA Code of Medical Ethics, Opinion 8.12). Notably, the AMA enjoined physicians to ensure the medical information they provide is "accurate," "commensurate with their medical expertise," and "based on valid scientific evidence and insight gained from professional experience." Physicians should "[c]onfine their medical advice to their area(s) of expertise and should clearly distinguish the limits of their medical knowledge where appropriate."

The AMA opinion also enjoined physicians to refrain from making clinical diagnoses of individuals in the public eye whom they have not personally examined. In the case of individuals they have examined, a physician should not disclose identifiable information unless given specific permission by the patient to do so. Finally, physicians commenting in the media should always disclose conflicts of interest and avoid situations that may lead to potential conflicts.

The American Psychological Association also weighed in on the debate, with its president issuing a statement in support of the Goldwater Rule, noting "psychologists should not offer a

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# The Wired Couch: Untangling the Promise and Peril of Telepsychiatry And Mental Health Apps

***BY TAMARA MCCLAIN, M.D.***

The human mind faces an unprecedented revolution in the digital age, transforming how we connect and access mental health care. Commercial telepsychiatry and mental health apps offer virtual therapy, self-help tools, and AI companions on smartphones. Despite promises of accessibility and convenience, psychiatry is grappling with ethical concerns and potential pitfalls in this technological shift.

## Bridging the Chasms: Democratizing Access to Mental Health Care

Imagine a world in which geographical barriers, long wait times, and extreme costs no longer impede the path to achieving and maintaining mental well-being. This is the utopian vision painted by telepsychiatry platforms, which leverage videoconferencing technology to connect patients with therapists from the comfort of their own homes. For millions struggling with mental health concerns, this virtual bridge holds immense promise. Rural communities, individuals with mobility limitations, and those facing transportation challenges can now access the crucial support they deserve, potentially averting mental health crises and fostering early intervention.

Tamara McClain, M.D., is a third-year psychiatry resident at Authority Health GME Consortium in Michigan and a member of APA's joint committees on Telepsychiatry and Mental Health Information Technology. Jessica Thackaberry, M.D., was the article's advisor.

In the current landscape, health care professionals contend with the reality of balancing the promises of telepsychiatry with the constraints imposed by the availability and affordability of technology. The digital divide persists as a tangible hurdle, with individuals and communities lacking regular access to devices, high-speed internet, or the financial means to acquire them. As people seek mental health services, the unequal distribution of technological resources becomes a critical consideration. Telepsychiatry extends access while simultaneously reshaping the dynamics of care delivery. Virtual consultations replace in-person visits, potentially affecting the overall capacity to meet the mental health needs of these communities. To best navigate these challenges, it becomes imperative to consider sustainable approaches that best use available technological resources. This involves expanding infrastructure and ensuring that technology adoption aligns with equity, inclusivity, and affordability.

## Beyond the Session: The App-tastic Arsenal of Self-Help

Beyond therapy sessions, various mental health apps offer diverse tools for self-care. From mood trackers to mindfulness exercises, these apps empower individuals in their journey toward mental well-being. Journaling anxieties, practicing tailored relaxation techniques, or receiving bite-sized nuggets of cognitive-behavioral therapy can provide valuable coping mechanisms, democratizing self-help tools and fostering a sense of agency over mental health.

## Navigating the Murky Waters: Ethical Considerations Ahoy!

While the allure of technology is undeniable, psychiatrists must tread cautiously through the ethical minefield that comes with commercialization. The therapeutic relationship, built on trust, empathy, and unwavering confidentiality, remains the bedrock of traditional mental health care. Concerns loom around data privacy, with questions swirling about who owns mental health data and how the data are used. Potential conflicts of interest between tech companies and therapists raise eyebrows, and the quality of care delivered through asynchronous platforms like chatbots warrants scrutiny. Can a text-based exchange replicate a face-to-face session's nuanced and profoundly personal interaction?

Furthermore, the specter of overdiagnosis and inappropriate prescribing lurks in the shadows, particularly with apps offering mental health assessments without adequate clinical oversight. We must get involved in championing robust ethical guidelines and regulatory frameworks to ensure the quality and safety of these digital therapy tools. Practitioners must remember that technology cannot replace the human connection and clinical expertise that remain the cornerstones of effective mental health care.

## From Competition to Collaboration: Building a Holistic Future

The future of mental health care involves a harmonious alliance between technology and human-centered care facilitated by psychiatrists. We must seamlessly integrate digital tools into their practice by fostering dialogue. This collaboration envisions therapists using virtual reality and AI-powered chatbots to enhance accessibility and empower individuals in their mental well-being efforts. The digital wave presents opportunities and challenges that require psychiatrists to uphold ethical standards and prioritize the therapeutic relationship. Embracing technology as a tool, not a replacement, can build a future in which mental health care is accessible, personalized, and empowering for all. The goal is to ensure that technology becomes a springboard, not a hindrance, on the path to a healthier and happier mind for every individual. **PN**

*Editor's note: This article was written with the assistance of AI technology.*

*continued from facing page*

diagnosis in the media of a living public figure they have never examined."

Some psychiatrists seeking to comment on public officials they believe to be dangerous opine that they have an ethical obligation to warn the public. Unfortunately, in taking such a position they have incorrectly applied an ethical duty—one that may exist in the context of a particular psychiatrist-patient relationship—to a nonpatient with whom there is no treatment or evaluative relationship. Even if such an obligation existed, it is somewhat misguided to believe that psychiatrists' opinions regarding a political candidate would hold much sway in the current polarized U.S. political climate.

Some have also argued that commenting about public individuals deemed "dangerous" is comparable to court testimony in which an individual being evaluated by a forensic psychiatrist has not been examined. As noted in APA's Ethics Opinion Q.3, this comparison is grossly misleading. Forensic ethics require psychiatrists retained in authorized legal proceedings to make appropriate efforts to examine the evaluee, and psychiatrists are ethically obligated to state that their professional opinion is limited if they are unable to examine the evaluee. In the latter case, psychiatrists are still required to review all relevant documents and obtain corroborative information by interviewing relevant parties. Without these activities, the objectivity of a psychiatrist's opinion would appropriately be called into question.

Although psychiatrists may hold contrary views regarding the Goldwater Rule, its violation has potentially serious consequences for both individuals and the profession. Public debates and assertions by psychiatrists regarding an individual's mental health without examination and authority to disclose the information could result in a degradation of trust in psychiatrists and in the expectation on the part of the public that patient confidentiality will always be protected. Additionally, psychiatrists should always be acutely aware that their public pronouncements have the potential to strip individuals of their humanity, dignity, and respect. Such power demands the highest degree of responsibility, accountability, and restraint.

Challenges to the Goldwater Rule are likely as the U.S. enters the throes of another contentious presidential campaign. Debates about the mental health of the presumed candidates of both parties have surged in the media with some commentators calling on mental health professionals to weigh in. Without the restrictions of the Goldwater Rule, the risk of psychiatrists arguing on opposite sides is high, thereby debasing our profession. The need for holding tight to its injunctions has never been greater. **PN**

**"Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry" is posted at http://apapsy.ch/Principles_of_Medical_Ethics. "Opinions of the Ethics Committee on the Principles of Medical Ethics" is posted at http://apapsy.ch/Ethics-Opinions. The 2017 Ethics Committee commentary on the Goldwater Rule is posted at http://apapsy.ch/physician-conduct. The AMA's "Ethical Physician Conduct in the Media" is posted at http://apapsy.ch/AMA-physician-conduct. The American Academy of Psychiatry and the Law's "Ethics Guidelines for the Practice of Forensic Psychiatry" is posted at https://www.aapl.org/ethics-guidelines.**

# How Psychotherapeutic Techniques Can Be Integrated Into Routine Pharmacotherapy

***BY DAVID MINTZ, M.D.***

In his studies of treatment-refractory and high-utilizing medical patients, Michael Balint (who gave us the concept of patient centeredness) advocated for primary care providers to develop skills for "six-minute psychotherapy" to address psychological factors undermining good outcomes. At the time, he could not have imagined that psychiatrists would need encouragement to use psychotherapy skills or to feel authorized to use those skills with complex and treatment-refractory patients in pharmacotherapy.

To effectively treat many treatment-resistant patients, the psychiatrist often has to understand psychological factors undermining treatment. This requires an "overall diagnosis" that includes inquiry into the patient's unconscious, relational patterns, and wishes for treatment, according to a 1967 paper by Enid Balint in *The Journal of the College of General Practitioners.* Once understood, skills for a kind of "ordinary medical psychotherapy" may address factors undermining the healthy use of medications.

Which psychotherapeutic skills are relevant in this context? In a 2000 paper in *Clinical Psychology,* Matthew D. Blagys and Mark J. Hilsenroth identified seven practices that were distinct to and characteristic of psychodynamic psychotherapy, all of which have potential applications in routine pharmacotherapy with complex patients.

- Focus on affect
- Exploration of avoidance
- Emphasis on past experiences
- Identification of patterns
- Focus on interpersonal experiences
- Emphasis on the therapeutic relationship
- Exploration of patients' wishes and/or fantasies

Such practices can help reorient patients to a healthier use of treatment. The main difference between such "ordinary medical psychotherapy" and psychotherapy proper is that our psychotherapeutic skills, in this case, are not intended to help patients develop insight in a general sense, but rather to support optimal pharmacotherapy.

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.

**Focus on affect:** In pharmacotherapy, attending to subtle affective shifts, using skills honed in psychotherapy, may illuminate unspoken ambivalence about treatment, as when patients agree to a medication, but then their foot starts anxiously tapping. Such attunement to affect helps to bring sources of resistance to treatment into awareness where they can be addressed rather than be left to be acted out.

Further, many patients may conflate "problems of living" with "problems of illness" (and perhaps not just our patients, but ourselves, too). Patients who have a medicalized understanding of their emotions may need help to understand that bad feelings are not always signs of pathology, but rather signals that there are problems that need to be addressed. By helping patients to recognize the signal function of affects, doctor and patient together can grapple to understand which types of suffering require medication and which are better addressed at a psychosocial level.

**Exploration of patients' avoidance:** One common form that avoidance may take in pharmacotherapy is the avoidance of meaning. Given a complex interplay between meaning and medication, an insistence on the part of patients that their problems are simply biological may raise suspicions that there are aspects of meaning (for example, feelings of guilt, responsibility, or blame) that are being avoided. Paradoxically, patients who are most attached to a biomedically reductionist understanding of their troubles may be those who are most in need of psychotherapy.

**Emphasis on past experiences:** To better understand factors undermining the healthy use of medications, the psychodynamically informed psychopharmacologist may explore patients' early developmental experiences with caregiving, as transference-based expectations may interfere with a good working alliance. Complicated reactions to medications may be transmitted transgenerationally, so an emphasis on past experiences with medications might also include an exploration of family or cultural experiences with treatment as well as more recent experiences with treatment and medications.

**Identification of patterns:** Practicing integratively, a pharmacotherapist may explore a patient's life patterns to identify potential sources of resistance to medications or psychiatric caregivers. For example, a patient who struggles to form stable relationships because of a need for control may experience problems with medicine adherence, as the patient may refuse to be controlled by the doctor's prescription. Emphasizing the psychiatrist's authority or expertise will backfire in promoting adherence. To help identify treatment-interfering patterns, it is useful to inquire about the patient's historical patterns of medication use. A history of stopping medications prematurely, at the moment of recovery, may mirror other patterns expressing the patient's fears of dependency. By naming these patterns, the psychiatrist and patient are better positioned to work collaboratively to optimize health outcomes.

**Focus on interpersonal experiences:** One relationship that may be particularly important in pharmacotherapy is patients' relationship with medications, especially since our patients have lively, and sometimes personified, relationships with medications (for example, can have functions like being soothing, or comforting, or containing, or oppressive, or punishing). Research suggests that patients tend to prioritize quality of life over symptomatic improvement. In a patient-centered approach that joins the patient's goals, we may measure treatment success through improvements in interpersonal functioning, rather than simply focusing on symptom reduction.

**Emphasis on the therapeutic relationship:** In biomedically oriented psychopharmacology, medications are seen as the key mutative factor. However, from an integrative perspective, it is often not clear how much the medication is the reason the patient gets better and how much is due to the psychiatrist. What is clear is that the quality of the pharmacotherapeutic relationship has a significant impact on treatment outcomes that is, in many cases, more potent than the active drug. Psychotherapeutic skills may help assess the psychiatrist-patient relationship and encourage the patient to feel safe expressing concerns, misgivings, and upsets with the psychiatrist, in the service of strengthening the alliance.

**Exploration of patients' wishes or fantasies:** Understanding patients' fantasies and feelings about medication can avoid later problems. A patient's wishes for treatment are often complex, multilayered, and conflicted (for example, wishing to feel better but not lose the secondary benefits of illness), so simply understanding goals for symptom reduction may miss conflicting goals or concerns that affect outcome. With insight into what a patient believes medication does, how it works, and what the psychiatrist's intentions are, the psychiatrist may tailor treatment to align with the patient's wishes and address fears or irrational expectations.

