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PSYCHIATRIC NEWS

The First and Last Word in Psychiatry

ISSN 0033-2704

David Hathcox

Vice President Joe Biden, speaking at APA's 2014 annual meeting in New York earlier this month, said that the field of mental health care is poised for major advancements that will "create the tools to find new ways to treat, cure, and even prevent conditions affecting the brain." He emphasized that "We need [psychiatrists] more than ever, and frankly we need more of you." See story at right. Full coverage of the annual meeting will begin in the next issue.

Biden Praises Vital Work Of Psychiatrists

Vice President Biden speaks with passion about the importance of mental health care and the bright future of psychiatric treatment.

BY MARK MORAN

Understanding of the brain and treatment of mental illness and brain diseases are at a transformative crossroads, said Vice President Joe Biden as he presented the William C. Menninger Memorial Convocation Lecture at APA's 2014 annual meeting May 5 in New York. Biden said passage of the mental health parity law and the release last year of regulatory guidance for the law, along with the new Brain Research Through Advancing Innovative Neurotechnologies (BRAIN) Initiative, announced by the Obama Administration last year, is creating a transformative moment for psychiatry and patients with mental illness.

"We are on the cusp of astounding possibilities," he said. "I know that we are poised to create the tools to find new ways to treat, cure, and even prevent conditions affecting the brain. And we are on the cusp of identifying the biomarkers for mental illness, designing early prevention treatments for psychosis and revolutionizing the understanding of the brain circuitry and function. Imagine the possibilities for millions of young people right at the age when they want to explore the world if we have these tools of early detection to prevent mental illness from taking over their lives."

Biden continued, "Just as we couldn't

see ***Biden*** *on page 33*

APA Files Amicus Brief Backing Lawsuit On Parity Violations

APA emphasizes that the nature of mental illness may make it difficult or impossible for patients to act on their own behalf in redressing parity-law violations.

BY MARK MORAN

APA is supporting the New York State Psychiatric Association (NYSPA) appeal of a lower court decision in NYSPA's lawsuit on behalf of member psychiatrists and their patients against United Behavioral Health for alleged violations of the federal parity law, which is part of the ERISA statute.

In an April 21 "friend of the court" brief filed with the U.S. Court of Appeals for the Second Circuit, APA supports NYSPA's claim that it has legal standing to take action on behalf of its member psychiatrists and their patients. An earlier decision from a lower court said that NYSPA did not have legal standing in the case, ruling that only the patients could bring the claim under the ERISA statute.

The original lawsuit was brought by NYSPA and several individual patients, a member psychiatrist, and a psychologist in March 2013 alleging that UnitedHealth Group and subsidiaries, including United Behavioral Health, systematically violated the federal parity law and the Affordable Care Act. The class action, filed in the U.S. District Court for the Southern District of New York, was brought on behalf of three beneficiaries. NYSPA joined the suit on behalf of its members and their patients.

At that time, Seth Stein, J.D., executive director of NYSPA, told *Psychiatric*

see ***Parity Lawsuit*** *on page 34*

PERIODICALS: TIME SENSITIVE MATERIALS

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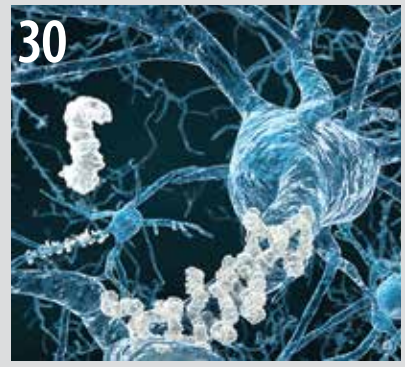


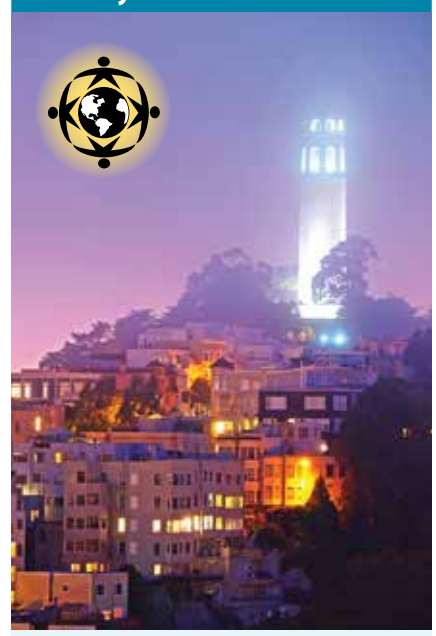
PROFESSIONAL NEWS

COMMUNITY NEWS

MEMBERS IN THE NEWS

CLINICAL & RESEARCH NEWS

Coming Next: APA's Institute On Psychiatric Services



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APA's next major meeting—the Institute on Psychiatric Services—is being held October 30 to November 2 in San Francisco at the San Francisco Marriott Marquis. The meeting is often referred to as APA's "little gem" because of its high quality and intimate size compared with the annual meeting. The theme of this year's institute is "Integrating Science and Care in a New Era of Population Health." Watch this space for more information about advance registration and housing options.

Departments

Bill Would Give Liability Exemption For Use of Overdose-Fighting Drugs

APA is backing a new bill that should make people more likely to intervene when they are with someone suffering a drug overdose.

BY MARK MORAN

APA has expressed its backing for the Opioid Overdose Reduction Act of 2014 (S. 2092), a bill sponsored by Sen. Edward Markey (D-Mass.) to help reduce the number of deaths attributed to opioid overdoses by exempting from civil liability individuals who under certain circumstances provide or administer a drug approved to combat an opioid overdose.

In an April 11 letter to Markey, APA CEO and Medical Director Saul Levin, M.D., M.P.A., noted that statistics from the Centers for Disease Control and Prevention indicate that deaths from drug overdoses increased from 16,849 in 1999 to 38,329 in 2010. Nearly 60 percent of the drug overdose deaths in 2010 involved prescription drugs, and 75 percent of those deaths (16,651) involved opioid analgesics, such as oxycodone, hydrocodone, and methadone.

The legislation states that "notwithstanding any other provision of law, a health care professional who prescribes or provides an opioid overdose drug to an individual at risk of experiencing an opioid overdose, or who prescribed or provided an opioid overdose drug to a family member, friend, or other individual in a position to assist an individual at risk of experiencing an opioid overdose, shall not be liable for harm caused by the use of the opioid overdose drug if the individual to whom such drug is prescribed or provided has been educated about opioid overdose prevention and treatment by the health care professional or as part of an opioid overdose program."

Similar language pertains to the limitation on civil liability for individuals working for or volunteering at a state or local agency opioid overdose program. That part of the law states that "…no individual who provides an opioid overdose drug shall be liable for harm caused by the emergency administration of an opioid overdose drug by another individual if the individual who provides such drug works for or volunteers at an opioid overdose program; and provides the opioid overdose drug as part of the opioid overdose program to an individual authorized by the program to receive an opioid overdose drug."

In the letter to Markey, Levin wrote, "APA recognizes that deaths from opioid analgesic overdoses may be prevented if an opioid overdose drug, such as naloxone, is administered in a timely manner. APA further recognizes that the willingness of medical and nonmedical personnel to administer this life-saving treatment may be weakened by potential civil liability. The Opioid Overdose Reduction Act of 2014 builds upon recent efforts in several states to exempt from civil liability individuals who provide or administer an opioid overdose drug under certain circumstances. This targeted exemption promises to save lives and reduce costly emergency department visits." PN

The APA letter to Markey is posted at http://www.psychiatry.org/file%20library/advocacy%20and%20newsroom/4-11-2014---s--2092-4-11-14.pdf. The text of the bill can be accessed at thomas.loc.gov by searching on the bill number, S. 2092.

EXCLUSIVE ONLINE CONTENT

In Memoriam
APA honors the members whose deaths were reported from January 1, 2014, to March 31, 2014.

Melatonin Studied for Prevention of Delirium in Elderly Patients
New evidence suggests that low levels of the hormone melatonin are implicated in delirium and that giving melatonin or a melatonin agonist may help prevent delirium.

Recalling Chestnut Lodge: Seeking the Human Behind the Psychosis
In this in-depth report, the psychoanalytic method and highly individualized treatment approach at Chestnut Lodge is described. This approach pointed toward the contemporary focus on early detection and intervention.

To access the articles above, go to http://psychnews.psychiatryonline.org/newsarticle.aspx?articleid=1812211 or scan the QR code with your smartphone.

Prisons, Jails Said to Need More, Better MH Treatment

For prisoners with mental illness, the decision making is simple: diversion when possible and treatment over objection when necessary.

BY AARON LEVIN

txking/Shutterstock

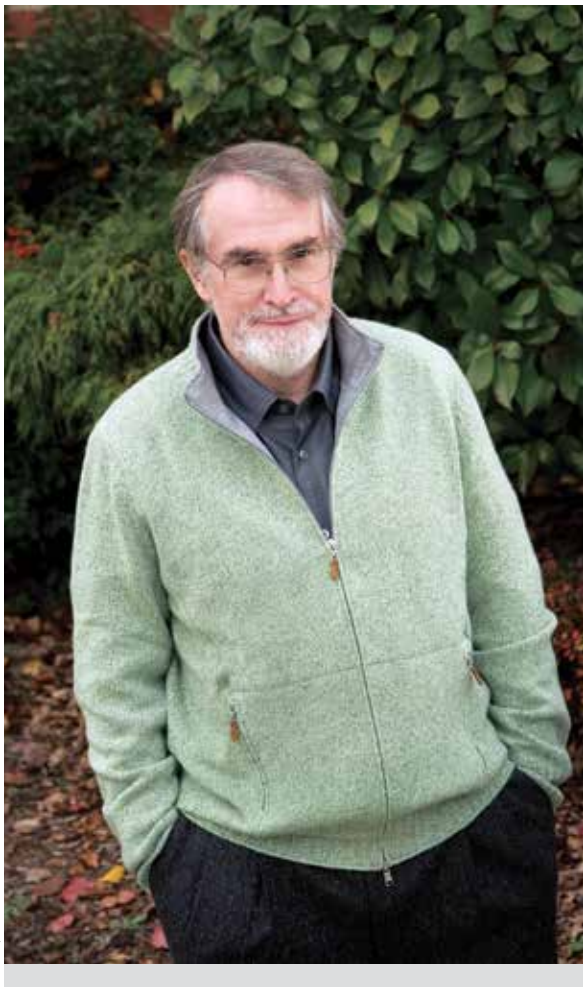
More than 350,000 individuals with serious mental illness are now housed in U.S. jails and prisons, institutions that were never designed or staffed to manage that population.

"It is a situation that is grossly unfair to both the inmates and the corrections officials and should be the subject of public outrage and official action," wrote psychiatrist E. Fuller Torrey, M.D., a member of the Board of Directors of the Treatment Advocacy Center in Arlington, Va., and six colleagues in an April report.

"The numbers are astounding, and the cost is unbelievable," said Ira Burnim, J.D., legal director of the Bazelon Center for Mental Health Law, an advocacy organization in Washington, D.C. "It's not a new problem. Why have we made so little progress on this front?"

The report draws on news reports, legal codes, and other sources to describe conditions in jails and prisons in 49 states and the District of Columbia. (Arkansas would not provide information for the survey, said the authors.)

"The report provides a state-by-state tally of a familiar problem and so contributes to a better understanding of what is going on," said forensic psychiatrist Steven Hoge, M.D., chair of APA's Council on Psychiatry and Law.



Clay Blackmore

Psychiatric treatment of state prison inmates over their objection was upheld by the Supreme Court in 1990, but is "often grossly underutilized," said E. Fuller Torrey, M.D., of the Treatment Advocacy Center.

The present situation is the reverse of the one in the mid-1950s when more than a half million individuals with severe mental illness were housed in state hospitals.

"In 44 of the 50 states and the District of Columbia, a prison or jail in that state holds more individuals with serious mental illness than the largest remaining state psychiatric hospital," wrote Torrey and colleagues. They noted that in 2012, 356,268 inmates with severe mental illness were housed in prisons and jails, compared with 35,000 patients in state psychiatric hospitals.

"The root cause of the problem is the continuing closure of state psychiatric hospitals and the failure of mental health officials to provide appropriate aftercare for the released patients," they said.