Obviously, ordinary medical psychotherapy does not have to be conceptualized through a psychodynamic lens. In another paper, Blagys and Hilsenroth (*Clinical Psychology Review,* 2002) also identified eight psychotherapeutic practices particular to cognitive-behavioral therapy, which are similarly relevant to pharmacotherapy. Regardless of one's preferred psychotherapeutic approach, it is important to recognize that too many of our patients fail to get better with solid, evidence-based pharmacotherapy. For many of these patients, a patient-centered, psychotherapeutically informed exploration reveals complex interactions between meaning and medication that influence pharmacotherapy outcome. It is not only our extensive education in psychopharmacology that gives us the skills needed to address complex and treatment-refractory patients, but also our psychotherapeutic skills as well. **PN**

**"The Overall Diagnosis: Psychodynamic Psychiatry, 6-Minute Psychotherapy, and Patient-Centered Care" is posted at http://apapsy.ch/6-minute. "The Possibilities of Patient-Centered Medicine" can be accessed at https://pubmed.ncbi.nlm.nih.gov/5770926/. "A Study of the Doctor-Patient Relationship Using Randomly Selected Cases" can be accessed at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2237644/. "Distinctive Features of Short-Term Psychodynamic-Interpersonal Psychotherapy: A Review of the Comparative Psychotherapy Process Literature" is posted at https://onlinelibrary.wiley.com/doi/abs/10.1093/clipsy.7.2.167. "Distinctive Activities of Cognitive-Behavioral Therapy. A Review of the Comparative Psychotherapy Process Literature" is posted at https://www.sciencedirect.com/science/article/abs/pii/S0272735801001179?via%3Dihub.**

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

PSYCHIATRIC NEWS
*Special Report*

# Special Report: Is Social Media Misuse A Bad Habit or Harmful Addiction?

*Many youth are spending hours each day on social media platforms, but it's how and why they are using social media that determine whether their use is problematic.*

***BY JAMES SHERER, M.D., AND PETROS LEVOUNIS, M.D., M.A.***

Last year, U.S. Surgeon General Vivek Murthy released an advisory report to call attention to a major public health problem apparent to many of us in the psychiatric community for years: the negative impact of social media on youth mental health.

While acknowledging that social media offers positive benefits to youth, the advisory warned that these platforms expose children to inappropriate or harmful content and can exacerbate negative feelings related to self-esteem, body image, and social standing.

Further, social media itself can be detrimental, as emerging evidence is showing that excess or unhealthy use of the platforms can alter brain physiology in a manner that bears some resemblance to the changes observed with substance use disorders. The dopamine rush that occurs as someone racks up likes on a tweet can potentially be addictive.

Two decades ago, the fascination with Blackberry mobile devices among many business professionals led to the rise of the "Crackberry" meme. As digital communication continues to become even more embedded in everyday life, the language of addiction is no longer employed lightheartedly; social media addiction—or more broadly pathological social media use—is a serious and pressing problem, especially among our youth.

## When Is the Line Crossed?

Social media addiction is a concept that seems intuitive but can be difficult to define. Most people can probably name the big social media platforms like X (formerly Twitter) and TikTok, but may be less clear on what criteria define these programs as a collective.

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One common definition is that social media are websites and/or apps that promote networking with others via the sharing of content; that content can encompass almost anything that can be shared digitally such as photos, videos, songs, recipes, opinions, comments, personal messages, and so on. What determines whether usage is pathological is how that content is consumed. When does the consumption of social media cross a line to be considered addictive? This too can be difficult to define as there is no recognized set of diagnostic criteria. As of *DSM-5-TR* (2022), gambling disorder is the only behavioral addiction diagnosis included in the manual. (Internet gaming disorder is listed in "Conditions for Further Study," and some provisional criteria are noted.)

By itself, time spent on social media does not tightly correlate with the risk of addiction. Someone can spend eight hours on social media on a slow weekend day without much issue. Excess social media use during school hours isn't ideal, but it may not be a problem if academics or socializing don't suffer. Rather, the engagement level of the user is more relevant; mindless link jumping or passive scrolling are riskier behaviors than actively posting or sharing photos.

Many individuals may have a serious social media habit, but only a small subset reach the threshold of having a clinically debilitating disorder. True pathological use requires that the desire to be on social media impairs functioning to the point that multiple aspects of daily life—school, friends, diet, sleep—are affected. Our goal as mental health professionals is to identify and manage social media addiction before the consequences become too severe.

**Bergen Social Media Addiction Scale**

| | Very Rarely | Rarely | At Times | Often | Very Often |
|---|---|---|---|---|---|
| You spend a lot of time thinking about social media or planning how to use it. | ☐ | ☐ | ☐ | ☐ | ☐ |
| You feel an urge to use social media more and more. | ☐ | ☐ | ☐ | ☐ | ☐ |
| You use social media in order to forget about personal problems. | ☐ | ☐ | ☐ | ☐ | ☐ |
| You have tried to cut down on the use of social media without success. | ☐ | ☐ | ☐ | ☐ | ☐ |
| You become restless or troubled if you are prohibited from using social media. | ☐ | ☐ | ☐ | ☐ | ☐ |
| You use social media so much that it has had a negative impact on your job/studies. | ☐ | ☐ | ☐ | ☐ | ☐ |

Source: Cecilie Schou Andreassen, Ph.D., et al., *Psychology of Addictive Behaviors,* March 2016.

**"By itself, time spent on social media does not tightly correlate with the risk of addiction. ... Rather, the engagement level of the user is more relevant; mindless link jumping or passive scrolling are riskier behaviors than actively posting or sharing photos."**

## Suggested Screening Tools

Though there are no official diagnostic criteria to guide us, researchers have developed and validated several tools that can screen young people for problematic social media use. Some popular ones include the following:

- **Bergen Social Media Addiction Scale:** This tool, originally developed as the Bergen Facebook Addiction Scale, consists of six statements, each related to a core domain of addiction: preoccupation, mood modification, conflict, tolerance, withdrawal, and relapse. Patients respond to each statement on a Likert scale of 1 to 5, with a score of 24 or above generally considered a warning of potential addiction. Straightforward and quick to administer, this is an ideal tool for children and adolescents.

- **Social Media Disorder Scale:** This measure includes nine yes/no questions, each based on one of *DSM-5's* proposed criteria for internet gaming disorder. These include symptoms related to the six addiction domains as well as consequences like family problems or job loss. A positive answer to five of the nine questions signals a potential disorder.

- **Social Media Addiction Scale:** This scale is a more comprehensive 41-item Likert-based assessment that focuses on four of the six addiction domains (it has no tolerance or withdrawal queries). Though time consuming, this test can provide greater insight into severity as there are score cutoffs for mild, moderate, and severe social media addiction.

The rapid evolution of social media apps will likely necessitate that these screening tools are updated and revised regularly. Whatever the method of assessment, any potential signs of social media addiction should be followed with a structured interview to confirm the problem and understand what is driving the behavior.

As with other behavioral use disorders, there are multiple routes by which social media use can convert from habit to addiction, and these can inform treatment.

- **The cognitive-behavioral route:** Here, excessive social networking is the consequence of users with maladaptive thinking (perhaps due to other conditions like major depression) who see social media as a means of relief or gratification.

- **The social skill route:** This is commonly initiated by people who gravitate to social media due to problems with self-esteem or self-presentation that impacts their real-world interactions. These same problems with the "self" make such users more vulnerable to social media overuse.

- **The socio-cognitive route:** Addiction is initiated by the continued social media use of someone with inflated self-efficacy toward social media (he/she believes it can help with any problem) coupled with reduced self-regulation to use social media in moderation.

Clinicians should also be on the lookout for pathological, nonaddictive social media use. This occurs when social media behavior may not meet a screening cutoff, but online behavior is clearly driving the development of internal (for example, loneliness) or external (for example, cyberbullying) problems.

A good starting point for an interview is to ask patients which sites they use and the time allocated during the day, night, and weekends. One might then follow up by asking patients how they use their social media time:

- Are they actively posting content or are they passively scrolling?

- Are their accounts named or anonymous?

- Does their online persona reflect their offline selves or is there a mismatch?

It is also useful to ask about patients' specific goals with their usage. For example, if an individual is continually scrolling through exercise or fad diet videos, it's possible the problematic social media use is an attempt to cope with body dysmorphia. If a patient is always browsing due to FOMO (Fear Of Missing Out), then the problem may reside in anxiety or self-esteem issues.

While a clinical interview is designed to understand the causes and harms of social media addiction, psychiatrists should also ask patients about any positive aspects of their social media use to get the full picture. As clinicians, we tend to focus

on the negative side of behavior, but social media can be a positive force. Many LGBTQ youth across the globe are growing up in homophobic environments and use social media to find friendship, solace, validation, and more. Given their adverse life experience, they are vulnerable to developing a social media addiction, but this creates a scenario where their interactions are both causing some problems and solving others.

Since treatment for social media addiction typically involves regulation of social media access, appreciating the full risk-benefit profile of each patient can optimize this regulation.

## Setting Treatment Goals

As commonly understood, social media has been around for only two and a half decades, and our clinical management of social media addiction is very much a work in progress. While best practices for more established addictions including gambling disorder may offer some guidance, some tenets of substance use disorder care, such as encouraging abstinence, are not feasible with social media use. Rather, we seek to promote healthy social media use while managing potential underlying causes of misuse.

What is healthy use? There is no magic standard of having someone limit their use to X hours a day on no more than Y number of platforms. Rather, the goal is to have patients be able to use social media in a way they can self-regulate. Child and adolescent patients will inherently struggle more with self-regulation, given that a certain amount of executive function is age dependent.

Self-regulation by youth who are misusing social media will take time, as children and adolescents are still developing their impulse control mechanisms. A practical approach is to start with external regulation enforced by parents and/or others in guiding roles such as coaches or counselors. The regulation typically involves some form of contingency management, such as a social media contract. Set amounts of social media time are granted when conditions are met; for example, after all homework is completed. All use should also be stated with a purpose—"I want to connect with some friends"—to minimize passive browsing.

While empowering patients to regain control of their social media habit, clinicians should aim to address underlying and/or comorbid problems that contribute to the addictive behavior. Though there is no "gold standard" approach, cognitive-behavioral therapy can be appropriate for many patients, particularly when a cognitive dysfunction like maladaptive thinking may be a root cause. Psychodynamic psychotherapy—in which therapists help patients communicate their inner feelings—can also be useful as many people who misuse social media struggle with different personas.

Adjunct medications may be useful, but the evidence is thin. Emerging data suggest that bupropion might be effective for internet gaming disorder, which many professionals see as a close cousin to social media disorder, given the social aspects of today's online games. Pharmacology for addictive behavior should be considered a short-term option, although maintenance medications can be useful in managing co-occurring psychiatric disorders like depression.

Finally, we should not forget the value of lifestyle interventions. Encouraging youth with social media problems to take up hobbies such as sports, hiking, reading books, or journaling can help keep idle hands busy and readjust brains to appreciate non-instant gratification. Let's turn that FOMO into JOMO (the joy of missing out).

## What Can Parents Do?

Unfortunately, our clinical time with patients is limited; parents are on the frontlines of keeping their children with a social media problem on the right path. While we can help develop a contingency management plan, parents need to monitor their child's social media use and other areas of concern (for example, schoolwork) to make sure the plan is followed.

There are steps parents can take to keep the home environment a healthy space. As part of a social media hygiene plan, they should designate certain activities or zones as tech-free; for example, no social media at dinner, when driving, and before bed. These should be shared ideas that parents commit to as well as good role models.

While keeping youth busy with nondigital activities is encouraged, parents can also guide their kids toward more productive digital hobbies; perhaps someone who posts incessant TikTok videos can be tasked with making a longer-form video project. This way the child can develop valuable audio and visual skills while remaining close to a technology that is found enjoyable.

All this effort may seem daunting, but if available, family-based therapies are an option. These psychoeducational sessions can help parents set and enforce limits while fostering the child's autonomy.

## Appreciating the Scope of the Problem

Beyond helping our patients control problematic social media use, psychiatrists need to be part of the discussion about addressing this problem on a broader scale, for the scale seems to be tilting in the wrong direction.

One recent analysis that used the Bergen Social Media Addiction Scale as a guide suggested a global social media addiction prevalence of 5% using a strict cutoff (total score of at least 24 and a score of at least 4 on each of the six questions). Using just a total score of 24+ raised the prevalence to 8%, while using a score of 18+ raised the prevalence up to 25%. The pool of people who may be on the cusp of an illness could be tremendous.

Based on what we have seen in my clinical practice, these prevalence numbers are not surprising, and they also mirror the realities that parents and teachers are reporting to me.

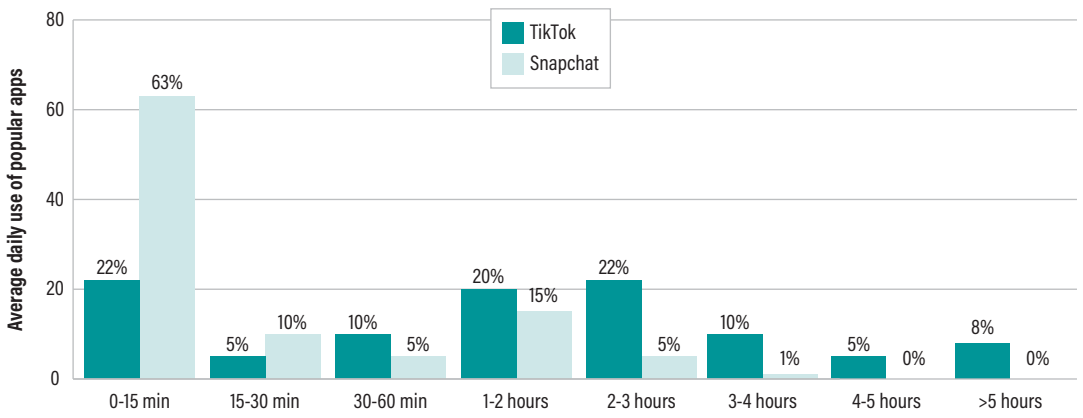
Some other data specific to today's youth are also striking if, again, not surprising:

*continued on next page*

**"While empowering patients to regain control of their social media habit, clinicians should aim to address underlying and/or comorbid problems that contribute to the addictive behavior."**

### Passive Social Media Apps More Risky Than Apps Encouraging Connection

Nearly half of youth aged 11 to 17 use TikTok for two hours a day or more, whereas most youth use Snapchat far less. Though time spent on social media is not a strong indicator of social media addiction, platforms like TikTok that facilitate passive content watching are more problematic than Snapchat, which promotes active communication among friends.