However, more inpatient beds would not solve the problem, said Hoge. "A majority of psychiatrists would not be in favor of large-scale commitment," he said. "Most people can live well enough in the community."

Ken Hoge

"Certainly there are people in jails and prisons who need treatment and are not receiving it," said forensic psychiatrist Steven Hoge, M.D. "But a bigger problem is whether the staff and infrastructure exist to safely and appropriately administer involuntary treatment."

Torrey offered several recommendations to address the problem, based on his view that "individuals with severe mental disorders who are in need of treatment belong in hospitals, not prisons and jails."

As preventive measures, he wants to promote greater use of assisted outpatient treatment and diversion programs like crisis intervention teams and mental health courts to keep people with mental disorders in the community and out of jail.

He also favors more treatment for inmates, including the use of psychiatric medications over the prisoner's objections, with procedural safeguards already in place in 31 states. That, too, is not the only difficulty in trying to treat prisoners.

"The problem is not only that people are untreated because they object to treatment, but that people who are on medications are often taken off those drugs when they are incarcerated," said Burnim. "They go into crisis because their medications are taken away or are switched to other drugs because of formulary issues."

Torrey and colleagues also suggested a model law to provide medication over inmates' objections.

"The primary problem is not the law," said Hoge. "It's that existing systems are inadequately funded, inadequately developed, and inadequately implemented to allow us to appropriately medicate people involuntarily in many facilities." PN

"The Treatment of Persons With Mental Illness in Prisons and Jails: A State Survey" is posted at http://www.tacreports.org/storage/documents/treatment-behind-bars/treatment-behind-bars.pdf.

Applications Invited for Congressional Fellowship

The American Psychiatric Foundation is inviting nominations for the Jeanne Spurlock Congressional Fellowship. This fellowship provides psychiatry residents, fellows, and early career psychiatrists a unique opportunity to work on Capitol Hill in a congressional office on federal health policy, particularly policy related to child and/or minority issues. The fellowship was established in honor of the late Jeanne Spurlock, M.D., who was deputy medical director and head of APA's Office of Minority/National Affairs and an advocate for child and minority issues.

The fellowship is open to all psychiatry residents, fellows, and early career psychiatrists. Applicants must be APA members and U.S. citizens or permanent residents. Applications, in the form of a letter, three letters of recommendation, and a CV, should be sent by July 10 to Marilyn King, APA Division of Diversity and Health Equity, 1000 Wilson Boulevard, Suite 1825, Arlington, Va. 22209. PN

PROFESSIONAL NEWS

Bipolar Patients in Integrated Systems May Need More-Intensive Care

Federally qualified primary care clinics, as well as primary care clinics where both uninsured and Medicaid patients are treated, are likely to have a significant percentage of patients with bipolar illness.

BY MARK MORAN

Primary care patients with bipolar disorder may require more-intensive services—including direct psychiatric care—than is currently provided in a collaborative care primary care model.

That's the finding from the study "Bipolar Disorder in Primary Care: Clinical Characteristics of 740 Primary Care Patients With Bipolar Disorder," published April 15 in *Psychiatric Services in Advance*.

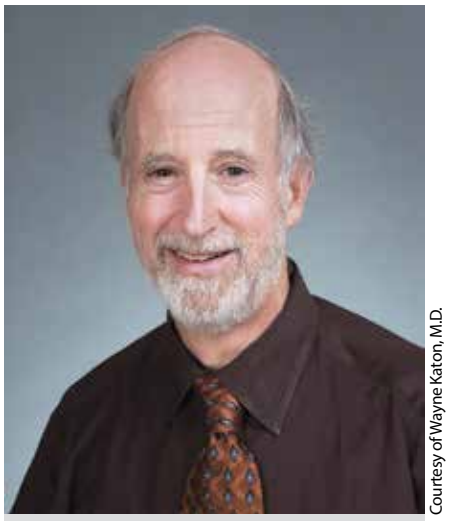
"Primary care patients with bipolar disorder experienced persistent depressive and anxiety symptoms despite higher-intensity collaborative care treatment, but they were infrequently referred to a community mental health center," the researchers stated. "Successful treatment of bipolar disorder in primary care may require additional clinical interventions aimed at either further improving the care delivered to patients in primary care or through more effective referrals to community mental health centers."

The authors were Joseph Cerimele, M.D., Ya-Fen Chan, Ph.D., Lydia Chwastiak, M.D., Marc Avery, M.D., Wayne Katon, M.D., and Jürgen Unützer, M.D., M.P.H., of the University of Washington, who have pioneered the development of collaborative care models integrating behavioral and general medical care.

They identified 740 primary care patients with bipolar disorder in the statewide mental health integration program (MHIP) between January 2008 and December 2011 using the Composite International Diagnostic Interview and clinician diagnosis. The MHIP uses collaborative care based on the IMPACT model (Improving Mood–Promoting Access to Collaborative Treatment), which was developed at the University of Washington to improve recognition and systematic treatment of patients with psychiatric disorders in primary care settings.

Primary care patients with bipolar disorder had high symptom severity on both depression and anxiety measures using the Patient Health Questionnaire (PHQ-9) and the Generalized Anxiety Disorder scale. Only about one-third of patients with bipolar disorder with baseline PHQ-9 scores of 10 or more experienced significant clinical improvement in depressive symptoms (with a PHQ score of less than 10 or a reduction in PHQ-9 score by 50 percent or more) during the time from initial MHIP assessment until treatment in MHIP or until the study ended.

Psychosocial problems were common, with approximately 53 percent reporting concerns about housing, 15 percent reporting homelessness, and 22 percent reporting lack of a support person. Yet only 26 percent of patients were referred to specialty mental health treatment. The average time from initial assessment to psychiatric consultation was 5.7 weeks among patients with bipolar disorder.



Courtesy of Wayne Katon, M.D.

Wayne Katon, M.D., says integration of psychiatrists, on site or by telemedicine, may be necessary for the care of bipolar patients in collaborative care systems.

Katon, vice chair of the Department of Psychiatry at the University of Washington, told *Psychiatric News* that the study indicates that these patients may need more-intensive care than is currently provided in a collaborative care model, in which a care manager, supervised by a psychiatrist, provides the direct patient care.

"The importance of this article is that the U.S. federally qualified primary care clinics, as well as many primary care clinics that treat both uninsured and Medicaid patients, are likely to have a significant percentage of patients with bipolar illness, especially bipolar II illness," Katon said. "This article emphasizes that despite the fact that only about one-third improve with treatment in these clinics, few are being referred to community mental health clinics or actually attend when referred. These clinics already had integrated collaborative care—that is, the use of a care manager supervised by a psychiatrist—so the inference is that these patients may need more-intensive psychiatric treatment, which could occur if psychiatrists are integrated into the clinics either in person or via telemedicine. Alternatively, the clinics need to establish better links with community mental health." PN

"Bipolar Disorder in Primary Care: Clinical Characteristics of 740 Primary Care Patients With Bipolar Disorder" is posted at http://ps.psychiatryonline.org/data/Journals/PSS/0/appi.ps.201300374.pdf.

Key Points

- Only about one-third of primary care patients in a statewide mental health integrated care program who had bipolar disorder and baseline PHQ-9 scores of 10 or more experienced significant clinical improvement in depressive symptoms.
- More than half of the patients reported concerns about housing, and 15 percent reported homelessness, while 22 percent reported lack of a support person.
- Only one-third of the patients were referred to a specialty mental health clinic.

Bottom Line: Primary care patients with bipolar disorder may require more intensive care, or better outreach with specialty mental health clinics, than is currently provided in a collaborative care system.

APA Mental Health Campaigns Win Advertising Awards

APA leaders emphasize that the Association will continue to seek out creative avenues for addressing key issues in mental health care.

BY VABREN WATTS

In March, the APA Office of Communication and Public Affairs (OCPA) and the American Psychiatric Foundation's Partnership for Workplace Mental Health program were awarded collectively eight Gold ADDY awards by the American Advertising Federation (AAF).

"We are really excited about our win," Eve Herold, director of OCPA, told *Psychiatric News*. "I have always known about the ADDY awards, so I knew the competition to win one was very fierce."

According to the AAF, the ADDY Award "represent[s] the true spirit of creative excellence by recognizing all forms of advertising from media of all types, creative firms of all sizes, and entrants of all levels from anywhere in the world."

OCPA received top honors in the digital-media category for its infographic, "A Veteran's Worst Wounds May Be the Ones You Can't See," which was a part of the public-service announcement series, "A Healthy Minds Minute," hosted by former member of Congress Patrick Kennedy. Kennedy is an APA senior advisor and spokesperson.

An infographic is a visual representation of complex information or data. OCPA's award-winning infographic includes an illustration of a military-camouflaged brain surrounded by statistical information highlighting military-related mental health concerns such as suicide, posttraumatic stress disorder, and traumatic brain injury (see page 34).

Jennifer Dart, social media and special projects manager in OCPA, told *Psychiatric News* that after a concept was generated to depict a visual for mental

see ***Awards*** *on page 34*

When Autism Entered the Lexicon

Curiosity and a deep interest in children led child psychiatrist Leo Kanner, M.D., to the earliest description of autism.

BY AARON LEVIN

"Of what's to come, the wise perceive things about to happen."

—Constantine Cavafy

In October 1938, Leo Kanner, M.D., the leading child psychiatrist at Johns Hopkins University School of Medicine, evaluated "Donald T.," a 5-year-old boy from Mississippi.

"He has no apparent affection when petted," his concerned parents had written in an earlier 33-page letter to Kanner. "He almost seems to withdraw into his shell and live within himself."

Curious, Kanner invited the couple and their child to Baltimore. "I saw a behavior pattern not known to me or anyone else," Kanner said in 1978 in a video recorded at Hopkins.

Children with this syndrome displayed "extreme autistic aloneness. . .an inability to relate themselves in the ordinary way to people and situations from the beginning of life," Kanner wrote afterward.

They also had "an anxiously obsessive desire for the maintenance of sameness" that brooked no disruption. They displayed "excellent rote memory," but little ability to use "language as a tool for receiving and imparting meaningful messages." They related to objects well but had very limited affective engagement with human beings.

"Kanner was puzzled, having seen nothing like this before, but over the next five years, he saw 10 similar children," said neuropsychiatrist James Harris, M.D., a professor of psychiatry and behavioral sciences and pediatrics at Hopkins, in an interview with *Psychiatric News*. "Because he was a skilled and careful clinician, he not only observed the child but also listened to the parents' description of the child's history and took them seriously. He began to synthesize the common features these children displayed."

Kanner described those 11 children in a now-classic paper—"Autistic Disturbances of Affective Contact"—published in 1943 in a short-lived journal, *The Nervous Child*.

Kanner had taken a long and winding road to that moment. He was born in 1894 in Klekotow, a Jewish village in Galicia, near the border between Russia and the Austro-Hungarian Empire. He trained in medicine and cardiology in Berlin, where he taught electrocardiography to an American doctor, Louis Holzt, M.D., from Aberdeen, S.D. That led to an invitation in 1924 to serve as an assistant physician at the state psychiatric hospital in Yankton, S.D.

His experience there produced a few papers on psychiatry, soon noticed by Adolph Meyer, M.D., chief of psychiatry at Hopkins. Meyer encouraged Kanner to apply for a Commonwealth Foundation Fellowship at Johns Hopkins to train psychiatrists and psychologists for work in juvenile courts and child guidance centers. Once at Hopkins, Kanner initiated the first pediatric psychiatric consultation service in a university setting and in 1935 published the first American textbook on child psychiatry.

Courtesy of the Alan Mason Chesney Medical Archives of the Johns Hopkins Medical Institutions

A portrait of Leo Kanner, M.D., by Nicholas Pavloff. Oil on canvas.

His office stood at the boundary of the Henry Phipps Psychiatric Clinic and the Harriet Lane Home for Invalid Children. The location was both symbolic and appropriate, given that until the early 1980s, child psychiatry was administratively a division of the pediatrics department, and the director's salary was evenly split between pediatrics and psychiatry.

He Could Enter 'the World of the Child'

It was a fortuitous appointment. He had a natural affinity for children, recalled his son, Albert Kanner, M.D., now a retired professor of ophthalmology at the University of Wisconsin. Sometimes when Kanner saw patients at his home, young Albert played with the children while his father talked with their parents. "He just had a way of interviewing children."