Source: Constant Companion: A Week in the Life of a Young Person's Smartphone Use. Common Sense Media, September 26, 2023.

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- The average teen is on social media over three hours a day, and over one-third of teenage girls reported "feeling addicted" to their social media accounts, according to the surgeon general's advisory.

- 51% of teens admit they are on social media too much, and more than three-quarters of these teens say it would be hard to give up social media, according to a 2022 survey from Pew Research.

- In 2021, nearly 40% of tweens (ages 8 to 12) reported using social media at least once, and 18% said they used it every day. Many of these tweens were logging on to social media apps that are rated for teens or older, according to Common Sense media.

As noted, just spending "too much time" on social media may not be a danger. Still, the prolonged and largely unfettered use of social media among tweens and teens is concerning from a health standpoint. The adolescent years are a critical period of brain and body development. Adolescence is also a period of high susceptibility to external pressures, such as those that can be found in social media feeds. Unhealthy social media use can adversely impact brain development and has been associated with risks of depression, sleep problems, disordered eating, and even attention-deficit/hyperactivity disorder.

Our clinical experience has also shown that the younger someone develops a problem, the more likely it becomes a persistent and severe problem. Identifying and managing problematic social media use in youth is thus an important component of pediatric mental health care.

## Need for Policy Setting

One clear goal in our field is to ensure continued, high-quality research on the etiology, presentation, and treatment of social media addiction and related technological use disorders; we need to continue to build the evidence base that will support the inclusion of these disorders in *DSM* and *ICD*.

Those of us who work in addiction psychiatry should also educate our colleagues in other areas of medicine, especially those who regularly see pediatric patients, about the nuances that distinguish general social media excess with social media addiction. Potential problems need to be identified early, but with psychiatrists and psychotherapists already in short supply, we need to save our resources for those who really need them. We should also strive to educate the public when opportunities arise; it's actually a golden opportunity in that we can easily reach people affected by pathological social media use where they are—on these platforms. Many younger psychiatrists are becoming savvy social media influencers and could be a key asset.

In the long run, though, it is vital that we develop measures that can limit the potential harm that social media can bring to youth. In recent years, we've heard several tech CEOs state that they don't let their children use social media—that should say something about the risks these sites pose.

On the plus side, the people with policy power have started to take notice. In 2023, 35 states and Puerto Rico introduced legislation related to social media use by children; 12 states successfully adopted measures, which ranged from establishing task forces to incorporating more digital literacy in school curricula to requiring companies to verify the age of all state residents. There are significant logistical challenges in enforcing a social media ban, and it's possible banning these sites will add to their allure and encourage youth to use them more. We believe social media should be available but regulated.

There are steps that parents can take now to protect their children, but time limits and other parental controls set on devices can do only so much. We need these platforms to put more safety and privacy measures in place, either via encouragement or enforcement. In this country, TikTok has an "under 13" mode that limits certain features and advertising, which is a good first step. However, this feature doesn't address that adolescents are also at risk for social media harms.

## Logging Off

It's amazing to think that social media is still in its infancy, given that it has become engrained in our social fabric, especially among today's youth, who were born in an online world. As these tools are increasingly becoming mainstays in how we live, work, and play, the potential for abuse will only grow. However, our society has made significant progress in addressing other addictions that were accepted norms, as evidenced by dramatic declines in smoking over the past few decades. If psychiatrists and other mental health professionals get motivated, we can prevent social media addiction from getting out of hand. **PN**

**"Unhealthy social media use can adversely impact brain development and has been associated with risks of depression, sleep problems, disordered eating, and even attention-deficit/hyperactivity disorder."**

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ON MENTAL HEALTH, PEOPLE, AND PLACES

# Reflecting on Forgiveness

***BY EZRA E.H. GRIFFITH, M.D.***

Ezra E.H. Griffith, M.D., is professor emeritus of psychiatry and African American Studies at Yale University.

I have been participating recently in a weekly group discussion with psychoanalysts. The talk generally focuses on scholarly writings of analysts, and sometimes others, who have been reflecting on race and its place in analytic discourse. I am indebted to this group's interest in and disciplined exploration of this intriguing arena of scholarship and clinical practice. In my case, it has meant expanding my intellectual horizons and engaging with a literature that, without explicit encouragement, I would probably have left untouched.

Not long ago, the assigned reading was Chapter 12 ("After the Offense: Thoughts on Forgiveness") from Donald Moss's 2017 text *At War With the Obvious: Disruptive Thinking in Psychoanalysis* (Routledge). Moss is a well-known public intellectual who enjoys linking psychoanalysis to contemporary social and political problems. Our group selected this chapter for exploration because it focused on forgiveness, a theme we have encountered repeatedly in texts framing discrimination, caste, and privilege.

In the chapter's introduction, Moss asserts that in the relation between any two people, "along with questions of retaliation, revenge, and punishment, the question of forgiveness emerges." He suggests that our ignorance of the term "forgiveness" stems from its lack of structured meaning, as well as from a plethora of interpretations that we attribute to it. Moss uses the film "Facing Fear" to help explain his frustration with our tendency to use terms, inexact as they are, to communicate the fundamental principles by which many of us live. The film's narrative portrays a young gay man's urban encounter with a group of skinheads. They get into a fight with the youth and mercilessly beat him almost to death while taunting him.

Twenty years later, one of the skinheads and the victim of the attack realize that they are both working in the same museum. They eventually get past the chasm that separates them and start "working together, giving presentations on forgiveness." Moss comments that the short film "celebrates forgiveness without going into its workings … ." The film leans on and confirms the idea that this sort of forgiveness is "best treated at its face value of self-evident good." Our psychoanalyst-author is not pleased with this reflexive conventional outcome. He wants contemplation of a more balanced story that includes consideration of the gay man eschewing forgiveness and even planning some form of revenge. Moss proposes that the victim should be no more "obligated to forgive than he is to seek vengeance." He dismisses, somewhat casually, the notion that forgiveness should be seen as the film's hero, while revenge is sort of banished offscreen. He is similarly not pleased with the easy slide from forgiveness into strategic reconciliation, while vengeance is relegated ignominiously. Moss states that impulsive forgiveness or vengeance, while promising relief, is not the way of psychoanalysis. After the offense, there must be a pause that heralds the transformation of impulsive thinking, which is, I believe, his gift to us.

Not surprisingly at all, Donald Moss employs case vignettes to be more persuasive. In doing so, he lapses into a specialized style of narrative that requires of us a disciplined familiarity with clinical praxis. However, at the end of his reflections, he concludes that the important goal for clinician and patient is "construction of a zone safe enough to promote separateness and thought." He underlines it. The essential task is for the patient "to find an exit from the … zone of pure reflex." Then will come nonreflexive possibilities for forgiveness and revenge.

It seems to me an overly intellectualized demand. I thought psychoanalysis, with its renewed emphasis on the needs of the community, would engage a broader swath of citizenry with simpler tools. We want a reduction in vengeance, not a therapeutic interlude that exalts the analyst.

Moss is persistent. He establishes a link to Fyodor Dostoevsky's famous *The Brothers Karamazov* and its account of Christ's encounter with the Grand Inquisitor. That interaction partially mimics the biblical description of the temptations of Jesus Christ found in the Gospels of Matthew, Mark, and Luke. Moss conjures up the turning of stone into bread, the question of Christ's protection by angels as he hurls himself from a height, and the offer of wealth in exchange for devil worship. After a long night of unsuccessful importuning by the Inquisitor, Jesus simply stands up, kisses the Inquisitor, and walks off. Moss asks us: "What do we do about this kiss?" He agrees we could interpret it as a kind of forgiveness, a convenient package all neatly tied up by Christianity. If we know that the "kiss means forgiveness, we will also know what forgiveness means."

Moss is toying with us. He points out that there is nothing certain about the kiss. After all, there is no commentary and no hints about its qualities or the intentions of the kisser. Nevertheless, in a strange twist, he notes that Christ strikes a posture of love and offers the possibility of a new beginning, one that sets us on the task of forgiving. Yes, Jesus appears to take a long time to reflect before walking away. However, I think the more important point is that the posture of love precedes everything. It vitiates the theatricality of the pause and asks us to think more about the possibility of reflexive and impulsive charity, which mobilizes forgiveness. **PN**

# APA Election

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to many others. She is a past secretary general of the American Society of Hispanic Psychiatry and was an advisor and presenter to the internationally recognized "Changing Minds, Advancing Mental Health for Hispanics" project.

"Our profession faces multiple challenges," Miskimen said. "We need a cohesive, actionable, multi-year strategy to enact effective and permanent change. As president, I will focus on the workforce challenges facing psychiatry, with the ultimate goal being to reverse these challenges, enabling greater fulfillment in our practices and achieving better patient outcomes."

Among Miskimen's priorities when she assumes the presidency in May 2025 are the following:

- Champion psychiatrist-led multidisciplinary team-based care.

- Leverage academic centers to explore and improve innovative ways to expand access, including integrated health care models.

- Advocate to retain telepsychiatry services.

- Promote diversity-enhancing interdisciplinary programs such as the American Academy of Pediatrics' Women's Wellness Through Equity and Leadership program.

### Other Election Results

The race for treasurer, which has a two-year term, was up for election this cycle. Steve Koh, M.D. M.P.H., M.B.A., of San Diego outpolled Cheryl D. Wills, M.D., of Cleveland. Wills is the current Area 4 trustee.

In the race for trustee-at-large, Patricia Westmoreland, M.D., of Denver emerged the winner. Her opponent was Farha Abbasi, M.D., of Lansing, Mich. The term of office is two years.

Sudhakar K. Shenoy, M.D., of Chicago won the race for early career psychiatrist trustee. He defeated Muhammad Zeshan, M.D., of Princeton, N.J. The term of office is three years.

Three of APA's seven geographic Areas voted for their trustee in this cycle. Area trustees hold three-year terms.

In the race for Area 1 trustee, John C. Bradley, M.D., of Hingham, Mass., defeated Manuel (Manny) Pacheco, M.D., of West Somerville, Mass. In Area 4 Dionne Hart, M.D., of Rochester, Minn., outpolled Suzanne J. Sampang, M.D., of Cincinnati. In Area 7, Mary Hasbah Roessel, M.D., of Santa Fe, N.M., ran unopposed for a second term.

The winner of the race for resident-fellow member trustee-elect was Nicolas K. Fletcher, M.D., M.H.S.A. of Grand Rapids, Mich. His opponent was Alexander W. Luo, M.D., M.B.S., of West Hartford, Conn.

"Congratulations to everyone who has been elected to APA's Board of Trustees," said APA President Petros Levounis, M.D., M.A. "I look forward to working with all of you to lead APA's critical efforts as we continue to innovate, advocate, and research on behalf of the doctors who serve millions of patients and families with substance use and other psychiatric disorders."

"I'm so pleased for Dr. Miskimen, a longtime colleague and friend of the APA, to become our president," said APA CEO and Medical Director Saul Levin, M.D., M.P.A. "With her long track record of leadership throughout the organization and in her home state, she is a proven leader and will bring much experience to her year as president."

The winning candidates will assume their positions on the Board at the close of APA's 2024 Annual Meeting in May. **PN**

# Brain's 'Background Noise' Changes With ECT, MST

Getty Images/iStock/ArtemisDiana

*The increase in aperiodic activity following electroconvulsive therapy or magnetic seizure therapy may reflect a restoring of the brain's inhibitory network.* **BY NICK ZAGORSKI**

Electroconvulsive therapy (ECT) has been a staple of depression care for more than 85 years, yet much remains unknown of how ECT produces its antidepressant effects. New research appearing in *Translational Psychiatry* suggests that a set of brainwave signals known as aperiodic activity may be important for both ECT and a related technology called magnetic seizure therapy (MST).

ECT and MST are tools that use electrical or magnetic energy, respectively, to deliver controlled, therapeutic seizures to the brain to jump start dysfunctional neurons.

As senior study investigator Bradley Voytek, Ph.D., explained, most research examining the brain's electrical activity focuses on rhythmic brainwaves that can be easily recorded by electroencephalography (EEG) machines. These brainwaves are divided into several groups based on their frequency (with names like alpha, beta, and theta waves). Underlying these rhythmic, or periodic, waves is a sea of seemingly random patterns known as aperiodic activity.

"It looks like background noise, but there are signals in that randomness," said Voytek, who is a professor of cognitive science at the University of California, San Diego, and on the faculty at UC San Diego's Halıcıoğlu Data Science Institute.

Patients with depression tend to display larger low-frequency brainwaves following ECT therapy—a phenomenon known as clinical slowing. Voytek wondered whether this rise in "slow" brainwave activity might be due to increased aperiodic activity making the rhythmic waves appear larger.