Young psychiatrists who trained under Kanner also stood in awe at his "capacity for entering the world of the child," as the late Leon Eisenberg, M.D., put it in a memorial in the *American Journal of Psychiatry* after Kanner's death in 1981.

"I joined Kanner's staff when I finished my fellowship," recalled Eisenberg in a 2009 interview. "The most valuable experience I had as his student was being what he called 'his baby sitter'—being with him for the history-taking and examination. I was so impressed with what he elicited from a child, establishing rapport."

Perhaps Kanner's most prescient conclusion from those first 11 cases was about the origin of autism, which he had diagnosed as appearing as early as at age 2.

"The children's aloneness from the beginning of life makes it difficult to attribute the whole picture exclusively to the type of early parental relations with our patients," he wrote in his 1943 paper. "We must, then, assume that these children have come into the world with innate inability to form the usual, biologically provided affective contact with people, just as other children come into the world with innate physical or intellectual handicaps."

During a time when psychoanalysis was flourishing, Kanner's formulation of an explicitly biological, and likely genetic, explanation was quite distinct, an aspect that was ignored until the 1970s, said Daniel Geschwind, M.D., Ph.D., a professor of neurology, psychiatry, and behavioral sciences at the David Geffen School of Medicine at the University of California, Los Angeles.

In his small group of patients, Kanner also noted in his 1943 paper that there "were very few really warmhearted fathers and mothers."

"The parents may not have been autistic, but Kanner's observations suggested a broader phenotype," Geschwind told *Psychiatric News*.

If his conclusions presaged the rise of a more biologically oriented psychiatry decades later, few appeared interested at the time. Kanner's paper was cited by others only 34 times between 1943 and 1954. However, citations rose to 2,400 by 2009, reflecting increased interest and research.

Originally, Kanner used "autistic" as an adjective. He employed "autism" for the first time as a noun in 1944, in the paper "Early Infantile Autism," published in the *Journal of Pediatrics.* In the paper, he added observations from nine more children.

Pediatrics Journal Spurred Interest

"More attention was paid when it was published in a pediatrics journal because pediatricians were curious about kids with developmental disabilities, but psychiatrists did not routinely evaluate those children," said Harris.

Today, when the word "autism" is a part of everyday speech, it is hard to imagine a time when the diagnosis did not exist. Before Kanner, children like these usually were diagnosed with "childhood schizophrenia" or "feeble-mindedness."

Also, pediatricians and parents had other, more immediate health concerns for children a century ago—such as acute infectious diseases.

"Conditions like autism became more visible as diseases with higher morbidity and mortality were increasingly controlled during the course of the 20th century," said Howard Markel, M.D., Ph.D., a professor of pediatrics and communicable diseases, psychiatry, and the history of medicine at the University of Michigan.

"As medicine grew better at diagnosing and treating infectious diseases, pediatricians began to see more low-morbidity, low-mortality conditions that doctors ignored when they had more deadly things to deal with," said Markel in an interview. "Lots of behavioral problems are observed and treated today that were not part of the field then."

Some cautionary notes should be applied to Kanner's two early papers, say historians of medicine.

"Most of these children came from families of higher socioeconomic status who could afford to have their child seen at Hopkins," said Markel. Ultimately, autism was diagnosed across the socioeconomic spectrum once children had greater access to services.

Then there was the association of autism and intellectual disability.

"Kanner firmly believed that autism was incompatible with mental retardation based on the lack of dysmorphic features in his patients, the remarkable feats of memory demonstrated by so many, and his belief that cognitive testing did not indicate their true abilities," wrote Jeffrey Baker, M.D., Ph.D., a professor of pediatrics and director of the Program in the History of Medicine at Duke University, in the September 19, 2013, *New England Journal of Medicine*. "More sophisticated testing would eventually show that children with autism had scattered intellectual functioning, marked by islets of ability as well as deficits."

Kanner continued his research into autism, and in a follow-up paper in 1971,

*see **Autism** on page 33*

COMMUNITY NEWS

Guns and Mental Illness Still An Uncertain Mix for Internists

Strategies for reducing firearm violence and death should include a variety of approaches to gun safety combined with strict background checks, according to one physician group.

BY AARON LEVIN

"Firearm violence is not only a criminal justice issue, but also a public health threat," said the American College of Physicians (ACP) in a position paper issued in April. "The medical profession has a special responsibility to speak out on prevention of firearm-related injuries and deaths, just as physicians have spoken out on other public health issues."

To that end, the ACP recommended several strategies, including discussing firearm risks and safety with patients, advocating for universal background checks, and increasing research on firearm violence and ways to reduce injuries attributable to firearms.

"The ACP position helps move the conversation forward and recognizes the importance of physicians attending to issues pertaining to firearms and public health," said psychiatrist Debra Pinals, M.D., assistant commissioner of forensic services at the Massachusetts Department of Mental Health and an associate professor at the University of Massachusetts Medical School. Pinals was the lead author on APA's July 2013 statement on firearms and their relationship to mental illness.

The ACP paper also addressed mental health issues. It recommended that background checks be used to keep guns out of the hands of "persons with mental illnesses that put them at a greater risk of inflicting harm to themselves or others."

However, it also cautioned "against broadly including those with mental illness in a category of dangerous individuals" and called for more access to treatment for people with mental illness. Physicians should have improved training in recognizing mental illnesses among their patients, said the authors.

"We agree that making a blanket statement about mental illness as a risk for firearm violence is not supported by the available evidence," said Thomas Tape, M.D., of the Nebraska Medical Center in Omaha. Tape is a member of the ACP's Board of Regents and was chair of the organization's Health and Public Policy Committee, which produced the paper.

"The paper takes a nuanced approach that makes physicians aware of the generally low likelihood of violence among those with mental health problems, while also calling for more research to better define who is at risk for violent behavior," said Tape in an interview with *Psychiatric News*. "In the interim, physicians must rely on their best clinical judgment based on their personal evaluation of the patient."

The ACP takes a different position from that of the Consortium for Risk-Based Firearm Policy, which argued for focusing attention more on dangerousness—whatever its origin—rather than on people with mental illness (*Psychiatric News*, December 27, 2013).

That approach means looking at people with a history of violent crime, domestic abuse, or substance abuse, said one member of the consortium, Beth McGinty, Ph.D., an assistant professor of health policy and management at the Johns Hopkins Bloomberg School of Public Health.

"The ACP paper speaks of increasing access to mental health services, but research shows that the vast majority of gun violence isn't due to mental illness," McGinty told *Psychiatric News*. "Access may be inadequate now, but even if we fixed our mental health system so that everyone who needs services gets services, it still wouldn't fix the overall gun-violence problem in the U.S."

Internists surveyed by ACP revealed some ambivalence about firearms. On one hand, 95 percent said they favored mandatory background checks for all firearms purchasers, and 85 percent supported "preventing people with mental illness from purchasing guns." However, 58 percent said they never ask about a gun in the home, 62 percent never suggest keeping guns away from children, and 77 percent wouldn't suggest that a patient voluntarily remove a gun from the home.

Furthermore, there is not much research on whether such discussions either prevent gun deaths or affect the doctor-patient relationship, said McGinty.

The ACP's Health and Public Policy Committee is looking into whether educational programs and materials might help physicians counsel patients about firearm safety, said Tape.

"The document may not have gone as far as APA did in asserting the need to protect individuals with mental illness from stigma," said Pinals. "That suggests an opportunity for further collaboration among all physician specialties related to these complex issues to continually refine our advocacy to ensure that stigma is minimized and access to care is maximized." PN

Labrador Photo Video/Shutterstock

"Reducing Firearm-Related Injuries and Deaths in the United States: Executive Summary of a Policy Position Paper From the American College of Physicians" is posted at http://annals.org/article.aspx?articleid=1860325&resultClick=24. APA's "Position Statement on Firearm Access, Acts of Violence, and the Relationship to Mental Illness and Mental Health Services" is posted at http://www.psychiatry.org/File%20Library/Learn/Archives/ps2013_Firearms.pdf.

COMMUNITY NEWS

APA Deputy Medical Director and Director of the Division of Diversity and Health Equity, Annelle Primm, M.D., M.P.H., welcomes attendees via a video recording to "Black and Blue: The State of African American Mental Health" held April 11 in Baltimore. Primm said that the "program exemplifies what OMNA on Tour is all about: convening community leaders from a wide array of backgrounds, disciplines, and perspectives to learn together and initiate a dialogue about mental health disparities and what can be done to prevent and eliminate them."

Carol Moore, M.S., R.N.C., provides comic relief to the conference as she emphasizes how laughter can help reduce mental distress.

African-American MH Concerns Addressed at Baltimore Forum

Experts say it's time to make mental health care an essential component in the lives of African Americans.

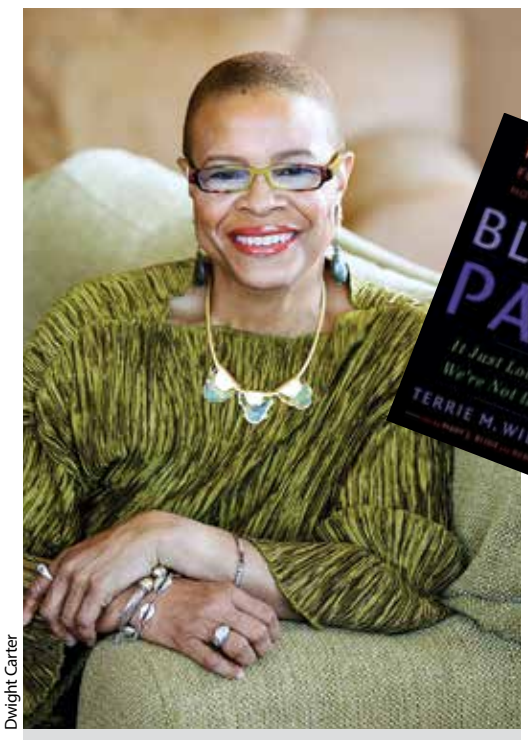
BY VABREN WATTS

Though more efforts have been set in motion to address the often unspoken presence of mental illness in the black community, mental health professionals are determined, more than ever, to keep this topic at the forefront of conversations pertaining to the health of African Americans.

Last month mental health professionals from around the nation gathered in Baltimore to discuss mental health care, or the lack thereof, among African Americans in urban communities.

"We are in great need of understanding the importance of our mental and emotional health," said Terrie Williams, L.C.S.W., author of the book *Black Pain: It Just Looks Like We're Not Hurting* and keynote speaker at "Black and Blue: The State of African American Mental Health," the inaugural event of this year's OMNA on Tour series, sponsored by APA's Division of Diversity and Health Equity.

Mental health care professionals listen to presentations at the OMNA on Tour event focused on the mental health of African Americans in urban areas.



Dwight Carter

Terrie Williams, L.C.S.W., author of *Black Pain: It Just Looks Like We're Not Hurting,* discussed how exposure to inner-city violence can have negative consequences on mental health.

Williams, who was raised and has a clinical practice in New York City, explained to conference attendees that African Americans face many hardships that affect mental health, ranging from racism to inner-city violence—yet many do not seek help.

Williams told *Psychiatric News* that it is impossible to quickly recover from traumatic events, such as witnessing a shooting, stabbing, or murder without receiving professional mental health care. "The mental health repercussions of these experiences will present themselves, either immediately or later in life," said Williams.

While the National Institute of Mental Health reports similar rates for mental illness among African Americans and the general population, African Americans are more likely to be burdened with disability associated with mental illness—stemming from lack of health insurance, absence of available services in the areas where many may reside, and a cultural stigma associated with mental health treatment.

Earlise Ward, Ph.D., a psychologist and an associate professor in the School of Nursing at the University of Wisconsin-Madison, explained that culturally competent care is crucial in improving utilization of mental health services by African Americans.

Photos: Alison Bondurant

Earlise Ward, Ph.D., speaks about culturally competent approaches, such as incorporation of religious beliefs, to more effectively treat depression in African Americans.

"Treatments for depression that are culturally sensitive tend to be four times more effective than the 'one size fits all' method," Ward told *Psychiatric News.*

According to Ward, efficacies of mental health treatments have been historically based on findings from white

see ***Baltimore Forum*** *on page 16*

MEMBERS IN THE NEWS

Psychiatrist Ready for Challenges Of Heading Huge MH System

Psychiatrist Ann Sullivan, M.D., will oversee reforms in New York state's mental health system, including a renewed focus on outpatient services and a move to Medicaid managed care.

BY EVE BENDER

As the first psychiatrist to helm the New York State Office of Mental Health (OMH) in nearly 30 years, Ann Sullivan, M.D., is poised to address the concerns and needs of her medical colleagues and their patients in the Empire State.

That is not to say she doesn't face critical challenges in the years ahead, as the funding environment shifts sharply, bringing changes in the ways psychiatrists practice and patients use services.

New York Gov. Andrew Cuomo (D) appointed Sullivan as acting commissioner in July 2013, and she took office in November. Her nomination is subject to confirmation by the New York Senate during the next legislative session. At press time, Sullivan was still acting commissioner.

It is in gradual yet significant steps throughout her career, she told *Psychiatric News*, that she prepared herself for her role as the leader of one of the nation's largest mental health systems.

It all began with her psychiatry rotation in medical school, which "was the most interesting thing I had ever done," she recalled. "I loved talking to patients and hearing their stories."

Community psychiatry was burgeoning during her psychiatry residency, which was at Bellevue Hospital Center from 1974 to 1978. In addition to the inpatient unit, there was a community residence, rehabilitation programs, and prevocational programs—"an intense continuum of services for patients at Bellevue had been arranged over the years that I had not seen elsewhere in medicine, and I found it fascinating."

Acting Commissioner Ann Sullivan, M.D., says psychiatrists can play a crucial role in the redesign of the mental health care system and encourages them to voice their opinions and concerns as leaders of treatment teams.

Administrative Experience Valuable

Sullivan experienced her first taste of psychiatry administration as chief resident, and later became medical director of Ambulatory Care Services at Gouverneur Health Services Diagnostic and Treatment Center, a community-based mental health center that provided a broad array of services to adults and families on Manhattan's Lower East Side. As medical director, Sullivan helped facilitate the referral process so that patients' primary care needs were also met. "This is where I first became interested in the interconnection between general medicine and psychiatry," she noted.

She moved on to become director of psychiatry at Elmhurst Hospital in Queens, where she established extensive Latino and Asian inpatient and outpatient services for the large immigrant community served by the hospital.

In her final role prior to being appointed acting commissioner, Sullivan was senior vice president for the Queens Health Network of the New York City Health and Hospitals Corporation, where she oversaw services provided by Elmhurst and Queens hospital centers.

As acting commissioner, Sullivan will oversee a plan to move patients with serious and persistent mental illness from Medicaid fee-for-service plans to Medicaid managed care plans that will provide integrated care—both psychiatric and general medical, she said. For those with the most serious mental illnesses, Sullivan noted, there will be "health and recovery services," which would extend above and beyond traditional treatment to cover peer supports, crisis intervention, employment readiness, and social skills training. She emphasized that "this is a statewide initiative—other states are trying to do this county by county, but we are unfolding this initiative as a state."

Outpatient Services to Be Bolstered

Yet another major initiative to trim excess health care costs will affect mental health practitioners and patients alike: beginning in July, Sullivan will start reducing the number of inpatient psychiatric beds across the state by approximately 400 so that there will be about 2,900 beds available. "Governor Cuomo has given us funding up front so that we can establish services before we start lowering the number of beds," Sullivan noted. The $25 million Sullivan receives this year will be invested in outpatient services such as home-based crisis intervention for children, supportive housing, mobile intervention teams, crisis respite beds, and basic clinic services, she said.

She acknowledged that psychiatrists, nurses, and others who had been accustomed to working on inpatient units may have to adjust their clinical skills to adapt to the changing environment, but there are learning tools to aid them—the New York State OMH and Columbia University's Department of Psychiatry established the Center for Practice Innovations in 2007 to promote the widespread use of evidence-based practices throughout New York state for this purpose (see box).

Sullivan and her team are also trying to find a solution to a mental health workforce shortage in New York, she said. "We have real problems with psychiatric coverage in the northern part of the state." OMH has formed a number of partnerships to ameliorate the problem. For instance it has collaborated with the American Academy of Pediatrics, the New York State Chapter of the American Academy of Family Physicians, and the Conference of Local Mental Hygiene Directors to establish Project TEACH, which provides consultation, education, and referral to primary care physicians statewide to provide care for children and adolescents with mental disorders.

APA Connections Forge Dialogue

Sullivan has for many years played an active role in APA and is a past speaker

see ***Sullivan*** *on facing page*

Innovation Drives Center's Education Efforts

To promote the widespread use of evidence-based practices, the New York State Office of Mental Health (OMH) and Columbia University's Department of Psychiatry in 2007 established the Center for Practice Innovations (CPI) at Columbia Psychiatry and the New York State Psychiatric Institute.

Acting OMH Commissioner Ann Sullivan, M.D., praised the agency's collaboration with Columbia to disseminate the evidence-based practices to providers in the state (see article above).

As part of this collaboration, the CPI features five initiatives that provide training in mental health and substance use disorders called Focus on Integrated Treatment, Assertive Community Treatment, Supported Employment via Individual Placement and Support, Wellness Self-Management, and First Episode Psychosis. There are also training initiatives on best practices with clozapine use, suicide prevention, and tobacco dependence.

According to Lisa Dixon, M.D., a professor of psychiatry at Columbia University Medical Center and director of the CPI, each initiative is taught using computerized modules, of which there are approximately 50. "We have shifted to think about how to train a new workforce using different learning strategies with these innovative methods," she told *Psychiatric News*.

Each of the computerized modules uses video presentations of people describing their experiences with recovery, for instance, or features clinical vignettes, interactive exercises, or knowledge checks for providers. Each initiative also features its own group of modules, and some target different audiences, including psychiatrists, psychologists, social workers, substance abuse counselors, and consumers, for instance.

According to Dixon, the collaboration between Columbia and OMH is mutually beneficial. "The public sector draws expertise from academia, and academia learns from best practices that emerge within the public sector. It is a very synergistic relationship."

More information about the CPI is posted at www.practiceinnovations.org.

FROM THE EXPERTS

Personality Disorders in a New Key

BY JOHN OLDHAM, M.D.

Personality and personality disorders are complex dimensional constructs, and it has been challenging to identify a single best classification system that could receive a strong consensus of support from the research and clinical communities. Furthermore, there is a growing drumbeat from the National Institute of Mental Health to move away from classification based on symptoms and, instead, to move toward research domain criteria (RDoC), referred to on the National Institutes of Health website as "new ways of classifying psychopathology based on dimensions of observable behavior and neurobiological measures."

I applaud this crusade to populate a roadmap of reliable biomarkers and genetic risk factors for psychiatric disorders. However, as laudable as that goal is, I do not believe it is ready for prime time. So in the meantime, as a bridge to that goal, we need to harness the best and most up-to-date evidence to identify, treat, and prevent brain disorders. That's how I think about *DSM-5*—the product of a lot of hard work by a lot of very smart and knowledgeable experts to update the shared language of our work.

A while ago I was asked, along with my co-editors Andy Skodol and Donna Bender, to put together a second edition of our *Textbook of Personality Disorders* and to include new material that would tie in to *DSM-5*. This new volume has just been published, with contributions from leading clinicians and researchers in the field, many of whom contributed to the first edition, plus some new contributors. All of them were asked to incorporate material referencing the Alternative Model (AM) for personality disorders (PDs) from Section III of *DSM-5*.

I thought it might be of interest to present a brief case from the new book to illustrate the useful new diagnostic term "personality disorder—trait specified."

Sara, a single, 25-year-old receptionist, had attended college for one year but dropped out to "go into advertising." Over the next five years, she held a series of receptionist, secretarial, and sales jobs, each of which she quit because she wasn't "getting ahead in the world." Sara lived alone in Chicago in an apartment that her parents had furnished for her. She ate all of her meals, however, at her mother's house and claimed not even to have a box of crackers in her cupboard. Between her jobs, her parents paid her rent.

Sara's "career" problems stemmed from the fact that although she felt ordinary and without talent for the most part, she had fantasies of a career as a movie star or high-fashion model. She took acting classes and singing lessons, but she never had even a small role in a play or show. What she desired was not so much the careers themselves as the glamour associated with them. Although she wanted to move in the circles of the "beautiful people," she was certain that she had nothing to offer them. Sara sometimes referred to herself as nothing but a shell and scorned herself because of it. She was unable to picture herself working her way up along any realistic career line, feeling both that it would take too long and that she would probably fail.

Sara had had three close relationships with men that were characterized by an intense interdependency that initially was agreeable to both parties. She craved affection and attention and fell deeply in love with these men. However, she eventually became overtly self-centered, demanding, and manipulative, and the man would break off the relationship. After breaking up, she would almost immediately start claiming that the particular man was "going nowhere," was not for her, and would not be missed. Between these relationships, Sara often had periods in which she engaged in a succession of one-night stands, having sex with as many as half a dozen partners in a month. Alternatively, she would frequent rock clubs and bars—"in-spots," as she called them—merely on the chance of meeting someone who would introduce her to the glamorous world of which she dreamed.

Sara had no female friends other than her sister. She could see little use for such friendships. She preferred spending her time shopping for clothes or watching television alone at home. She liked to dress fashionably and seductively, but often felt that she was too fat or that her hair was the wrong color. She had trouble controlling her weight and would periodically go on eating binges for a few days that might result in a 10-pound weight gain. She read popular novels but had few other interests. She admitted she was bored much of the time but also asserted that cultural or athletic pursuits were a waste of time.

This patient demonstrated clear personality pathology, and she met the general criteria for a PD using the Alternative Model (the first two of which are key: [A] moderate or greater impairment in self [in terms of identity and self-direction] and interpersonal [in terms of empathy and intimacy] functioning, and [B] one or more pathological personality traits). However, her pathological personality traits did not align with the patterns typical of any of the six specific PDs. As a result, her diagnosis using the AM would be "personality disorder—trait specified" and could be summarized as follows:

A. Severe impairment in personality functioning manifested by difficulties in

1. **Identity:** lack of a sense of self-worth, chronic feelings of emptiness (feeling like an empty shell)
2. **Self-direction:** inability to plan and implement a realistic career path, disconnect between acknowledged lack of talent and fantasies of stardom
3. **Empathy:** little ability to mentalize and consider another's viewpoint except in terms of meeting her needs, mostly self-referential
4. **Intimacy:** overintense and unrealistic involvement with romantic partners, inevitably not lasting due to lack of reciprocity and mature mutuality.

B. Pathological personality trait domains:

1. **Negative affectivity:** separation insecurity (overreliance on parents), submissiveness
2. **Detachment:** periods of anhedonia, depressivity, withdrawal, restricted affect
3. **Antagonism:** grandiosity, attention-seeking behavior, seductiveness, manipulativeness
4. **Disinhibition:** periods of impulsive overeating, sexual behavior, risky socializing.

Unlike the traditional diagnosis of PDNOS (referred to in *DSM-5* Section II as "other specified PD"), PD—trait specified is both a "rule-out" and a "rule-in" diagnosis; that is, not just a diagnosis by exclusion, but also an opportunity to individualize a patient's pathological trait profile, as demonstrated by the case above. In surveys and in the *DSM-5* field trials, clinicians have reported that the Section III new model for PDs enhances communication with patients and families and facilitates treatment planning. It is also worth underscoring that the AM is not in the "Conditions for Further Study" part of Section III, but, rather, is truly an alternative model that can be selected for clinical use if preferred. I would encourage trying it on for size. It may take a little getting used to, but in my opinion, it provides a coherent template that defines and organizes all of the PDs in a way that is logical and easy to remember and apply. PN

John Oldham, M.D., is chief of staff at the Menninger Clinic, professor and executive vice chair of the Menninger Department of Psychiatry and Behavioral Sciences at Baylor College of Medicine, and a past president of APA. He is co-editor of *The American Psychiatric Publishing Textbook of Personality Disorders, Second Edition,* which APA members can order at a discount at http://www.appi.org/SearchCenter/Pages/SearchDetail.aspx?ItemId=62456.