A few years back, Voytek and his lab developed a software program capable of distinguishing periodic and aperiodic signals from an EEG reading. With graduate student Sydney Smith leading the way, Voytek and colleagues at UC San Diego and elsewhere examined EEG data from nine adults with major depression who were receiving ECT at the VA San Diego Health System. Using Voytek's software algorithm, the team found that the post-ECT increases in low-frequency waves were due to increased aperiodic activity.

Sydney Smith wears one of the EEG headsets that the researchers used to measure aperiodic activity in patients with depression.

The researchers next analyzed EEG data from a sample of 22 patients with depression who had received ECT and 23 patients with depression who had

*see* **ECT/MST** *on page 32*

# TMS Found to Make People More Hypnotizable

Getty Images/iStock/LightFieldStudios

*Boosting someone's receptiveness to hypnosis, even transiently, may make more people candidates for hypnosis-based therapy, which is utilized for several psychiatric conditions.* **BY NICK ZAGORSKI**

Hypnosis-based therapy is employed in the management of several psychiatric conditions such as phobias and other anxieties, somatic disorders like fibromyalgia, and smoking cessation. While hypnotherapy can be very effective for some patients, its reach is limited as people inherently have differing levels of suggestibility; while about 20% of people can be hypnotized readily, 20% are basically not hypnotizable.

A clinical study in *Nature Mental Health* reported that transcranial magnetic stimulation (TMS) can temporarily increase how easily individuals can be hypnotized. Though this proof-of-concept study needs follow-up investigations, the findings are exciting in demonstrating that a trait believed to be stable across the lifespan can be modified.

Though people may be familiar with hypnosis as a stage act, its role in therapy does not involve placing someone in a trance, explained senior study author David Spiegel, M.D., who is the Willson Professor and associate chair of psychiatry at Stanford University School of Medicine. Rather, hypnotherapy mobilizes an individual toward a state of focused attention and heightened cognitive flexibility; together, these states of being can facilitate the goal of behavioral change.

"Hypnosis has commonalities with psychedelics, which are also promising adjuncts for psychotherapy," said Spiegel. He told P*sychiatric News* that both approaches suppress the brain network that controls rumination thinking (for example, daydreaming and mind wandering), which inhibits many preconceived notions and facilitates trying out a new identity.

The seeds for this current study were planted several years back, when Spiegel's team used brain imaging data to identify potential brain connections associated with hypnotizability. They found that readily hypnotizable people had stronger nerve connections between the dorsolateral prefrontal cortex (DLPFC) and the dorsal anterior cingulate cortex (dACC) than nonhypnotizable people. That two regions are relevant for hypnosis makes sense; the DLPFC controls decision-making and executive function while the dACC processes and filters external stimuli.

"We realized both these regions are salient targets of TMS," said Spiegel, who decided to reach out to psychiatry colleague Nolan Williams, M.D., the director of the Stanford Brain Stimulation Lab and a pioneer in precision neurostimulation techniques. Together, their teams set out to see whether they could modulate the hypnosis response.

The Stanford team recruited 80 adults (aged 18 to 69, 94% female) with fibromyalgia, a chronic condition characterized by heightened pain response, fatigue, and cognitive problems. All participants were rated as being low to moderately hypnotizable according to the hypnotic induction profile (HIP), a brief test in which a therapist gives a standardized set of suggestions, such as having individuals roll their while closing them and raising their hand by making it feel lighter. Individuals had to score 8 or lower on the 0- to 10-point

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# Substance Use in Pregnancy Ups Risk of ADHD for Child

*Children whose mothers used alcohol, tobacco, and/or cannabis while pregnant were two to four times more likely to have ADHD symptoms than those whose mothers did not use these substances.* **BY TERRI D'ARRIGO**

General medical advice to pregnant people is to avoid drinking alcohol, smoking, and using substances such as cannabis because of the potential harm to both mother and child. Now a study in the *American Journal of Preventive Medicine* bolsters that advice by showing an increased risk of attention-deficit/hyperactivity disorder (ADHD) in children whose mothers used these substances while pregnant.

"With cannabis legalization increasing, we are seeing more women of childbearing age using cannabis along with other common substances such as alcohol and tobacco," lead author Jennie E. Ryan, Ph.D., told *Psychiatric News*. She is an assistant professor at Thomas Jefferson University in Philadelphia. "Furthermore, recommendations for alcohol use support abstinence, but this is based on little scientific evidence, leaving many pregnant people wondering how much harm can result from small to moderate substance use? We therefore wanted to provide information to inform [health professionals] as well as pregnant people."

Ryan and colleagues examined data from 11,874 children in the Adolescent Brain Cognitive Development (ABCD) Study, a longitudinal study designed to assess brain and cognitive development from childhood through adolescence. The researchers measured parent-reported ADHD symptoms as defined by the annual Child Behavioral Checklist scale. At baseline, they also asked the children's biological mothers whether they used substances once they knew they were pregnant.

Overall, 5.27% of the children had parent-reported ADHD. Compared with children of mothers who did not use any substances during pregnancy, children whose mothers used both alcohol and tobacco while pregnant had 4.27 times the odds of having parent-reported ADHD. Those whose mothers used tobacco and cannabis while pregnant had 2.18 times the risk and those whose mothers used cannabis but no other substances while pregnant had 2.09 times the risk of having parent-reported ADHD.

"While the primary aim of our study was to examine patterns of polysubstance, that is, combinations of substances that may affect ADHD outcomes, the finding of cannabis-only use stood out to me," Ryan said. "This is concerning given the growing number of pregnant people using cannabis during their pregnancy. The endocannabinoid system plays an important role in fetal development, and we have not fully elucidated the effects of exogenous cannabis consumption on the developing endocannabinoid system of the fetus. Like much of the research on the endocannabinoid system, we still have a lot to learn."

Thomas Jefferson University

Patients who use cannabis for medicinal reasons should be counseled on the risks of continuing use during pregnancy, said Jennie E. Ryan, Ph.D.

Ryan stressed the importance of talking with pregnant people and women of childbearing age about the risks of using substances.

"Many Americans use medicinal cannabis for several ailments, and [cannabis] use for certain diseases is well documented in the literature," Ryan explained. "If a patient is using cannabis medicinally, psychiatrists and other [health professionals] should have a discussion with that patient about the risk versus benefit of continuing use throughout the pregnancy."

Ryan noted that the study had some limitations, notably the low prevalence of reported maternal substance use in the sample and the retroactive reporting of prenatal substance use.

"Despite these limitations, the study's findings provide important information for patients and [health professionals] and will help inform conversations between [health professionals] and their pregnant patients."

This study was supported by Thomas Jefferson University and the National Institute on Drug Abuse. **PN**

**"Prenatal Polysubstance Use and Attention-Deficit/Hyperactivity Disorder (ADHD)" is posted at https://www.ajpmonline.org/article/S0749-3797(23)00483-X/fulltext.**

*continued from facing page*

HIP scale to be eligible.

The participants were randomly allocated to receive one session of theta-burst stimulation, a rapid form of TBS that can be delivered in about 90 seconds, or sham stimulation. Like another TMS protocol developed by Williams known as SAINT, each participant in this trial underwent an MRI scan to pinpoint the region in the DLPFC that had the strongest connection to the dACC. (SAINT stands for Stanford Accelerated Intelligent Neuromodulation Therapy.) The participants were then given another HIP assessment immediately after stimulation and again one hour later.

On average, the HIP scores of participants who received active TMS increased by about one point immediately after stimulation whereas scores among sham participants remained the same. The changes to HIP scores wore off after one hour.

Though the effects were modest and transient, Williams believes they are encouraging given this was a first attempt involving just one stimulation session; regular TMS therapy for depression typically requires numerous sessions spaced out over days or weeks to achieve any robust effects. He is planning to conduct additional tests to see whether the effects of TMS on hypnotizability can be extended in duration and/or augmented in power.

Williams acknowledged that this mechanistic study assessed only individuals' hypnotizability index; the researchers did not provide any detailed hypnotherapy to see whether the fibromyalgia patients responded more robustly following TMS.

Williams and Spiegel are hoping to launch a clinically focused trial to explore whether TMS can boost the efficacy of hypnotherapy in people looking to quit smoking. TMS is being tested as a standalone therapy for smoking cessation, so it's possible that combining it with hypnotherapy may provide a synergistic effect.

Spiegel believes that boosting hypnotizability may have broad applications. He told *Psychiatric News* that several modalities of psychotherapy, including cognitive-behavioral therapy, could be enhanced if people had more focus and were open to trying news ways of thinking.

This study was supported by an Innovation Award grant from the National Center for Complementary and Integrative Health. **PN**

**"Stanford Hypnosis Integrated With Functional Connectivity-Targeted Transcranial Stimulation (SHIFT): A Preregistered Randomized Controlled Trial" is posted at https://www.nature.com/articles/s44220-023-00184-z.**

## Termination

*continued from page 16*

providing the patient with a list of at least three referrals, including a mental health agency, it is important to provide details for crisis centers and emergency service provisions. Avoid situations in which the patient attempts to negotiate to stay under your care.

Here are other risk management measures to reduce your exposure:

- Document the record to reflect the clinical assessments and impacts to the treatment plan that led to termination.
- Follow state medical board licensing regulations.
- Provide the patient with written notification per state regulations.
- When appropriate, provide a prescription for medication up to the termination date with no refills.
- Refer to APA's "The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry."
- Consult with a risk management professional or legal counsel. **PN**



**"The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry" is posted at http://apapsy.ch/Principles_of_Medical_Ethics. Additional information is available in the *Psychiatric News* article "Ending a Treatment Relationship," posted at https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2023.06.6.17.**

# Look Beyond Mood Swings to Distinguish Borderline Personality From Bipolar Disorder

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*As noted in APA's upcoming practice guideline, appreciating that self-harm is a common behavior in borderline personality disorder can help physicians make a differential diagnosis.* **BY NICK ZAGORSKI**

APA's new practice guideline on borderline personality disorder is hoped to help clinicians improve their ability to identify this condition in the face of common differential diagnoses such as bipolar disorder. Available now as a preprint, the final document and supporting materials will be available this fall.

The confusion between borderline personality disorder and bipolar disorder arises since both conditions share some hallmark symptoms like mood instability and impulsivity. However, the underlying reasons why these symptoms manifest are quite different, as are the treatment recommendations; treating a patient with borderline personality disorder for bipolar disorder, or vice versa, can lead to serious health risks. To reduce misdiagnosis, two experts advise psychiatrists and other physicians to look beyond the mood features of the disorders.

"The *DSM* lists mood instability as a criterion for borderline personality disorder, but it's just one of nine and not the most important," Nassir Ghaemi, M.D., M.P.H., a professor of psychiatry and pharmacology at Tufts University School of Medicine, told *Psychiatric News*.

Differentiating between borderline personality disorder and bipolar disorder has long been a challenge for many physicians, explained Marsal Sanches, M.D., Ph.D., a professor of psychiatry and behavioral sciences at Baylor College of Medicine. Even after the addition of borderline personality disorder to *DSM-III* in 1980, some psychiatrists questioned whether it was a valid diagnostic construct.

The argument made by these psychiatrists, as described by Marsal Sanches in a 2019 review article in the journal *Diseases*, was that borderline personality disorder was a bipolar illness characterized by ultrarapid mood cycles.

"I am against the concept of this spectrum where everyone who has mood swings has some type of bipolar disorder," said Joel Paris, M.D., an emeritus professor of psychiatry at McGill University in Montreal as well as a psychiatrist and researcher at Jewish General Hospital. "The mood swings occurring in bipolar disorder and borderline personality disorder are completely different phenomena."

The emotional highs of borderline personality disorder, for example, are highly sensitive to the environment. "If someone with borderline in an elevated state feels invalidated or rejected, they can crash straight into a depression. It's more mood instability than mood swings." Bipolar mania, meanwhile, is episodic and is more resistant to such psychosocial trigger factors.

One clinical distinction that is often cited is that the mania-like symptoms of borderline personality disorder are transient; they typically last a couple of days or sometimes end within hours. In contrast, the *DSM-5* criteria state that an episode of bipolar mania must be present for at least seven days, while

*see* **Borderline** *on page 33*

CLIMATE CHANGE & MENTAL HEALTH

# Guinea-Bissau: One Place Among Many Facing Climate Catastrophe

*Fear and anxiety about climate disaster and the resulting migration coupled with poverty and sickness will lead to significant mental health challenges, which Guinea-Bissau's medical infrastructure is not prepared to face.* **BY CAROL LIM, M.D., M.P.H.**

Have you heard of Guinea-Bissau, a small country in the Sahel region on the west coast of Africa? I visited there on a medical service trip at the end of November 2023. With a population of just 2 million, Guinea-Bissau is one of the poorest and least-developed countries in the world. It endured extractive colonialism by Portugal, which focused only on turning the port of Bissau into a slave trading center.

When I arrived in Bissau, the country's capital, the six-month rainy season had ended, and the dry season (November to April) had just begun. Red Saharan dust was covering the entire country in 95-degree heat. Once green in the rainy season, the tin rooftops were brown due to a thick layer of settling dust. The school classrooms I visited to donate soccer balls had windows without glass panes since there were no air conditioners or fans to combat the extreme heat. Thus, the red dust entered children's respiratory tracts as they learned.

The children looked listless and hungry because their families could not provide them with breakfast. The school did not offer meals and held only morning classes. A teacher, Lifna, a farmer in his 50s, said farming yields were rapidly decreasing. Due to rising sea levels, seawater is slowly seeping into the *bolanha* (the low coastal plain used for rain-fed agriculture), ruining farming and infrastructure. Also, fishing yields

Carol Lim, M.D., M.P.H., is an instructor in psychiatry at Harvard Medical School and a psychiatrist at the MGH Psychosis Clinical and Research Program. She is the medical director of the MGH Clozapine Clinic.

are decreasing sharply due to rising sea temperatures. Moreover, the price of cashew nuts, a key export, has plummeted this year, making it difficult for many to put food on the table. Other teachers told me that the people were not just distressed, but in constant fear for their lives due to climate change.

When I reached a small village called Patcheiala, a two-hour drive from Bissau, with a team of a dozen health care workers to provide medical care, we encountered a surge of over 450 patients. Many reported chronic chest pain; severe high blood pressure, including hypertensive crises, was prevalent. Since there are no refrigeration facilities, people suffer from diseases due to spoiled food and bacterial infections. They are plagued by endemic typhoid fever and malaria, exacerbated by extreme temperatures. Children suffer from scabies, which causes mites to leave holes in their skin. With climate change, these conditions will only worsen. Even now, people go to Senegal for medical treatment due to a lack of well-equipped hospitals in Guinea-Bissau.

West Africa is among the most vulnerable and the least-resourced hotspots of climate change, with its temperature rising 1.5 times faster than the rest of the world. It has benefited little from industrialization and thus contributes little to global emissions, but it disproportionately suffers the consequences.

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# Adult Stimulant Initiations Via Telemedicine Found to Rise at Height of Pandemic

*While some have voiced concerns that prescribing stimulants via telemedicine may lead to diversion, patients are also more likely to have a follow-up visit following telemedicine stimulant initiation.* **BY TERRI D'ARRIGO**

The number of adults receiving their first prescription for a stimulant medication per month rose during the COVID-19 pandemic, a study in *Psychiatric Services* has found. A similar rise was not seen with first stimulant prescriptions in children.

The study also found that telemedicine was used for a sizable portion of these stimulant initiations, was more commonly used by psychiatrists, and was associated with greater odds of receiving follow-up care.

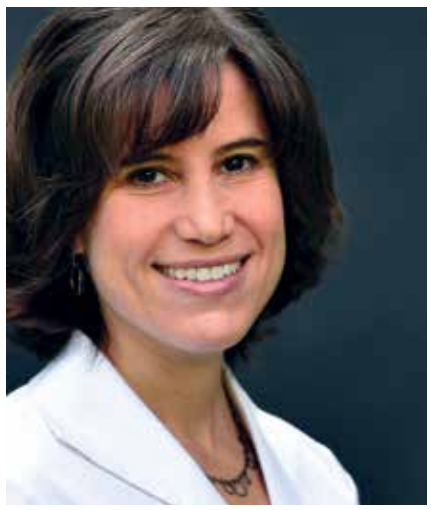
Alisa B. Busch, M.D., M.S., an associate professor of psychiatry at McLean Hospital in Belmont, Mass. and an associate professor of health care policy at Harvard Medical School, and colleagues analyzed data on commercially insured individuals recorded in the Optum Labs Data Warehouse from January 2019 through April 2022. The study used data from 535,629 children aged 2 to 17 years and 2,116,160 adults aged 18 to 64 years.

After the researchers adjusted for pre-pandemic trends in stimulant initiation and for patient characteristics, they found that the average monthly number of stimulant initiations per 100,000 children was similar before and during the COVID-19 pandemic, 57 compared with 56 initiations, respectively. However, stimulant initiations per 100,000 adults rose from 27 before the pandemic to 33 during the pandemic.

Busch and colleagues noted that recent data from the Centers for Disease Control and Prevention also identified an increase in stimulant prescription fills during the pandemic among adults; these new data now show the increase was not just limited to adults who had previously taken these medications.

Many of these adults who initiated stimulants during the pandemic did so via telemedicine. The telemedicine prescription rate peaked early—52.7% of adults received their initial stimulants via telemedicine in April 2020—then dropped to 27.9% by April 2022. This rate was still twice as high as that for children, which dropped from an peak of 56.8% in April 2020 down to 13.9% by April 2022.

Psychiatrists were much more likely than other prescribers (such as primary care physicians or other specialists) to initiate stimulants via telemedicine for both adults and children, which Busch said was not surprising. "We know that, in general, psychiatrists and other mental health specialists continue to use telemedicine much more than other health care providers," she told *Psychiatric News*.



Harvard Medical School

Telemedicine could serve an important role in improving access to care, but in some circumstances, there are concerns that it may contribute to overprescribing or diversion, said Alisa B. Busch, M.D., M.S.

Busch reflected on the current debate in health policy about initiating and prescribing controlled substances, including stimulants, via telemedicine.

"Some are concerned that it may, in some circumstances, contribute to overprescribing or diversion," she said. "[However], in a lot of prior research, patients reported improved satisfaction with telemedicine compared with in-person care because telemedicine provides increased convenience, better geographical access to [health professionals] when there is a shortage in the community, and opportunities for privacy in seeking psychiatric care."

In this analysis, Busch and colleagues found that between January 2019 and April 2022, on average only 21.8% of stimulant initiations for adults were followed up with a visit with the prescribing health professional within 30 days. However, patients were about 60% more likely to have a follow-up visit if they received stimulant initiation via telemedicine.

"We are limited in how much we can differentiate quality of care in claims data, so while it is noteworthy that we observed improved quality in terms of follow-up care when stimulants were initiated via telemedicine, there are other aspects of quality that we are not able to observe in these data," she said. "These would be things like whether the initiations were clinically appropriate and whether there was adequate monitoring for clinical outcomes and side effects."

Busch said policy decisions on telemedicine prescribing will have important implications for patients and their family members or caregivers in terms of accessing care.

"There is a risk that if the regulations do not strike the right balance between access and reducing diversion, patients who need care will have more difficulty in obtaining it," Busch said. "Rather than prohibiting stimulant initiation via telemedicine, it would be better for policymakers to identify providers or companies that are inappropriately prescribing stimulants or other controlled substances, and also to develop policies that make inappropriate prescribing absent an adequate clinical evaluation more difficult."

This study was supported by the National Institute of Mental Health and the National Institute on Drug Abuse. **PN**

**"Trends in Use of Telemedicine for Stimulant Initiation Among Children and Adults" is posted at https://ps.psychiatryonline.org/doi/10.1176/appi.ps.20230421. "Trends in Stimulant Prescription Fills Among Commercially Insured Children and Adults — United States, 2016–2021" is posted at https://www.cdc.gov/mmwr/volumes/72/wr/mm7213a1.htm?s_cid=mm7213a1_w.**

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Neighboring countries of Senegal and Côte d'Ivoire, former colonies of France, are economically and politically more stable, reflected by the extensive presence of embassies and NGOs. Guinea-Bissau has had difficulty attracting foreign aid since coups and power struggles within the government are so frequent. On one December day, I heard sounds of heavy gunfire, with police fighting the military during an attempted coup while the president was attending the United Nations Climate Change Conference (COP28) in Dubai. In part due to poverty and unstable governance, Guinea-Bissau has been a major transit point for drug distribution to Europe for 20 years. Of the 88 small islands off Guinea-Bissau, approximately half are uninhabited and are used for trafficking drugs like cocaine. There are no police officers or helicopters to limit these criminal activities, and high-ranking executives and officials in the country have been linked to drug cartels.

Nowadays, climate adaptation and resilience have become buzzwords, yet these apply only when there is a stepwise plan for recovery, which Guinea-Bissau does not have. If climate change worsens, it will soon become inevitable for people to migrate to neighboring countries with more livable conditions and access to food, clean water, cooling centers, and medical facilities. I witnessed firsthand the severity of the country's climate crisis, which not only poses physical health risks but also threatens mental well-being. Fear and anxiety about climate disaster/migration coupled with poverty and sickness will lead to significant mental health challenges, which this country's medical infrastructure is not prepared to face. It is critical that we advocate to international organizations to mobilize the investment and support necessary for Guinea-Bissau to address the impending mental health crisis and develop a systematic recovery plan. **PN**

## Exhibit

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M.D., the founding national chair of the BPA; and Altha Stewart, M.D., APA's first Black president.

"Our history should be celebrated," Shepherd said. "We have dealt with many travesties and injustices, true, and yet we also have made significant positive contributions to the field and continue to have a seat at the table, and that should be celebrated."

The exhibit features primary source documents such as the program book from the 1969 Annual Meeting and books such as *Beyond Black and White* by James Comer, M.D., one of the founding members of the BPA. APA members may visit the exhibit until August, and the virtual gallery is live indefinitely. **PN**

**The exhibit can be viewed at https://legacy.psychiatry.org/Historic-Highlights/Voices-of-Progress-A-Historical-Journey-of-Black. Members who wish to visit APA headquarters to view the exhibit should contact Deena Gorland at dgorland@psych.org.**

# Poor Quality Sleep in Midlife Linked To Poor Cognition 11 Years Later

*Researchers found that restless sleep in midlife was associated with worse cognition more than 10 years later. Duration of sleep, however, was not associated with cognition later in life.* **BY KATIE O'CONNOR**

The relationship between sleep and cognition has been a popular research topic in recent years, and studies have shown that there is a link between dementia and poor sleep. The direction of that association—whether poor sleep is a risk factor for dementia or dementia symptoms cause poor sleep—has been harder for researchers to determine, explained Yue Leng, Ph.D., an associate professor of psychiatry at the University of California, San Francisco, Weill Institute for Neurosciences.

Leng and her colleagues explored this association further by analyzing data from a prospective cohort. They found that individuals whose sleep is characterized by high restlessness at about 40 years of age may have a higher risk of poor cognitive functioning 11 years later compared with individuals whose sleep is better. Their findings were published in *Neurology*.

The quality of adult sleep is an area of research that needs more attention, which may result in tools that people can use to improve sleep and mental health outcomes, said Ebony Dix, M.D.

The authors used data from the Coronary Artery Risk Development in Young Adults (CARDIA) study, during which participants were assessed every two to five years over 30 years. The current study took place from 2003 to 2005 and included 526 White and Black adults with a mean age of 40 years (58%/42% women/men and 66%/44% White/Black). Participants wore wrist activity monitors for three consecutive days and nights on two occasions about one year apart. The wrist monitors measured both sleep duration and each participant's sleep fragmentation index, a measure of restlessness during their sleep calculated by measuring the amount of time they spent moving and the amount of time they were still for one minute or less. Participants also reported the times they went to bed and woke up and the quality of their sleep by completing the Pittsburgh Sleep Quality Index.

Cognitive assessments were conducted about 11 years later. Interviewers administered tests that assessed the participants' processing speed, executive function, working memory, verbal memory, fluency, and global cognitive function.

Participants slept an average of about six hours a night, and 45.6% reported poor-quality sleep. While there was no relationship between sleep duration and cognition, participants with the greatest amount of sleep fragmentation were two to three times more likely than participants with moderate or low sleep fragmentation to have poor cognitive performance 11 years later on nearly all the cognitive measures except verbal memory. These findings did not differ by race or sex.

Leng noted that previous studies have resulted in conflicting findings on whether sleep duration is associated with cognition, but the current study showed no association. "Many studies have shown a U-shaped relationship between sleep duration and cognition," Leng said. "This study really helps to resolve these conflicting findings. It emphasizes the importance of sleep quality and that we should be paying attention to how fragmented our patients' sleep may be."

She also noted that the study found an association, not causation, and it is too early to make conclusions about prevention. More research is needed. Leng and her colleagues are currently looking at how sleep across the different stages of life, including early adulthood, is associated with cognition later in life.

Ebony Dix, M.D., said she would like to see more studies that investigate how risk factors for dementia could be balanced with other lifestyle changes. If more research does show that poor sleep quality is a risk factor for poorer cognition, what can people do to offset those issues? She pointed out that some may not be able to avoid fragmented sleep, such as new parents, those with undiagnosed sleep apnea, or those caring for elderly relatives. Dix is an assistant professor of psychiatry at Yale School of Medicine, medical director of the inpa-

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# Omega-3 Supplementation May Reduce Schizotypal Symptoms in At-Risk Youth

*One expert who reviewed the report said future research should examine which groups might benefit most; Omega-3 supplementation may be especially beneficial for that subset of at-risk youth with chronic low-grade inflammation.* **BY MARK MORAN**

Children with schizotypal personality symptoms may benefit from dietary supplementation with omega-3 fatty acids, according to a report in *Schizophrenia Bulletin*. Schizotypal personality (or "schizotypy") is marked by symptoms such as aggression, interpersonal difficulties, and cognitive problems that can be precursors to schizophrenia.

"Poor nutrition has long been associated with schizophrenia-spectrum disorders, including schizoid personality and schizotypal personality," wrote Adrian Raine, D. Phil., the Richard Perry University Professor of Criminology, Psychiatry, and Psychology at the University of Pennsylvania, and colleagues. A 2003 study in the *American Journal of Psychiatry* by Raine and colleagues found that providing youth with a fish-rich dietary intervention could improve brain function and reduce schizotypy symptoms.

"Because the children in the intervention received 2.5 child portions of fish per week more than the control group, we hypothesized that omega-3 could be the active ingredient in the enrichment that reduced schizotypy," Raine and colleagues wrote in the *Schizophrenia Bulletin* study.

In the study, 290 community-dwelling children aged 11 and 12 years were randomly assigned to receive three months of daily omega-3 supplementation alone, cognitive-behavioral therapy (CBT) alone, omega-3 supplementation plus CBT, or no intervention (control). All children met criteria for conduct disorder or oppositional defiant disorder or had higher-than-average scores on a standardized test for aggression.