Sullivan

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of the Assembly, former member of the Board of Trustees, and is on the *Psychiatric News* Editorial Advisory Board. She has also been active in the New York State Psychiatric Association (NYSPA) as treasurer, so Sullivan—as mental health commissioners have done before her—met with NYSPA leadership in March "to see how we can work together to foster mental health in New York." However, noted Seeth Vivek, M.D., president of the NYSPA, this meeting was somewhat different.

"It was a pleasure to meet with Commissioner Sullivan," he told *Psychiatric News*. Vivek explained that it had been difficult to convey to previous commissioners who weren't psychiatrists what issues were important to the practice of psychiatry. "Commissioner Sullivan has worked in the trenches, so she understands what it is like to work in a psychiatric ER, for instance."

Together with Sullivan, NYSPA leadership tackled an agenda involving obstacles to access to care for patients receiving treatment in the public sector, and they have agreed to ongoing meetings, Vivek noted.

Sullivan has been meeting with other administrators and provider groups as well to describe OMH initiatives and what the office hopes to accomplish. She also makes time to see long-term patients at the New York State Psychiatric Institute. "I continue to see them because I have known them for so many years," she said.

"I would really encourage young psychiatrists to consider work in the public sector," she added "This is a wonderful career, and there are a multitude of opportunities—whether working as a team leader on a crisis unit, or working as an administrator, or setting policy. . .this is very exciting work." PN

CLINICAL & RESEARCH NEWS

Effects of Childhood Bullying Extend Into Middle Age

In light of data showing the long-term sequelae of childhood bullying, experts urge psychiatrists to take a more active role in attempts to reduce bullying in schools.

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BY VABREN WATTS

The consequences of being bullied in childhood may persist at least until middle age, taking an emotional toll and affecting multiple areas of life.

Researchers from the Institute of Psychiatry at King's College, London, conducted a study that followed 8,000 individuals for up to 50 years to assess the ramifications of childhood bullying victimization into adulthood. They reported their findings April 18 in *AJP in Advance.*

"This large-scale, longitudinal study documents the persistent and pervasive detrimental effects of childhood bullying," commented David Fassler, M.D., a clinical professor of psychiatry at the University of Vermont and a child and adolescent psychiatrist, who was not involved with the study.

"Despite increased awareness and the widespread implementation of school-based prevention programs, bullying remains a common experience for many young people," he told *Psychiatric News*, "with recent surveys indicating that as many as half of all children and adolescents are bullied at some time during their school years—and at least 10 percent being bullied on a regular basis."

According to the new study, relatively little is known about the long-term impact of bullying. Previous studies have assessed the impact of being the victim of childhood bullying into early adulthood—ages 18 to 25—but none have shown how being bullied during a person's formative years can affect mental health in middle adulthood.

To assess the consequences of childhood bullying victimization on midlife mental wellness, the researchers collected data from the British National Child Development Study, which has been following the lives of all children born in England, Scotland, and Wales during one week in 1958. The researchers analyzed information obtained from those individuals—along with information reported by their parents—concerning bullying exposures between ages 7 and 11. Follow-up assessments of participants were conducted between ages 23 and 50.

The results showed that childhood bullying was relatively common among this population in the 1960s, with 28 percent of the participants having been victimized by bullying and 15 percent having been exposed to frequent bullying.

Moreover, the sequelae were long-lasting for many of those on the receiving end of the bullying. Victims of childhood bullying had higher rates of depression, anxiety, and suicidal ideation at age 45, for example, compared with those who were not bullied. In addition, victims of childhood bullying were less likely to be living with a partner and have social relationships and were more likely to endure economic hardships, have a poor perceived quality of life, and self-report poor cognitive functioning at age 50.

The authors noted that the findings "emphasize the importance of gaining a better understanding of the mechanisms underlying the persistence and pervasiveness of the impact of childhood bullying victimization," adding that these findings "suggest that intervention efforts should aim to minimize poor health outcomes in young victims of bullying."

Stuart Twemlow, M.D., a retired professor of psychiatry at the Menninger Clinic at Baylor College of Medicine and an expert on bullying, agreed. "These results are straightforward and are fully expected as it relates to any type of childhood traumatization." Twemlow said that more psychiatrists need to address bullying behavior, which often has its origins in school settings.

"Psychiatrists need to have a more active role in school issues," Twemlow told *Psychiatric News.* "Psychiatrists need to be willing to sit down with schools and help to manage the extraordinary amounts of victimization indicated by the current studies. British schools represented in this study are no different from the schools in the U.S. when it pertains to this issue."

Because previous research has shown childhood bullying to negatively affect scholastic performance and coping skills into early adulthood, Twemlow stated that psychiatrists need to talk to all patients—no matter their age—about childhood bullying. Failure to do so, he said, "is a tragedy."

Twemlow concluded that because psychiatrists have a knowledge of the mind and body, as well as knowledge of the responsibilities of being a health care professional, "psychiatrists are in a unique position to help parents and schools tackle this major mental health issue." PN

"Adult Health Outcomes of Childhood Bullying Victimization: Evidence From a Five-Decade Longitudinal British Birth Cohort" is posted at http://ajp.psychiatryonline.org/data/Journals/AJP/0/appi.ajp.2014.13101401.pdf.

Baltimore Forum

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populations, with little or no incorporation of data from racial minority groups, as well as their beliefs, traditions, and value systems.

Data from research conducted by Ward and colleagues showed that treatment of African Americans for depression was more effective when they were being treated by clinicians of the same race, participated in regular group-therapy sessions, and were able to incorporate their personal religious beliefs.

"African Americans want to feel as though they are not struggling with mental illness alone, and [many] still want prayer to remain the first line of coping with mental illness. These findings are very important," Ward stated. "It's time to make changes and rally for mental health and illness as very essential issues in African Americans," she told the audience.

Other event speakers included Jean Smith, M.D., a clinical specialist with the Maryland Department of Mental Hygiene, who spoke on the warning signs of mental illness; and Carol Moore, M.S., R.N.C., an educational specialist at the Peninsula Regional Medical Center in Salisbury, Md., who discussed the benefits of laughter during periods of stress. The event also set a stage for community attendees to discuss openly their personal struggles with mental illness.

Alison Bondurant

A conference attendee relates her personal story about mental illness.

In speaking with *Psychiatric News*, Cynthia Major-Lewis, M.D., director of the Psychiatry Emergency Services at Johns Hopkins Hospital, who gave an overview of the racial disparities concerning the incidence of postpartum depression, said, "I've been in practice and going to conferences for 13 years. It was so impressive to see so many people feeling comfortable enough to give testimonies of their experiences with mental illness. We are really beginning to make some headway in the right direction to end mental health stigma in the black community." PN

More information on the OMNA on Tour programs is posted at http://www.psychiatry.org/practice/professional-interests/diversity/omna-on-tour-meetings.

Much More Being Learned About Tourette's Syndrome

A cognitive-behavioral intervention that helps suppress Tourette's tics—the comprehensive behavioral intervention for Tourette's— is one of the effective treatments that have recently emerged.

BY JOAN AREHART-TREICHEL

Ruth Bruun, M.D., is a semi-retired psychiatrist in Riverhead, N.Y. Her interest in Tourette's syndrome started during her psychiatry residency in the early 1970s. "I asked my superiors whether they would give me some exposure to neurologically based patients," she recalled during a recent interview. "So they sent me a Tourette's patient. Nobody knew anything about it really. It was considered an extraordinarily rare disease."

Even during the 1980s, "Tourette's was considered to be an extremely rare condition, one that most physicians wouldn't expect to see in their practices," Cathy Budman, M.D., a professor of psychiatry at Hofstra University and a Tourette's expert, said.

For example, the first Tourette's patient she encountered during her psychiatry residency "was spitting, twirling, and making all sorts of complex repetitive movements and sounds." He had been misdiagnosed as having schizophrenia, because the complex vocal tics he uttered were presumed to be psychotic ramblings, she recalled.

The good news for Tourette's patients and their families, however, is that vastly more has been learned about the illness since the 1970s and 1980s, John Walkup, M.D., said. He is director of the Division of Child and Adolescent Psychiatry at New York-Presbyterian Hospital and Weill Cornell Medical College and a Tourette's expert.

For instance, Walkup said, "In the mid-1980s, if you saw a youngster with Tourette's symptoms, then maybe one of his parents had them too. And once we realized that the condition ran in families, we were quite sure that genes were involved." And just this year, a gene that appears to play a causal role in Tourette's—at least in one family—has been identified, Budman said. It is a rare mutation in the histadine decarboxylase gene. When the mutated gene was incorporated in knockout mice, it produced Tourette-type symptoms.

The environment also may play a role in Tourette's, James Leckman, M.D., a professor of child psychiatry at Yale University and a Tourette's expert, pointed out. For instance, if two identical twins have Tourette's, the one with the lower birth weight is almost always the one with the worse tics. "And this raises the issue of what is going on during embryonic development. There is some evidence that maternal smoking during pregnancy and maternal stress during pregnancy can contribute to more severe Tourette's illness."

Psychosocial stress, even excitement, can provoke outbursts of tics in individuals with Tourette's, Leckman pointed out. "It is not uncommon for me to get a phone call from a family getting off the plane in Orlando, Florida, and complaining about how bad their child's tics have become because the child is so excited about visiting Disney World."

Scientists now realize that Tourette's tics probably arise from deep in the brain—at the level of the basal ganglia, Budman said. And the interneurons within the basal ganglia causing these excessive hyperkinetic movements may be to blame, Leckman reported, since postmortem brain studies have indicated that interneurons in the basal ganglia are diminished in individuals with severe Tourette's. Interneurons, he explained, exist within the basal ganglia and orchestrate, to some degree, what types of information the neurons in the basal ganglia convey to other parts of the brain.

"There is also some emerging information about the importance of neuroinflammatory processes in the brains of individuals with Tourette's," Leckman noted.

halfpoint/Shutterstock

"Actually one of the interesting features about Tourette's is that if you do something that requires focus, attention, and motor control – say, sing a song, juggle a ball, or play ping pong – the tics stop," said James Leckman, M.D., a professor of child psychiatry at Yale University.

Tourette's Syndrome Experts Cite Rewards

Treating patients with Tourette's syndrome can be very gratifying, experts on the illness interviewed by *Psychiatric News* agreed.

"Many young patients with Tourette's profit from treatment," said Cathy Budman, M.D., a professor of psychiatry at Hofstra University. "And the good news about Tourette's syndrome is that for most people, the tics tend to improve quite a bit by late adolescence and early adulthood."

"Most patients get better, most patients do very well," John Walkup, M.D., director of the Division of Child and Adolescent Psychiatry at New York-Presbyterian Hospital and Weill Cornell Medical College, attested. "You can help them not only with their tics, but with their anxiety, obsessive-compulsive disorder, attention-deficit/hyperactivity disorder, or other comorbidities. Often such comorbidities are more of a problem for someone with Tourette's than their tics are."

"Getting to know Tourette's patients and their specialness can also be rewarding," said James Leckman, M.D., a professor of psychiatry at Yale University School of Medicine. "Tourette's patients are often extremely artistic or creative, I've found. It may be because their brains interconnect in ways that differ from the brains of other people."

Effective Treatments Become Available

And just as more has been learned about Tourette's in recent years, progress has also been made in devising effective treatments for it.

There are two medication groups that are effective in subduing Tourette's tics, Walkup said. "One is the alpha agonists—medicines like clonidine—and the other is the antipsychotics. They help because they block dopamine."

Regarding the alpha agonists, he explained, "Most side effects are identified early in treatment, and if a young person can't tolerate them at a certain dose, then you go down in the dose. And if that doesn't work, then you discontinue it. There are really no ill effects from having given the medication to see whether it is useful or not in a particular patient." As for the antipsychotics, he said, "Many people do well on low doses, but the doses are not always easy to tolerate."

"Usually when patients come to me and require medication for tics, I start them on what I consider to be the mildest medication, which would be the alpha adrenergic blockers such as clonidine, especially if they are children," Bruun said. "If that doesn't work, then I go on to the antipsychotics. In the old days, haloperidol was considered the medication to use, but not today, and I use it only as a last resort. I try to use the newer antipsychotics first and in low doses. Most patients don't require that much."

Then during the past two years or so, a cognitive-behavioral intervention for Tourette's has emerged that appears to be effective in suppressing tics, said Walkup. It is called the comprehensive behavioral intervention for Tourette's (CBIT).