Jack Kearse

"There are many reasons for psychiatrists to be talking to their patients, especially young patients, about the merits of a healthy diet and exercise," said David Goldsmith, M.D., M.Sc.

The omega-3 supplement consisted of a daily 200 ml fruit-flavored drink containing 1,000 mg of various omega-3 fatty acids along with two chewable multivitamin tablets. CBT was delivered in 12 weekly one-hour sessions, supplemented with weekly home exercises. Schizotypy was assessed at baseline and at three, six, and 12 months using the self-report Schizotypal Personality Questionnaire-Child (SPQ-C19). It assesses the three key domains of schizotypy—interpersonal difficulties, cognitive and perceptual problems, and disorganized features like odd speech or behaviors.

In the omega-3 only and omega-3 plus CBT groups, total schizotypy was reduced by 28.0% and 21.3%, respectively, at three months (the end of treatment), and by 25.7% and 36.6%, respectively, at six months. Children in both groups showed greater symptom improvement than children in the control group at these time points.

The strongest improvements were seen for the interpersonal domain of the SPQ, which assesses such variables as discomfort in social situations and ability to establish close relationships.

But Raine and colleagues also noted

*see* **Omega-3** *on page 31*

# Trauma-Focused CBT, Racial Socialization Build Resilience in Black Youth

*Experts have created a manual on integrating trauma-focused cognitive-behavioral therapy with racial socialization, which refers to the ways in which adults transmit attitudes and behaviors to youth that help them deal with racial stressors.* **BY KATIE O'CONNOR**

Early on in her therapy sessions with Ashley Dandridge, Psy.D., a 14-year-old Black patient told Dandridge: "I didn't know race or racism was something that we could talk about in therapy."

Previous outpatient clinicians had never spoken with Sarah (not her real name) about her identity as a Black girl, racism, or racial stressors. Dandridge worked with Sarah to address the racism she encountered in daily life and some of the traumatic experiences she had experienced at home.

Dandbridge is a psychologist at Allegheny General Hospital's Center for Traumatic Stress in Children & Adolescents. She shared Sarah's story during a session at the American Academy of Child and Adolescent Psychiatry's (AACAP) annual meeting in New York. Key to her work with Sarah was trauma-focused cognitive-behavioral therapy (TF-CBT), combined with racial socialization. "I did a lot of psycho-education with Sarah's mom on the different forms of racial stress and trauma," Dandridge said.

She also educated Sarah and her mom about racial socialization, using handouts created by Isha Metzger, Ph.D., L.C.P. Metzger is an assistant professor of psychology at Georgia State University and director of the EMPOWER Lab, which aims to increase engagement in mental health treatment within the Black community.

TF-CBT is an evidence-based treatment for children and teens that usually is provided both to the child individually and with the child and caregiver together. It was developed by Judith Cohen, M.D., and colleagues for traumatized children.

"In addition to talking about interpersonal stressors, when we're working with Black youth, we have to talk about those racial stressors that are culturally specific and integrate protective factors that Black families are already using," said Isha Metzger, Ph.D., L.C.P.

Cohen is a professor of psychiatry at Allegheny Health Network (AHN) and Drexel College of Medicine in Pittsburgh.

The concept of integrating TF-CBT and racial socialization was Metzger's vision. Last year, Metzger; Dandridge; Cohen; and Anthony Mannarino, Ph.D., chair of psychiatry at AHN, wrote an implementation manual on integrating TF-CBT and racial socialization. The manual outlines strategies clinicians can take for incorporating racial socialization into TF-CBT when treating Black youth aged 3 to 17 and their parents.

At the AACAP meeting, Metzger described the well-documented negative outcomes that Black children experience due to various forms of racism, such as interpersonal or systemic racism. Racial socialization refers to the ways in which minoritized caregivers teach their children how to safely navigate a society in which they will likely experience racism in some form.

"It's the ways in which we talk about our pride and our sense of self-esteem in order to combat those negative messages that we're … receiving and that can lead to negative outcomes," Metzger said.

While experiences of racism can lead to outcomes like posttraumatic stress disorder (PTSD), depression, or anxiety, racial socialization can improve a child's sense of safety, racial identity, and overall psychological resilience, she said. Most Black families are already practicing racial socialization, she added.

Clinicians are not trained to routinely ask their patients about racial stressors and other traumatic experiences related to racism, said Judith Cohen, M.D. Implementing integrated TF-CBT and racial socialization can address that problem.

"TF-CBT has been used for Black youth, and it has strong evidence, with 25 randomized, controlled trials that document that TF-CBT is efficacious … for improving not only PTSD, but also depression, anxiety, and trauma-related cognition," Cohen said at the AACAP meeting. It has also been shown to help parents or caregivers with their own mental health issues, she added.

Metzger outlined numerous practice components through which racial socialization can be integrated into TF-CBT. Psychoeducation, for example, is designed to normalize and validate experiences, in this case racial stressors. "We talk to kids about the negative impacts of experiencing abuse, and we also need to normalize experiences related to discrimination, as well as their reactions to those experiences," she said.

During the joint meetings with youth and their caregivers, clinicians should focus on promoting healthy, positive communication about racial stressors. "You can really utilize these sessions to encourage ongoing communication about racial stress as well as those coping strategies that are really important," Metzger said. Clinicians can encourage families to incorporate racial socialization strategies into their routines that promote bonding, such as cooking a traditional African meal together or watching a movie or television show focused on Black heritage.

Dandridge said that, by the end of her therapy sessions, Sarah's score on the Child PTSD Symptom Scale for *DSM-5* dropped from 33 (considered moderate PTSD) to 8 (which is in the normal range). Dandridge said she encouraged Sarah and her mom to do activities together. They signed up for a gym membership shortly after Sarah started therapy, as they both enjoyed exercising, and went almost daily together. They also got part-time jobs making hair and skincare products for Black women.

"This really helped boost Sarah's self-esteem around her hair and skin," Dandridge said. "It made her feel beautiful." **PN**

**The implementation manual is posted at https://tfcbt.org/tf-cbt-and-racial-socialization.**

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tient geriatric psychiatry unit at Yale New Haven Hospital, and a member of APA's Council on Geriatric Psychiatry.

"Is it possible to reverse the damage that poor sleep has already done?" she asked. "If a person has a healthy lifestyle and feels generally positive about their sleep habits, could that offset any potential damage caused by fragmented sleep earlier in life? These are some of the questions I'm hoping more research can answer so that we can give patients more direction."

Sleep, especially among older adults, is an issue that certainly needs more attention, she added. "If you think about older adults and some of the things that disrupt their sleep, there are often issues that their care teams should pay more attention to," she said. "They may have issues with chronic pain, frequent urination, or other medical issues. Sometimes disrupted sleep may be due to a medication side effect."

The study was funded by the National Heart, Lung, and Blood Institute. **PN**

**"Association Between Sleep Quantity and Quality in Early Adulthood With Cognitive Function in Midlife" is posted at https://www.neurology.org/doi/10.1212/WNL.0000000000208056.**

## Key Points

- Racial socialization refers to the ways in which minoritized caregivers teach their children how to safely navigate a society in which they will likely experience racism in some form.
- Trauma-focused cognitive-behavioral therapy (TF-CBT) is an evidence-based treatment for youth who have experienced trauma. It is often delivered first individually to the child and then to the family together.
- The implementation manual on integrating racial socialization with TF-CBT can provide guidance to clinicians on how to implement TF-CBT with important cultural considerations for Black families and youth.

**Bottom Line: Racial socialization integrated with TF-CBT can benefit Black youth aged 3 to 17 years and their caregivers who experience racial-related stress or trauma as well as other types of significant trauma.**

# Gepirone Finally Gets FDA OK as Depression Treatment

*The drug offers something new for patients—a side-effect profile that does not include sexual or weight gain risks.* **BY NICK ZAGORSKI**

Last year, the Food and Drug Administration (FDA) approved three novel medications related to psychiatric disorders. Of these, two made big headlines: lecanemab, the first amyloid antibody to demonstrate some clinical benefits in Alzheimer's; and zuranolone, the first oral medication for postpartum depression.

At the end of September 2023, after 20 years of trying, the antidepressant Exxua (gepirone hydrochloride extended-release tablets) also received the green light from the FDA. Exxua, manufactured by Fabre-Kramer, modulates serotonin activity in the brain; however, it does so in a manner that is different from selective serotonin reuptake inhibitors (SSRIs). While SSRIs block the reabsorption of serotonin into cells, gepirone specifically activates one serotonin receptor called 5-HT1A.

That specificity offers the benefit of fewer side effects, the company noted. Notably, the Exxua label does not include sexual side effects or weight gain as potential adverse events. In clinical studies, the most common side effects were dizziness, nausea, and insomnia.

In a press statement following the approval, Exxua manufacturer Fabre-Kramer noted the favorable safety data including lack of sexual side effects was based on data from over 5,000 patients.

But as Exxua becomes available at pharmacies this year, it may be worth considering whether this medication—which enters a much more crowded market than lecanamab or zuranolone—is innovative enough to find a foothold, especially given a history of multiple FDA rejections and some questions over its efficacy.

## A Long and Winding Road

Though many medications submitted to the FDA for approval require multiple attempts, the clinical path of gepirone could be one for the history books. Organanon first submitted gepirone to the FDA in 2001, with a package of data that included one positive phase 3 clinical trial. In that randomized trial of over 200 participants with depression, adults who took gepirone on average experienced a 9.04-point decrease in the 17-item Hamilton Depression Rating Scale (HAMD-17) after eight weeks, compared with a 6.75-point decrease among adults who took placebo.

These findings were not enough to convince the FDA, which in 2002 told the company it needed two large trials with positive results for consideration. Organon submitted another application at the end of 2003, which added the results of a trial measuring depression relapse following gepirone discontinuation. While this trial did show that patients maintained with gepirone had a lower relapse rate (23%) than those who discontinued (35%), the FDA did not consider the results "positive"; the agency believed that not every eligible patient was included in the data.

Fabre-Kramer, who had initially acquired gepirone 1993 but then transferred the drug license to Organanon in 1998, took back the license of this drug in 2005. Though recruitment was slow, the company eventually conducted a second randomized trial of symptom reduction with 238 adult participants; results were similar to the first trial—participants' HAMD-17 scores were about about 2.4 points greater with gepirone compared with placebo.

So, in 2007, incorporating these new data, a New Drug Application for gepirone was submitted for the third time to the FDA and was subsequently rejected. In this instance, the agency acknowledged the two positive phase 3 results but said that negative outcomes in several smaller depression studies left doubt as to whether gepirone was effective. Fabre-Kramer appealed this decision in 2012, which eventually led to a hearing with the FDA's Psychopharmacologic Drugs Advisory Committee (PDAC) in December 2015.

The hearing did not go the company's way, as the committee ruled in a 9-4 vote that the negative results outweighed the two positive trials. Although that seemed to be the end of the road for gepirone, the following year the FDA overturned the committee's decision and stated there was enough evidence to demonstrate effectiveness. The company was told it could resubmit a New Drug Application, which it eventually did in 2022, leading to approval last year.

## A Drug Worth Considering in Some Cases

"It took a while, but the FDA eventually got it right," said David Pickar, M.D., a private practice psychiatrist and an adjunct professor of psychiatry at both Johns Hopkins University School of Medicine and the Uniformed Services University of the Health Sciences. Pickar was a member of the PDAC committee in 2015 and one of the four members who supported moving gepirone forward.

As he explained, the problem he saw was that the advisory committee decided to assess the medication's clinical performance based primarily on HAMD-17 improvements. Though this ostensibly allowed for easier comparison of the data, Pickar pointed out that several of the negative trials did not choose the HAMD-17 as the primary outcome; it was a secondary measure in these trials. He noted that the primary measures for clinical trials must be identified ahead of time, and those should be the outcomes prioritized in reviews.

Madhukar Trivedi, M.D., said that recently-approved Exxua (gepirone) may be a good option for individuals with anxious depression, given clinical trial findings and the medication's chemical similarity to the anxiolytic buspirone.

"This is a classic FDA maneuver," he said, "but you cannot change the rules after the fact."

Pickar acknowledged that "Gepirone is not the greatest drug out there," citing the modest 2.5 point improvement on the 52-point HAM-D scale. All things considered, though, he would like to see more well-tolerated medications of moderate efficacy than a push toward agents like ketamine that come with potent side effects, cognitive disruptions, and a high potential for abuse.

"By demonstrating a lower level of side effects, Exxua may indeed be a popular choice in the near future," added Madhukar Trivedi, M.D., the Betty Jo Hay Distinguished Chair in Mental Health and Julie K. Hersh Chair for Depression Research and Clinical Care at the University of Texas Southwestern Medical Center. Trivedi was not involved in the clinical development of this medication.

As with a few other newly available psychiatric medications, cost will be one obstacle for many patients, which Trivedi sees as an overarching problem in mental health care. "Cost issues seem to be very selective to psychiatry; you don't see rheumatology constantly required [by insurers] to go with the cheapest options first."

Trivedi believes that cost concerns can be alleviated once psychiatrists are better able to predict which antidepressant—new or old—has the best chance of success with each patient.

In the case of Exxua, individuals with anxious depression could be good candidates, he noted. Gepirone is chemically related to buspirone, an FDA-approved anti-anxiety medication that is also used off label as an adjunct in depression. Supporting this, a follow-up analysis of the original clinical trial data found that adults with anxious depression who took gepirone had a greater response than those with nonanxious depression.

The greater goal, Trivedi said, is to fulfill the potential of precision psychiatry. "These new antidepressant approvals have been welcome, but now let's find the biomarkers that can match the right medication with the right patient." **PN**

**Prescribing information for Exxua is posted at https://www.accessdata.fda.gov/drugsatfda_docs/label/2023/021164s000lbl.pdf.**

BY TERRI D'ARRIGO

## Psilocybin Promising For Anxiety Disorder

Incannex's investigational ***psilocybin*** product ***PSX-001*** appeared to be effective in relieving symptoms of generalized anxiety disorder in a phase 2 clinical trial, the company announced in February.

In the PsiGAD1 trial, 72 patients with generalized anxiety disorder were randomized to receive psychotherapy with either psilocybin or placebo for seven weeks. Their symptoms were measured with the Hamilton Anxiety Rating Scale (HAM-A) at baseline and at 11 weeks.

The reduction in HAM-A score from baseline in the psilocybin group was 12.8 points, compared with a reduction of 3.6 points in the placebo group. In addition, 44% of patients in the psilocybin group showed a clinically meaningful improvement (at least a 50% reduction in anxiety scores from baseline), which was more than four times higher than that of the placebo group. Further, 27% of patients in the psilocybin group achieved full disease remission, a rate more than five times higher

## FDA Rejects Roluperidone For Negative Symptoms Of Schizophrenia

In February the Food and Drug Administration (FDA) rejected the New Drug Application (NDA) for ***roluperidone*** for the treatment of negative symptoms in patients with schizophrenia, Minerva Neurosciences announced.

In its Complete Response Letter, the FDA cited several clinical deficiencies:

- Although one study (MIN-101C03) demonstrated statistical improvements in negative symptoms, it is insufficient on its own to establish substantial evidence of effectiveness.
- The NDA submission also did not establish that the change in negative symptoms with roluperidone treatment was clinically meaningful.
- The NDA submission lacked data on concomitant antipsychotic administration.
- The safety data did not include enough patients exposed to roluperidone at the proposed 64 mg dose for at least 12 months.

The FDA's letter stated that Minerva must submit at least one additional positive, adequate, and well-controlled study to support the safety and effectiveness of roluperidone for the treatment of negative symptoms of schizophrenia. The letter added that Minerva must also provide additional data to demonstrate the safety and efficacy of roluperidone co-administered with antipsychotic medications, to support that observed effect on negative symptoms with roluperidone treatment corresponds to a clinically meaningful change, and to demonstrate the long-term safety of the proposed dose.

## Latozinemab Gets Breakthrough Status for Frontotemporal Dementia

The FDA granted Breakthrough Therapy designation to ***latozinemab*** for frontotemporal dementia with a progranulin gene mutation, Alector Inc. announced in February. Progranulin regulates immune activity in the brain and helps keep neurons and other brain cells healthy.

A Breakthrough Therapy designation expedites the development and review of drugs for serious conditions. The criteria for breakthrough therapy designation require preliminary clinical evidence indicating that the drug may demonstrate substantial improvement over existing options on at least one clinically significant endpoint.

The FDA granted Breakthrough Therapy designation for latozinemab based on the results of the phase 2 clinical trial INFRONT-2. This trial evaluated 12 patients with a progranulin mutation causative of frontotemporal dementia who were treated with 60 mg/kg of latozinemab every four weeks over 12 months. The study found that treatment with latozinemab in these patients slowed disease progression by about 47% over one year compared with a control group of frontotemporal dementia patients. The study also found that latozinemab elevated progranulin in both plasma and cerebrospinal fluid in the patients for the duration of treatment.

## Motpoly XR Now Available For Treatment of Partial-Onset Seizures

In February Aucta Pharmaceuticals Inc. announced its launch of ***Motpoly XR (lacosamide)*** extended-release capsules C-V in the 100 mg, 150 mg, and 200 mg doses for the treatment of partial-onset seizures in adults and in pediatric patients who weigh at least 50 kg (110.2) pounds. Motopoly XR is bioequivalent to Vimpat (lacosamide) film-coated tablets C-V and provides a once-daily option at equivalent doses. It will be available through retail pharmacies.

The prescribing information for Motopoly XR notes that prescribers should monitor patients for suicidal behavior and ideation. It also notes that the drug may cause dizziness, ataxia, and fainting. In addition, it recommends that prescribers obtain an electrocardiogram before beginning the medication and after titration to steady-state maintenance and to closely monitor patients with underlying proarrhythmic conditions or on concomitant medications that affect cardiac conduction. Finally, Motopoly XR should be gradually withdrawn to minimize the potential of increased seizure frequency. **PN**

## Omega-3

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that treatment effects for total schizotypy largely washed out nine months after supplementation was terminated, except for the interpersonal symptoms where reduction was sustained in both omega-3 groups at 12 months. Raine and colleagues suggested future studies that use larger doses of omega-3s and/or provide booster sessions may help produce longer-term reductions in schizotypy.

David Goldsmith, M.D., M.Sc., who is an assistant professor of psychiatry at Emory University and reviewed the report for *Psychiatric News*, said the study is a valuable one showing dietary supplementation may have "a measurable and clinically significant effect on schizotypal symptoms." He noted that the study cohort—children with conduct disorder or oppositional defiant disorder—tend to have higher rates of schizotypy.

Goldsmith is also director of research at the Clinical and Research Program for Psychosis at Grady Health System and director of the Inflammation, Motivation, and Negative Symptoms of Schizophrenia Lab at Emory University School of Medicine.

"Finding nonmedication-based interventions is especially important in children," he told *Psychiatric News*. "Moreover, the effects of omega-3 fatty acids … in this study may yield important insights into pathophysiological mechanisms underlying risk for schizotypy and perhaps later psychosis that will be interesting to follow up on."

The *Schizophrenia Bulletin* study is not the first to show the beneficial effects of omega-3 fatty acids; a study by G. Paul Amminger, M.D., in 2010 and follow-up in 2015 showed that omega-3 supplementation reduced conversion to psychosis among youth with subthreshold psychosis. But Goldsmith noted that other studies were not able to replicate those findings.

He added that youth at high risk of psychotic disorders are highly heterogenous; some will benefit from omega-3 supplementation and others may not. "Given the mixed findings on omega-3 supplementation in the literature, I think it suggests that we really need to understand who may stand to benefit the most from these treatments," Goldsmith said.

"For example, one potential mechanism by which omega-3 fatty acids may work is by reducing inflammation, but only a subset of individuals with psychotic illness appear to have evidence of chronic low-grade elevated inflammation," he said.

Goldsmith concluded: "This study highlights diet as a possible intervention that is too often ignored in clinical practice. There are many reasons for psychiatrists to be talking to their patients, especially young patients, about the merits of a healthy diet and about regular exercise, and this study highlights another reason for psychiatrists to incorporate these conversations into practice."

This study was funded by a grant from the Pennsylvania Department of Health with additional support from the Clinical & Translational Research Center at the University of Pennsylvania and a grant from the Eunice Kennedy Shriver National Institute of Child Health and Human Development. **PN**

**"Omega-3 Supplementation Reduces Schizotypal Personality in Children: A Randomized Controlled Trial" is posted at https://academic.oup.com/schizophreniabulletin/advance-article-abstract/doi/10.1093/schbul/sbae009/7595970. "Effects of Environmental Enrichment at Ages 3–5 Years on Schizotypal Personality and Antisocial Behavior at Ages 17 and 23 Years" is posted at https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.160.9.1627. "Long Chain w-3 Fatty Acids for Indicated Prevention of Psychotic Disorders" is posted at https://jamanetwork.com/journals/jamapsychiatry/fullarticle/210554. "Longer-Term Outcome in the Prevention of Psychotic Disorders by the Vienna Omega-3 Study" is posted at https://www.nature.com/articles/ncomms8934.**

# JOURNAL DIGEST

***BY NICK ZAGORSKI***

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## Cognitively Demanding Tasks Associated With Faster Concussion Recovery

The symptoms of adolescents who return to school after a concussion and participate in cognitively demanding activities may resolve faster than those who do not, according to a study in the *British Journal of Sports Medicine*. However, improved symptom resolution was not seen if the activities involved significant screen time.

Researchers at Children's Hospital in Columbus, Ohio, and colleagues followed 83 adolescents aged 11 to 17 who had a concussion within 72 hours for up to 45 days. The participants recorded the intensity and duration of the cognitive activities they performed each day as well as any post-concussive symptoms. Cognitive intensity was grouped into three categories: low (for example, listening to music), medium (for example, being in class), or high (for example, taking a test). On average, the participants performed 191, 166, and 38 minutes of low- , moderate- , and high-intensity cognitive activities, respectively, each day.

Overall, the researchers found that every 10 minutes per hour spent doing a moderate- or high-intensity cognitive activity was associated with 22% faster symptom recovery. In contrast, every day postinjury that the adolescent did not go to school was associated with 8% slower symptom recovery.

Not all activities were positively associated with improvement. For example, the researchers found that every 10 minutes per hour spent video gaming (considered a moderate-intensity activity) during the first week of concussion recovery was associated with 29% slower symptom recovery.

"These findings suggest that low-intensity cognitive activities such as listening to music, watching TV, and texting may be permitted in the days following concussion, but gaming and surfing the internet for more than a few minutes should be discouraged," the researchers wrote.

**Yang J, Alshaikh E, Asa N, et al. Exploring the Association Between Cognitive Activity and Symptom Resolution Following Concussion in Adolescents Aged 11-17 Years. *Br J Sports Med.* 2024; 58(6): 328-333. https://bjsm.bmj.com/content/58/6/328.long**

Getty Images/iStock/Grafissimo

## Low-Frequency TMS Improves Psychomotor Schizophrenia Symptoms

Low-frequency transcranial magnetic stimulation (TMS) can improve symptoms of psychomotor slowing in individuals with schizophrenia, according to a clinical trial from investigators at the University of Bern, Switzerland. Psychomotor slowing involves impairment to both fine and gross motor movements, making tasks like walking or talking difficult.

"Psychomotor slowing often comes with multiple disadvantages, such as cognitive impairment, sedentary behavior, cardiometabolic risks, poor quality of life, lower subjective well-being, and impaired functioning," the investigators wrote in *JAMA Psychiatry*.

This trial involved 88 adults (aged 18 to 60) with schizophrenia spectrum disorder and severe psychomotor slowing, defined as a score of 15 or more on the Salpêtrière Retardation Rating Scale (SRRS). The participants were evenly divided to receive repetitive TMS (rTMS) at 1-hertz, intermittent theta burst stimulation (iTBS) at 50-hertz, or sham stimulation or be placed on a waiting list. All stimulation protocols involved 15 sessions across three weeks targeting the supplementary motor area; after three weeks, the wait list group all received the low-frequency rTMS. Participants were allowed to continue taking their existing medications.

After three weeks, 68% of adults who received rTMS responded to treatment, defined as at least a 30% improvement in SRRS scores. By comparison, 36% of iTBS recipients, 32% of sham participants, and 18% of adults on the waitlist responded to treatment. After adjusting for demographic variables and medication use, the researchers estimated someone receiving rTMS had more than 80% greater odds of responding than someone receiving iTBS or sham.

Further, 63% of the waitlist group responded to rTMS once they got the treatment. The investigator reported that no participants experienced severe adverse events, and the most common side effects were fatigue and head/neck pain.

**Walther S, Alexaki D, Weiss F, et al. Psychomotor Slowing in Psychosis and Inhibitory Repetitive Transcranial Magnetic Stimulation: A Randomized Clinical Trial. *JAMA Psychiatry*. February 28, 2024. Online ahead of print**

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# ECT/MST

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received MST. Smith and colleagues observed that MST and ECT resulted in slightly different patterns of clinical slowing; however, in both cases, the brainwave changes were due to increases in aperiodic activity.

"The brain wave changes we observed line up with a long-standing theory about depression called the cortical inhibition theory," Smith said. This theory posits that individuals with depression have broad deficits in their inhibitory neurons, which help regulate the activity of excitatory neurons. These deficits in inhibitory control contribute to the exaggerated stress response seen in people with depression.

Research has shown that aperiodic activity is partially derived from inhibitory neurons; thus, the increase in aperiodic activity following ECT or MST treatment may reflect a restoring of the brain's inhibitory network. Increased aperiodic activity following stimulation was not found to be directly related to changes in depressive symptoms, however.

Bradley Voytek, Ph.D., hopes that his work with the brain's "background noise" will encourage other researchers to look for hidden signals in brain activity that may correlate with mental health symptoms.

"Despite being linked to a promising mechanism of action, the lack of evidence for a direct relationship between increases in aperiodic exponent and the therapeutic effects of ECT and MST in this study presents a strong limitation," the researchers wrote. "Although aperiodic exponent increases simultaneously as depression symptoms improve, the magnitude of these changes are unrelated in this sample, so aperiodic changes cannot be directly interpreted as a therapeutic mechanism of action for either treatment at this point."

Smith is hopeful that obtaining data from larger samples of patients with depression who receive ECT or MST may identify changes in the patterns of aperiodic activity that predict treatment response.

"This research is an example of the type of work that needs to be done in the neuromodulation field," said Sarah Lisanby, M.D., director of the Noninvasive Neuromodulation Unit at the National Institute of Mental Health. Lisanby, who co-developed MST, was not involved with the current study.

"Understanding how ECT works is a high priority because it is used in severely ill patients," she said. "Unlocking its mysteries could lead to safer and even more effective treatment protocols."