"Actually, one of the interesting features about Tourette's is that if you do something that requires focus, attention, and motor control—say, sing a song, juggle a ball, or play ping pong—the tics stop," Leckman said. "CBIT is based on this principle. First a patient has to become aware of the urges to tic, then produce a competing response—say, sing a song or toss a ball—whenever he or she feels the urges. And as the patient engages in the competing response, the urge to tic diminishes."

"CBIT has been demonstrated to be quite effective for both children and adults with Tourette's tics," Budman commented, "and in the case of children, it actually has an effect size that is comparable to risperidone, which is pretty exciting considering that it is a nonpharmacological intervention."

More Help for Patients Is on Horizon

And still more knowledge about Tourette's and ways to treat Tourette's patients may be coming during the next decade or so.

"I think we'll have a better understanding of what the brain mechanisms of Tourette's are," Leckman predicted. "I think the neuroinflammatory story will emerge. Also regarding the affective disorders, autism, and schizophrenia, there is a limited amount of data emerging that suggest that inflammatory processes may be an important element in the etiology of these conditions."

"We would love to be able to identify the genetic causes," Walkup stated. "That is something various Tourette's experts are working on. Although certain brain regions appear to be involved in Tourette's, we still don't know where Tourette's really originates. So brain imaging studies are important. And even though most patients get better with medication or behavioral treatment, there is still a minority who have symptoms in spite of what we do. It would be great to have more effective treatments."

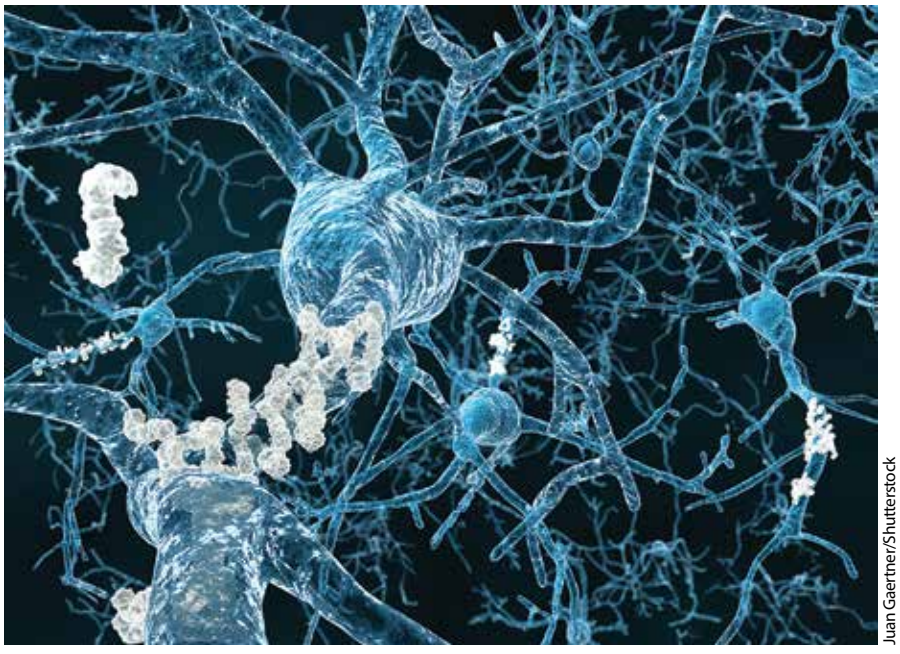
"It is quite likely that we will be learning more about the genetics of Tourette's," Budman said, "and such knowledge will help us become much more adept at treating different clinical presentations of Tourette's instead of the trial-and-error method we have been using up to now. I think the neuroimaging and neurophysiology studies will be very fruitful. And if we come up with a good animal model for Tourette's, progress in combatting it will be that much faster." PN

CLINICAL & RESEARCH NEWS

Artery Stiffness Linked With Amyloid Plaques in Brain

Consistent and long-term treatment of high blood pressure may blunt the progression of arterial stiffness and perhaps prevent deposition of beta-amyloid in the brain.

BY JOAN AREHART-TREICHEL



Juan Gaertner/Shutterstock

Recent studies have shown that more than half of individuals aged 80 or older have significant amounts of beta-amyloid plaques—a hallmark of Alzheimer's disease—in their brains. Yet with the exception of the presence of the APOE-e4 gene variant, the reasons why beta-amyloid plaques accumulate in the brains of older people are not well understood.

Some research has suggested, however, that the stiffness of arteries in the body—a sign of subclinical vascular disease—might play a role in the plaque deposits. So Timothy Hughes, Ph.D., and colleagues at the University of Pittsburgh conducted a longitudinal study to determine whether there might be an association between the degree of arterial stiffness in the body and the accumulation of beta-amyloid in the brains of older people.

Their study included 81 individuals aged 83 or older and lasted two years. Arterial stiffness was measured with a noninvasive method called pulse-wave velocity. Brain levels of beta-amyloid were detected with PET scans, both at baseline and at follow-up.

As the researchers reported March 31 in *JAMA Neurology*, the proportion of beta-amyloid-positive individuals increased from 48 percent at baseline to 75 percent at follow-up. Moreover, even when some possible confounders were considered, each standard-deviation increase in arterial stiffness was associated with a fourfold increase in the odds of being beta-amyloid-positive at follow-up. Furthermore, arterial stiffness in the subjects was strongly associated with the amount of beta-amyloid deposited in their brains at follow-up.

Thus "arterial stiffness is a strong indicator of the extent of beta-amyloid deposition and its longitudinal accumulation over time," the researchers concluded.

Although the exact mechanisms linking arterial stiffness and beta-amyloid deposition are unknown, the researchers suggested potential explanations. For example, "It is possible that increased arterial stiffening has a direct influence on penetrating arterioles of the brain, leading to altered structure and function, with subsequent effects on beta-amyloid clearance from the brain via cerebrospinal fluid drainage along the perivascular space."

"Even at this early stage, these findings have clinical relevance for several reasons," Hughes, who is now a postdoctoral scholar at Wake Forest School of Medicine, told *Psychiatric News*. "First, this and other recent studies suggest that amyloid plaque formation appears to be part of the aging process (shared with Alzheimer's disease). . . . Second, arterial stiffness measured by pulse-wave velocity is a strong predictor of the extent. . .and progression. . .of brain amyloid; yet blood pressure alone is not informative," he pointed out. "Neurologists, psychiatrists, or other clinicians aren't going to rush out and get pulse-wave analyzers like those used in our study. However, they can appreciate that controlling factors that contribute to arterial stiffness may also be important for the brain. These include longstanding hypertension, insulin resistance, dyslipidemia, and atherosclerosis. They are already established risk factors for Alzheimer's. . . ." He emphasized that, "Consistent and long-term treatment with antihypertensives, as soon as hypertension is detected, may blunt the progression of arterial stiffness. Future research will tell if this approach can also prevent the deposition of brain amyloid."

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

An abstract of "Arterial Stiffness and Beta-Amyloid Progression in Nondemented Elderly Adults" is posted at http://archneur.jamanetwork.com/article.aspx?articleid=1851478.

Drug to Enhance NMDA Receptors Studied to Treat Negative Symptoms

Though one NMDA receptor enhancer has shown mixed results in treating negative symptoms, experts on the subject believe that these medications might help some patients with such symptoms.

BY JOAN AREHART-TREICHEL

An experimental drug called bitopertin, which enhances NMDA receptor activity—that is, boosts glutamate action in the brain—was found in a phase 2 clinical trial to exert modest effects against the negative symptoms of schizophrenia, according to a study by Luca Santarelli, M.D., senior vice-president of neuroscience at Switzerland-based F. Hoffman-La Roche, and colleagues published online April 2 in *JAMA Psychiatry.*

Deficient NMDA receptor activity has been thought to play a role in the negative symptoms of schizophrenia. The NMDA receptor transmits the signaling of glutamate, the major excitatory neurotransmitter in the brain. However, to do its job, the receptor also needs the amino acid glucine to bind to it.

Thus Santarelli and his team wondered whether a drug that boosts glycine levels and in turn enhances NMDA receptor activity, such as the experimental drug bitopertin, might counter negative symptoms in individuals with schizophrenia. And they launched a phase 2 randomized, double-blind, placebo-controlled trial in 66 sites in Brazil, France, Germany, Hungary, Japan, Mexico, Poland, Russia, and the United States to find out.

The trial involved 323 subjects with schizophrenia and with predominantly negative symptoms. The subjects were randomized to receive, for eight weeks, not only standard antipsychotic therapy, but one of four treatments—bitopertin in daily dosages of either 10 mg, 30 mg, or 60 mg a day, or a placebo. The main outcome measure was a change from baseline in the Positive and Negative Syndrome Scale (PANSS) negative factor score. Functioning was evaluated with the Personal and Social Performance (PSP) scale.

The reduction of the PANSS negative factor score was significantly greater in the subjects who received 10 mg or 30 mg a day of bitopertin than in subjects who received a placebo. In contrast, the reductions of the score in subjects who received 60 mg a day of bitopertin and in subjects who received a placebo were comparable.

Moreover, the greatest effect of bitopertin on functioning as evaluated with the PSP scale was observed in the bitopertin group taking 10 mg a day. Changes from baseline PSP total score for the other two bitopertin dose groups did not differ from those in the placebo group.

"Overall, 10 mg a day of bitopertin was most efficacious in reducing negative symptoms. . .while 30 mg a day produced a similar, but somewhat weaker, effect," the researchers concluded. They had found comparable results in preclinical studies, they noted. Thus, low or moderate doses of bitopertin appeared to be optimal for best clinical efficacy.

In an accompanying editorial, Donald Goff, M.D., a professor of psychiatry at New York University and an expert on translational schizophrenia research, said, "Although the therapeutic effect [of bitopertin] was only modest, this is very

see ***NMDA Receptors*** *on page 33*

Several Therapies Show Success In Treatment of Personality Disorders

Although trying to help individuals with personality disorders can be challenging for clinicians, several evidence-based psychotherapies are available to treat these patients.

BY JOAN AREHART-TREICHEL

If there is anything that personality disorder experts tend to agree on, it's that attempting to help individuals with the illness can be challenging.

For example, a number of years ago, during his residency, John Gunderson, M.D., a professor of psychiatry at Harvard Medical School and a personality disorder expert, encountered his first borderline personality patients. "These were patients everybody was complaining to their supervisors about," he related during a recent interview, "and nobody knew what to do for them. I published some descriptive comments about them because I wanted to place some control on the situation, which seemed scary to me. After that, colleagues started sending me patients with not just borderline, but with narcissistic personality disorder or with antisocial personality, because they thought I knew how to treat them. But I didn't!"

"You have to have a thick skin in attempting to treat borderline patients," stated Joel Paris, M.D., a professor of psychiatry at McGill University in Montreal, Canada. "These can be difficult patients. They tend to be emotional, sometimes contrary. They attempt suicide or threaten to. Some psychiatrists don't want to deal with such behavior."

"Each personality disorder presents its own challenges," pointed out Stuart Yudofsky, M.D., chair of psychiatry at Baylor College of Medicine and a personality disorder expert. "People with paranoid personality disorder have trouble trusting what the clinician advises. People with narcissistic personality disorder often feel that it is demeaning to acknowledge that they have a problem and need help from another person. People with borderline personality disorder are often unstable and moody."

But during the past decade or two, evidence-based psychotherapies have become available to treat patients with some of the personality disorders.

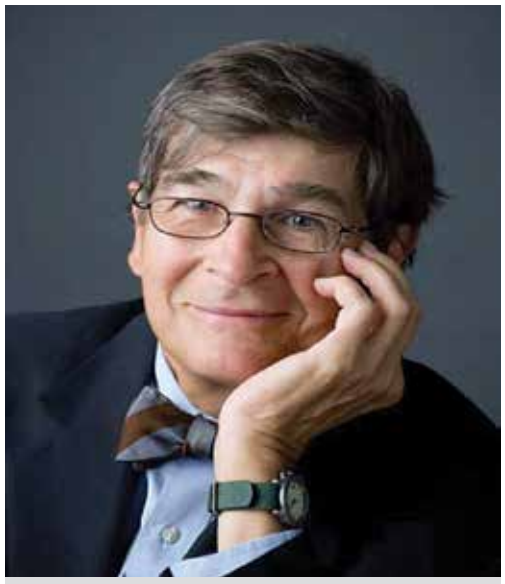
Evidence Builds for Psychotherapy Efficacy

"We had no evidence-based treatments for personality disorders at all until psychologist Marsha Lenahan published her first results regarding dialectical behavioral therapy [DBT] and borderline personality disorder in 1991," Paris said. "DBT is a form of cognitive-behavioral therapy. Since then, evidence in this regard has become so strong that DBT has become kind of the gold standard for treating borderline."

Gunderson agreed: "The strongest evidence base as far as borderline treatment is concerned is for DBT."

"The psychotherapy with the next strongest evidence base is mentalization therapy, followed by transference-focused therapy," said Kenneth Silk, M.D., a professor of psychiatry and director of the personality disorders program at the University of Michigan.

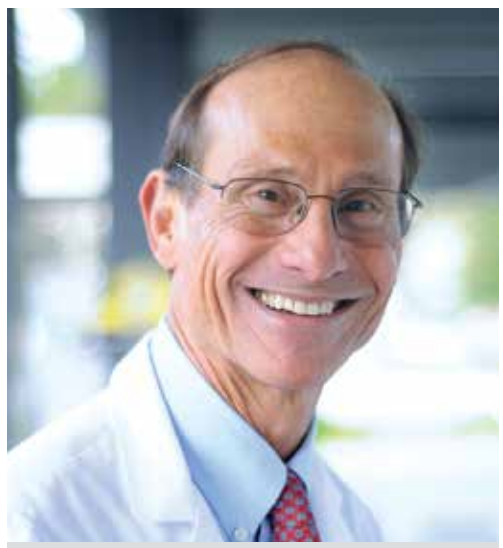
"More recently, Nancee Blum, L.I.S.W., a psychotherapist at the University of Iowa, and her colleagues have developed the STEPPS [Systems Training for Emotional Predictability and Problem Solving] program, which has gained tremendous traction for treating borderline personality disorder," James Reich, M.D., a clinical professor of psychiatry at the University of California, San Francisco, told *Psychiatric News*. And as Paris explained, "STEPPS is a shorter therapy, similar to DBT, and is offered to groups to augment treatment in general clinics."



John Gunderson, M.D.: "These are people who can change more than we thought, and clinicians can be more helpful than they think in facilitating change."

"Evidence also suggests that schema therapy, which includes the extensive processing of negative childhood experiences with work to evoke emotions and facilitate emotional change, is effective for borderline personality," Reich pointed out. "Schema therapy has also been found to benefit prison populations—which includes individuals with antisocial personality disorder."

And a study published in the March *American Journal of Psychiatry* found that schema therapy could benefit patients with avoidant, dependent, obsessive-compulsive, histrionic, narcissistic, or paranoid personality disorders. "This study is of interest as it suggests that a therapy centered on re-experiencing trauma in a supportive treatment may be helpful in treating some forms of personality disorder," noted Larry Siever, M.D., a professor of psychiatry at Mount Sinai School of Medicine.



Stuart Yudofsky, M.D.: "I believe that all people with personality disorders are treatable, even those with antisocial personality disorder."

"There is less evidence for psychodynamic forms of treatment than there is, for example, for behavioral forms of treatment. But that doesn't necessarily mean that one is better than the other," Yudofsky pointed out.

No medications have been approved by the Food and Drug Administration to treat personality disorders, but there is evidence that some medications can help in this domain.

Several Medications Studied

"For instance, some interesting preliminary studies have suggested that the anticonvulsant Depakote can help with impulsive behavior," Reich said. "Also, as avoidant personality disorder appears to be the same disorder, only more severe, than social anxiety disorder, medications that help social anxiety disorder will likely help avoidant personality disorder. There is good evidence that when anxiety or depression happens to be present at the same time as personality disorders, treating the anxiety or depression can help reduce the personality pathology."

And low-dose antipsychotics "can calm people with borderline personality down a bit, but unfortunately they don't produce remission," Paris remarked.

"As for the emotional lability of borderline personality disorder, there is probably a tad more evidence for the use of mood stabilizers than for atypical antipsychotics," said Silk.

What Does Future Hold?

Will the next decade bring more evidence-based treatments for personality disorders? Donald Black, M.D., who collaborated with Blum on the STEPPS program, is optimistic: "I think my experience is not unlike that of a number of other researchers in the personality disorder field. We are seeing an explosion of research, but often it is research that is not well supported by the government. It is work that we have had to figure out how to do without good sources of funding."

In any event, Black said, "Hopefully we'll have a better understanding of the psychotherapies that have been developed for personality disorders so that we can match patients to treatments. And hopefully we'll also have a better sense of which patients respond to which type of medication. For example, perhaps one borderline patient would do better with a mood stabilizer, another might do better with an atypical antipsychotic, whereas another might do better with an SSRI antidepressant. And hopefully, the psychotherapy programs that are now evidence based will become more widely available so that people will be able to find those treatments available in their own regions."

Meanwhile, personality disorder experts are urging their psychiatrist colleagues to use the tools available now to help patients with these disorders. "I think the most important thing is, these are patients who are treatable, but you have to make the diagnosis first," Paris asserted.

"These are people who can change more than we thought, and clinicians can be more helpful than they think in facilitating change," Gunderson observed.

"I believe that all people with personality disorders are treatable, even those with antisocial personality disorder," said Yudofsky. "But the big thing is that the person must be engaged in treatment, which means that he or she must be motivated to change and willing to work with the therapist." PN

JOURNAL DIGEST

BY VABREN WATTS

Drug Education Prompts Elderly to Reduce Benzodiazepine Use

Discontinuing use of benzodiazepines by the elderly is made easier when patients are educated about the medication's potential harm, according to a study published last month in *JAMA Internal Medicine*.

Researchers from the departments of pharmacy and geriatrics at the University of Montreal conducted a study to determine whether educating older patients on the health risks of benzodiazepines would serve as an effective method to discourage the use of such drugs. The study included 303 long-term users of benzodiazepines aged 65 to 95. The participants were randomly selected to receive a booklet describing adverse health risks of benzodiazepines, along with instructions on how to safely reduce use of the medication and information on alternative strategies for treating insomnia and anxiety. They were compared with a cohort that received no such information.

At the six month follow-up, the results showed that 62 percent of the patients who received booklets initiated a conversation with their physician or pharmacist about benzodiazepine cessation, while 27 percent discontinued their use. Patients who were not educated on the potential harms of benzodiazepines had a discontinuation rate of 5 percent.

The authors said, "In an era of multimorbidity, polypharmacy, and costly therapeutic competition, direct-to-consumer education is emerging as a promising strategy to stem potential overtreatment and reduce the risk of drug harms." They concluded that "the value of the patient as a catalyst for driving decisions to optimize health care utilization should not be underestimated."

Tannenbaum C, Martin P, Tamblyn R, et al. "Reduction of Inappropriate Benzodiazepine Prescriptions Among Older Adults Through Direct Patient Education: The EMPOWER Cluster Randomized Trial." 2014. JAMA Intern Med. Apr 14. [Epub ahead of print] https://archinte.jamanetwork.com/article.aspx?articleid=1860498

Mobile App Aids in Recovery From Alcohol Abuse

A study in *JAMA Psychiatry* suggests that smartphones could be effective in providing continued intervention for individuals recovering from alcohol use disorder (AUD).

Researchers in the departments of Industrial Engineering and Preventive Medicine at the University of Wisconsin-Madison randomized 349 patients who were recently released from a residential program for AUD to receive typical treatments, such as monthly therapy sessions, or typical treatments plus a smartphone with the Addiction-Comprehensive Health Enhancement Support System (A-CHESS) application. The application consisted of audio-guided relaxation techniques and alerts if patients neared a high-risk location for drinking, such as a bar they once frequented.

After one year of follow-up, the smartphone intervention group reported approximately 1.5 fewer risky drinking days—days in which a male patient exceeded four standard drinks and a female patient exceeded three standard drinks in a two-hour period—than those who did not a receive the smartphone intervention. In addition, 52 percent of individuals in the smartphone cohort reported abstinence from drinking in the 30 days prior to the one-year follow-up, compared with 40 percent in the non-smartphone cohort.

John Luo, M.D., a senior informaticist and professor of clinical psychiatry at the University of California at Los Angeles, who was not involved in the study, told *Psychiatric News* that the study's "smartphone [app] works similarly to apps that help patients lose weight by having them record their caloric intake—since the process of entering values and seeing results helps shape behavior." Luo explained that the main innovation in the current study is the GPS tracking device, which serves as a "panic button" when patients are near high-risk locations for drinking. Luo concluded that though no one app is a perfect fit for all, "any application that increases the likelihood for patients to maintain abstinence is a start in the right direction."

Gustafson D, McTavish F, Chih M, et al. "A Smartphone Application to Support Recovery From Alcoholism." 2014. JAMA Psychiatry. Mar 26. [Epub ahead of print] http://archpsyc.jamanetwork.com/article.aspx?articleid=1847578&resultClick=3

Alternative Therapy May Help Prevent Onset of Major Depression in Elderly

Scientists from the University of Pittsburgh Medical Center report in *Psychiatric Services in Advance* that problem-solving therapy for primary care (PST-PC)—an intervention delivered by nonmental health professionals to help patients improve coping skills and confidence—may be beneficial for older adults who are at risk for major depression.

Charles Reynolds III, M.D., a professor of geriatric psychiatry, and colleagues evaluated the efficacy of PST-PC in preventing episodes of major depression and reducing depressive symptoms in elderly adults. The study included approximately 250 individuals with subsyndromal depressive symptoms who received 15 months of PST-PC, a technique that has been shown to reduce stress, or dietary coaching, which had been shown to reduce depression risk in an elderly population in a previous study by Reynolds. The two cohorts were compared with each other in addition to being compared with age-matched cohorts from previously published studies of those who received neither therapy for subsyndromal depressive symptoms.

After two years, the analysis showed PST-PC to be as effective as dietary coaching in preventing episodes of major depression in this at-risk cohort. Incident rates for major depression in both cohorts were approximately 9 percent, compared with published rates of 20 percent to 25 percent in those who received neither treatment. The researchers also observed a significant reduction in depressive symptoms in both the PST-PC and dietary-coaching groups.

"Avoiding episodes of major depression can help people stay happy and engaged in their communities," said Reynolds. "This project tells us that interventions in which people actively engage in managing their own life problems. . .tend to have a positive effect on well-being and a protective effect against the onset of depression."

Reynolds C, Thomas S, Morse J, et al. "Early Intervention to Preempt Major Depression Among Older Black and White Adults." 2014. Psychiatr Serv. Mar 17. [Epub ahead of print] http://ps.psychiatryonline.org/article.aspx?articleid=1850038

Flashon Studio/Shutterstock

Participation in cardio fitness activities during young adulthood helps prevent loss of memory and thinking skills during middle age.

Aerobic Activity in Young Adulthood May Preserve Midlife Cognitive Function

Young adults who participate in cardio fitness activities such as running may be doing more than helping to preserve their heart function—they may be helping to preserve their memory and thinking skills as well.

Researchers at the University of Minnesota conducted a study with nearly 3,000 healthy individuals in their mid-20s to assess the relationship between aerobic exercise and cognitive function. The participants were subjected to one year of treadmill tests at study initiation and another series of treadmill tests, in addition to cognitive tests, 20 to 25 years later. During the treadmill tests, participants were evaluated on their ability to endure increasing speeds and inclines without shortness of breath.

Results showed that participants lasted an average of 10 minutes on treadmills during young adulthood, compared with an average of 7.1 minutes at middle age. Every additional minute completed on the treadmill during young adulthood was significantly associated with more words and numbers being recalled on tests evaluating memory and psychomotor speed at ages 45 to 55—even after adjusting for factors such as smoking, diabetes, and cholesterol level.