Lisanby was the lead on a recently published clinical trial that found ECT and MST are comparable in their antidepressant efficacy. Voytek and Smith's study showing the two approaches produce similar changes in aperiodic activity supports the idea that the shared element of MST and ECT—seizures—is the therapeutic key.

Lisanby noted that both ECT and MST (which is still an experimental treatment) have been used to treat conditions such as schizophrenia and obsessive-compulsive disorder. "It would be interesting to see how aperiodic activity changes in people without depression. For instance, is this strictly an antidepressant response or is it a broad therapeutic effect of a [controlled] seizure?"

This research was supported by a grant from the National Institute of General Medical Sciences, along with a UC San Diego Pace Grant, Majda Grant, and Veterans Medical Research Foundation Pilot Grant. **PN**

**"Magnetic Seizure Therapy and Electroconvulsive Therapy Increase Aperiodic Activity" is posted at http://apapsy.ch/MST-ECT-aperiodic-activity. "Clinical EEG Slowing Induced by Electroconvulsive Therapy is Better Described by Increased Frontal Aperiodic Activity" is posted at http://apapsy.ch/EEG-aperiodic.**

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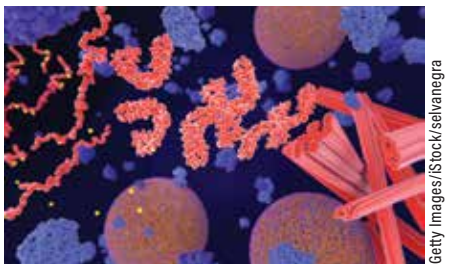

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## Receptor Identified That Brings Toxic Tau Fragments Into Neurons

While much Alzheimer's research focuses on the amyloid protein, another protein called tau has also been implicated in this disorder. In laboratory research published in *Advanced Science*, a team at Johns Hopkins University and colleagues identified the receptor that may be responsible for carrying toxic tau fragments into cells. This receptor, called LAG-3, is already the target of a recently approved melanoma antibody therapy (relatlimab), suggesting it may be a valid therapeutic target for Alzheimer's.

While the tau protein can attach to numerous receptors on the surface of neurons to get inside, the researchers observed that LAG-3 was special in that it specifically binds to fibrillar tau—a misfolded and sticky version of the protein that induces other tau proteins to misfold and clump together, forming toxic aggregates.

The researchers generated a mouse model that lacked LAG-3 receptors in the brain and then injected them with fibrillar tau; compared with regular mice, the LAG-3-deficient mice accumulated far less toxic tau in their neurons. The mice deficient in LAG-3 that were injected with tau also showed fewer behavioral deficits, such as increased anxiety or reduced sociability than regular mice. The researchers could replicate the protective effects of LAG-3 deletion by giving regular mice an LAG-3 antibody that blocks the entrance to the receptor.

"Emerging studies have shown the expression of [LAG-3] receptors is on neurons, microglia, and astroglia, where they exert diverse functions," the researchers wrote. "It would be valuable to determine the roles of these tau receptors in different cell types."

**Chen C, Kumbhar R, Wang H, et al. Lymphocyte-Activation Gene 3 Facilitates Pathological Tau Neuron-to-Neuron Transmission. *Adv Sci (Weinh)*. February 7, 2024. Online ahead of print. https://agsjournals.onlinelibrary.wiley.com/doi/10.1111/jgs.18736**

Getty Images/iStock/DragonImages

## Peer-Led Workshop For Postpartum Depression Found Effective

A one-day, online workshop about postpartum depression, delivered by mothers who experienced postpartum depression, is both an effective and cost-effective therapeutic strategy, according to a study in *Psychotherapy and Psychosomatics*.

The efficacy of a workshop, which condenses key principles of cognitive-behavioral therapy (CBT) into a one-day session, has been demonstrated previously, but earlier sessions were delivered by professionals. The investigators from McMaster University in Hamilton, Ontario, and colleagues noted that many individuals with postpartum depression "express a preference for treatments delivered by someone who they feel truly understands their experiences."

They enrolled 405 mothers of infants up to 12 months old to take part in the workshop or continue with their usual care and take part in the workshop after 12 weeks (waitlist). All participants had Edinburgh Postnatal Depression Scale (EPDS) scores of 10 or higher. The workshop included six hours of instruction along with breaks, delivered by a pair of peer facilitators who had undergone brief CBT training from a perinatal psychiatrist.

After 12 weeks, the mothers who took the CBT workshop decreased their EPDS scores by 4.58 points, compared with a 2.97-point deduction in the waitlist group; this difference was statistically significant. The mothers in the workshop group also reported greater improvements in general anxiety, infant-focused anxiety, parenting stress, and infant temperament compared with the waitlist group.

Further, workshop participants accrued almost $100 less (Canadian) in health care costs per person over 12 weeks ($968 versus $1,063 in the waitlist group), primarily due to fewer emergency department visits. Given that each workshop can accommodate up to 30 participants and the peer facilitators cost only $30/hour each, the investigators calculated a high likelihood that this protocol is cost-effective.

**Babiy Z, Layton H, Savoy CD, et al. One-Day Peer-Delivered Cognitive Behavioral Therapy-Based Workshops for Postpartum Depression: A Randomized Controlled Trial. *Psychother Psychosom*. January 25, 2024. Online ahead of print. https://karger.com/pps/article-abstract/doi/10.1159/000536040/894500/One-Day-Peer-Delivered-Cognitive-Behavioral**

Getty Images/iStock/BAKERYLY

## Menthol Cigarette Bans May Lead Some People To Quit Smoking

A systematic review and meta-analysis published in *Nicotine and Tobacco Research* suggests that menthol cigarette bans can encourage some smokers to quit, though a large majority may switch to nonflavored cigarettes or other products like e-cigarettes.

Researchers at the University of North Carolina and colleagues reviewed 20 studies that explored real-world outcomes of places that enacted a menthol ban, as well as 32 studies that surveyed smokers about their response to a hypothetical ban.

The real-world data indicated that smoking cessation rates among menthol smokers were higher following a menthol ban compared with other smokers. National menthol bans (such as implemented in Canada or the European Union) appear more effective than bans at the state and local levels because smokers were still able to keep smoking menthol cigarettes obtained in neighboring areas.

To obtain more quantitative data, the researchers next conducted a meta-analysis of three studies that assessed smoking behaviors one to two years following national bans in Ontario, across Canada, and in the Netherlands. The results indicated that about 24% of menthol smokers quit smoking, while 50% switched to another tobacco product and 24% continued smoking menthols.

"This review provides a snapshot of what is known about the impacts of menthol bans," the researchers concluded. "This literature is an evolving area as more localities and countries implement menthol bans, the tobacco industry responds to the changing regulatory environment with new products, and the longer-term impacts of menthol bans emerge." **PN**

**Mills SD, Peddireddy S, Kurtzman R, et al. The Impact of Menthol Cigarette Bans: A Systematic Review and Meta-Analysis. *Nicotine Tob Res*. February 21, 2024. Online ahead of print. https://academic.oup.com/ntr/advance-article/doi/10.1093/ntr/ntae011/7611609**

## Borderline

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bipolar hypomania must be present for at least four.

Ghaemi, however, suggested not placing too much emphasis on episode duration. He told *Psychiatric News* that research going back to the 1970s suggests that hypomania episodes can be present for as few as two days.

"Instead of mood, focus on the many areas where these disorders differ," Ghaemi advised. For example, cutting and/or other self-harm behaviors are present in about two-thirds of individuals with borderline personality disorder, but only about 5% of those with bipolar. Substance use problems are also more frequent in people with borderline personality disorder, as is a history of sexual trauma.

Bipolar disorder, meanwhile, has a stronger hereditary component than borderline personality disorder, Ghaemi continued; one of the best ways to confirm a bipolar diagnosis in a patient is to find out whether there is any family history of the disorder. That is why obtaining a thorough patient and family history is important for differentiating these conditions.

A big obstacle in accurate diagnosis is that physicians have personal biases and limited time, Paris said. Many doctors—consciously or subconsciously—diagnose a patient with bipolar diagnosis rather than borderline personality disorder because that lets them prescribe a treatment.

It's a harmful assumption, Paris noted. "In the short term, antipsychotics may help reduce borderline mood swings a little bit, but otherwise the medications you might prescribe for someone with bipolar disorder are useless for borderline personality disorder," he said.

Paris, who has been working with patients with borderline personality disorder for decades, acknowledged there are always instances in which patients' symptom history presents a challenge, but that by and large a clinician can differentiate these disorders by taking a little time and asking the right questions. **PN**

**The preprint of APA's Practice Guideline for the Treatment of Patients With Borderline Personality Disorder is posted at https://www.psychiatry.org/psychiatrists/practice/clinical-practice-guidelines. "The Limits Between Bipolar Disorder and Borderline Personality Disorder: A Review of the Evidence" is posted at https://www.mdpi.com/2079-9721/7/3/49. "Borderline Personality Disorder and Bipolar Disorder: What Is the Difference and Why Does it Matter?" is posted at https://journals.lww.com/jonmd/abstract/2015/01000/borderline_personality_disorder_and_bipolar.2.aspx.**

# Maternal Mortality

*continued from page 5*

they join the military compared with the general population," she said.

The VA has seen the number of hospital deliveries it covers skyrocket in recent years, from 2,567 in fiscal year 2011 to 4,766 deliveries in fiscal year 2020, an 85% increase, according to the GAO report. The severe maternal morbidity rate also increased from 93.5 per 10,000 VA-paid delivery hospitalizations in fiscal year 2011 to 184.6 per 10,000 in fiscal year 2020. The rate was highest among Black veterans.

The GAO also investigated mental health screenings among perinatal veterans. Each VA medical center is required to designate a maternity care coordinator who serves as a liaison between pregnant and postpartum veterans and their health care providers. These coordinators, who are not required to have a particular degree, screen veterans for depression and suicide risk. As of last October, they were also required to screen for anxiety and PTSD.

The GAO report recommended that the VA begin monitoring the occurrence and results of those screenings. The VA concurred with the GAO's recommendation and stated in the report that it would aim to begin compiling and reviewing data from the screenings by March, a goal that Johnson said the department was on track to meet.

While experts such as Byatt noted the importance of screening, what happens before and after a perinatal woman is screened for mental illness is just as important, if not more so, Byatt said. "Along the care pathway, we ideally start with prevention. If the illness cannot be prevented and the patient screens positive, we need to follow that with assessment, treatment initiation, monitoring, and follow-up," she said. "Screening is just one step in the pathway, and ideally it's the second step after prevention."

Johnson explained that, in the VA, if a veteran screens positive for an urgent mental health condition during a call with a maternity care coordinator, she is connected with the department's crisis line and a warm handoff is attempted to directly connect veterans to care. The veteran's primary care team is also notified.

Johnson also noted that in recent years, the VA has made an effort to expand its capacity to treat veterans with perinatal mental health conditions and reproductive mental health across the lifespan. It maintains a national roster of mental health clinicians who have completed a foundational course in reproductive mental health care that patients can search by facility and region. It also has a Reproductive Mental Health Consultation Program, allowing clinicians to consult their reproductive mental health colleagues when they have questions.

### Ensuring Enough Data Are Available

It has only been a few years since the United States joined the rest of the developed world in establishing infrastructure for systematically assessing maternal deaths, as the authors of a 2019 *Health Affairs* report wrote. Congress passed the Preventing Maternal Deaths Act in 2018. The legislation authorized $12 million a year in new funds for five years for states to establish and support MMRCs. In a 2018 article, ProPublica called it "an unprecedented level of federal support."

The law needs to be reauthorized this year. APA has been strongly advocating for Congress to pass the Preventing Maternal Deaths Reauthorization Act (HR 3838/S 2415), as it would continue the funding MMRCs need to continue collecting and analyzing data on these deaths. The bill passed the House with a vote of 382-12 on March 5.

Data from MMRCs can be invaluable, Byatt said. The biggest challenge is ensuring that policies and funding decisions are responsive to the findings from the data being collected and support interventions that truly work to prevent pregnancy-related deaths, she said. Further, MMRCs do not exist in every state, which creates gaps in knowledge about these deaths across the country.

In their *JAMA Psychiatry* article, Wisner and colleagues pointed out that precisely estimating maternal mortality rates and deaths due to mental conditions is challenging because data sources may use different methodologies.

"Clear consensus definitions of the criteria that are used to define a maternal death associated with a mental health condition that are applied across all MMRCs are the goal," Wisner told *Psychiatric News*. "With this standard definition, the interpretation is transparent, and rates can be compared across MMRC sites and across time."

Byatt said she has seen tremendous strides to address perinatal mental health over the last 15 years. But the need remains significant. "People are still dying. They're dying at increasing rates," she said. "I believe we have been in a mental health crisis in this country for decades, and now we're in an emergency." **PN**

**"Pregnancy-Related Deaths: Data From Maternal Mortality Review Committees in 36 U.S. States, 2017–2019" is posted at http://APAPsy.ch/MMRC-2022. "Prioritizing Maternal Mental Health in Addressing Morbidity and Mortality" is posted at http://APAPsy.ch/JAMA-Maternal-Mortality. "VA Should Improve Its Monitoring of Severe Maternal Complications and Mental Health Screenings" is posted at http://APAPsy.ch/GAO-report. "Perspectives on barriers and facilitators to mental health support after a traumatic birth among a sample of primarily White and privately insured patients" is posted at http://APAPsy.ch/Traumatic-birth-study.**