Dilip Jeste, M.D., director of the Sam and Rose Stein Institute for Research on Aging at the University of California, San Diego, and a professor of psychiatry and neurosciences, told *Psychiatric News* that "though the findings need to be replicated in prospective longitudinal research, . . . the findings suggest that activities such as running can potentially reduce cognitive impairment in later life. Following these adults into old age may help determine if neurocognitive disorders such as dementia are less common in the individuals who engaged in vigorous exercise at younger age." Jeste, who is a past president of APA, urged clinicians to encourage physical activity, especially aerobic exercise, in all of their patients—young and old—according to the patient's personal physical capacity. "It can help not only their muscles and heart, but possibly also their brains in later life." PN

Zhu N, Jacobs D, Schreiner P, et al. "Cardiorespiratory Fitness and Cognitive Function in Middle Age: The CARDIA Study." 2014. Neurology. 82(15):1339-46. http://www.neurology.org/content/82/15/1339.short?sid=2c5a3f20-d2e6-418f-83db-cf73a8a661dd

Ellen Stover, Ph.D., Pioneering AIDS Researcher, Dies

Ellen Stover, Ph.D., a neuroscientist with a distinguished career at the National Institute of Mental Health (NIMH) died March 16.

Stover began work at NIMH in the 1970s, embarking on a career in behavioral science research that would span decades. She became the director of the Center for Mental Health Research on AIDS at NIMH in 1988 and a division director in 1997, first of the Division of Mental Disorders, Behavioral Research, and AIDS and most recently of the Division of AIDS Research. As the director of the Division of AIDS Research, her work on the behavioral and psychological factors contributing to HIV/AIDS transmission was instrumental in developing successful programs for education, prevention, and treatment. In more recent years, she expanded her work to include research programs on schizophrenia.

NIMH Director Thomas Insel, M.D., said in a statement that Stover's international leadership fighting for those at risk for or already infected with HIV led to many awards, including NIMH and NIH Director's awards and the UCLA/Drew University Distinguished Achievement Award. "In addition to her leadership in AIDS research, Ellen and her colleague Wayne Fenton led the NIMH effort to find new treatments for the cognitive deficits in schizophrenia. Ellen recruited some of the best and brightest to the NIMH extramural program, using her administrative and leadership skills to create outstanding program officer teams," Insel said.

Immediate Past APA President Jeffrey Lieberman, M.D., said, "Ellen's passing is sad in so many ways for me personally as well as for the field of mental illness research. She was my first program officer at the NIMH who supported me through my first successful grant application. But it was a short-lived relationship, as this was the early 1980s and Ellen was selected to head up the NIMH's initiative in AIDS. We connected again professionally when she assumed responsibility for the Adult Translational Division. In this context, she formed a close relationship with Wayne Fenton who had recently joined the NIMH and proved a quick study of the mechanics of clinical research from the NIH side and became a valuable addition to the institute. Ellen and Wayne were inseparable and shepherded many grants and investigators successfully. . . . I will remember Ellen fondly and as representing what the NIMH does best—encouraging and supporting young investigators and advancing the field of research on mental illness." PN

Biden

continued from page 1

imagine how the moon landing would yield technologies for semiconductors and the iPhone, I don't think we can begin to imagine the breakthroughs that will occur tomorrow as a consequence of this BRAIN Initiative."

He added that the Mental Health Parity and Addiction Equity Act and the Affordable Care Act open new opportunities for patients to access treatment. "A major step forward is breaking down the structural barriers [to care] and expanding access," he said. "I am fully aware that enforcement is the key, but patients are now empowered to find out more information and to hold their insurer accountable if they are denied coverage. None of us believe that will automatically happen—this is new territory. But rest assured that we know the next step is enforcement and getting it right."

Biden hailed the work of psychiatrists, recalling a visit he received from a college roommate whose son had serious mental illness. "I remember the metaphor he used. . . . He said, 'I don't know what to do. I feel like my boy is at the end of a string, and if I pull too hard it will break. And I will lose him forever.'

"I found the metaphor incredibly compelling," Biden said. "There are too many people who know that feeling—they don't know what to do, but they know if they pull too hard that string may break and they will lose their blood.

"But you give them hope they are not alone," Biden said to the thousands of psychiatrists sitting before him and watching from monitors placed at a number of annual meeting locations. "We need you more than ever, and frankly we need more of you. You are the only ones who can help pull the string and significantly decrease the prospect that it will break."

APA leaders hailed the vice president's remarks. "I am delighted that Vice President Biden accepted our invitation to address the thousands of attendees at APA's 2014 annual meeting," said APA President Jeffrey Lieberman, M.D. "The vice president has been an ardent advocate for improved mental health services, the elimination of stigma, and increased research on mental illness. The administration's pledge last year to devote $100 million to increasing access to mental health services, convening the White House National Conference on Mental Health in 2013 and the Brain Research Through Advancing Innovative Neurotechnologies Initiative, has demonstrated the president's and vice president's commitment to addressing this critical public-health need. Vice President Biden has shown great insight and compassion for the plight of individuals with mental illness and appreciation for the ability of health care services to reduce the suffering of the people so afflicted and the burden of illness to our country."

Incoming APA President Paul Summergrad, M.D., called Biden a "staunch ally in the battle to end the stigma surrounding mental illness and to guarantee that everyone who needs appropriate psychiatric care receives it. It was a rare honor to hear Mr. Biden say this with the true passion that he so clearly feels. We are grateful for the support of the vice president and the administration for making sure that mental health care occurs for all who need it."

APA CEO and Medical Director Saul Levin, M.D., M.P.A., said, "It is to the nation's benefit that we in the mental health and psychiatric treatment field can look forward to participating in the work with Vice President Biden that will transform the way mental illness is treated in this country with respect to equality of services, access, and network adequacy for persons with mental health needs." PN

Autism

continued from page 7

he reported on what became of those first 11 children. Even with similar initial presentations, they showed heterogeneous outcomes.

Donald T., who had good family and social support, would go on to earn a college degree and work in a bank, said Harris. "He didn't make eye contact or understand the feelings of others, but he was the best person the bank had to count out money."

Others led productive lives as well, one running copying machines in an office and another working first on a farm and then as an assistant to elderly nursing-home residents. Among the others, two were lost to follow-up and several were institutionalized.

Kanner saw little concrete progress in 1971 toward understanding or treating autism, but he was not without hope. "[A] 30- or 20-year follow-up of other groups of autistic children will be able to present a report of newly obtained factual knowledge and material for a more hopeful prognosis than the present chronicle has proved to be," he concluded. PN

Kanner's paper, "Autistic Disturbances of Affective Contact," is posted at http://neurodiversity.com/library_kanner_1943.pdf. An article in *The Atlantic* that brings the story of Donald T into the 21st century is posted at http://www.theatlantic.com/magazine/print/2010/10/autisms-first-child/308227/.

NMDA Receptors

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welcome news because the path to drug development in schizophrenia has been littered with disappointments."

The bad news, however, Goff pointed out, is that on January 21, Roche announced that two phase 3 trials of bitopertin for negative symptoms failed to achieve primary end points. "Once again, we are faced with the dilemma of an initial rigorous trial providing support for a compound that is well-grounded in preclinical and clinical studies, followed by a failure to replicate. . . ."

While expressing his disappointment with the phase 3 results for bitopertin, Serdar Dursun, M.D., a professor of psychiatry and neuroscience at the University of Alberta in Canada, said that he remains optimistic that drugs that enhance the NMDA receptor might ultimately prove useful in treating negative symptoms. "There must be improved clinical trial methods that include identification of biomarkers so as to reduce the patient heterogeneity problem in schizophrenia studies," he explained. "It is possible that modulating the NMDA receptor complex via the glycine site may require a personalized patient-tailored approach involving perhaps pharmacogenetic and/or other studies on biomarkers."

Indeed, "It's possible that a subgroup of patients might benefit from these agents, but Roche wasn't able to identify a biomarker that would predict response," Goff commented to *Psychiatric News.*

The study was funded by F. Hoffman-LaRoche Ltd. PN

An abstract of "Effect of Bitopertin, a Glycine Reuptake Inhibitor, on Negative Symptoms of Schizophrenia" is posted at http://archpsyc.jamanetwork.com/article.aspx?articleid=1852597.

Awards

continued from page 6

health issues within the military, the office contracted with Homefront Communications to execute graphic designs. "After being presented with three graphic design choices, we were convinced that the camouflaged brain was a great way to illustrate military mental health concerns," Dart said.

Dart, whose father served in the Vietnam War and lost his life to suicide, said that the award-winning infographic was intended to relay to service members, veterans, and their families that "getting help for mental illness is a sign of strength, not weakness."

Though the infographic was released around Veterans Day 2013, Dart said that the infographic continues to receive positive feedback from social media and other media outlets.

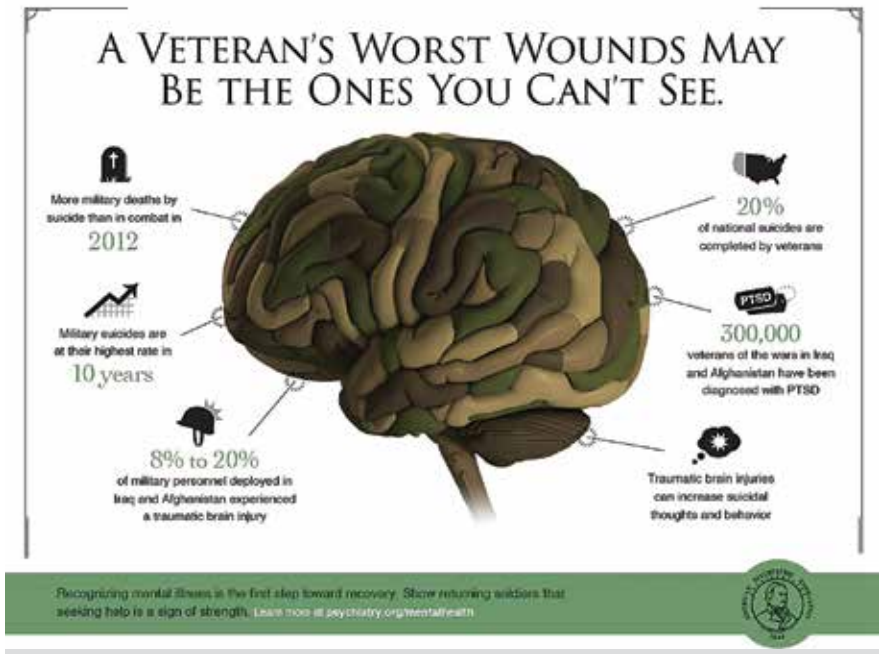
A total of seven gold ADDY awards were given to the American Psychiatric Foundation's (APF) Partnership for Workplace Mental Health for the program's Right Direction initiative.

The Right Direction campaign's "Got a Case of the Mondays" wins an award for best handout.

Clare Miller, director of the partnership program, told *Psychiatric News* that she was not too surprised by the wins. "We have had so much fabulous feedback about the campaign. I had expected that the campaign might get recognition because it is innovative and not your typical mental health campaign," she stated.

Right Direction is a program that employers can use to raise awareness about depression in the workplace and encourage employees to seek help for signs mental illness. The campaign is a collaborative effort by APF and Employer Health Coalition Canton, Ohio (*Psychiatric News*, August 8, 2013).

APF worked with Grabowski and Company to create the campaign's marketing materials, which features a grizzly bear that is alone and lost in the wilderness, trying to find his way out—suggesting a feeling of being apart from the world that is often characteristic of depression.



APA's infographic "A Veteran's Worst Wounds May Be the Ones You Can't See" wins a Gold Addy for digital advertising.

In speaking with *Psychiatric News*, APA CEO and Medical Director Saul Levin, M.D., M.P.A., said that he is "appreciative of all those who were involved in helping APA receive these prestigious accolades."

Levin emphasized that "as APA moves forward, it will continue to seek out creative ways to raise awareness of the needs of those living with mental illness throughout the nation and to end the unnecessary stigma directed against those with a mental illness." PN

The inforgraphic titled "A Veteran's Worst Wounds May Be the Ones You Can't See" is posted at http://www.psychiatry.org/File%20Library/Mental%20Illness/Miscellaneous/Veteran-Infographic.pdf. More information and a webinar on the "Right Direction" campaign is posted at http://www.workplacementalhealth.org/Spotlights/Right-Direction.aspx.

Parity Lawsuit

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News that the district branch had fielded numerous complaints from its members about denial of mental health and substance use treatment by United (*Psychiatric News*, April 5, 2013).

At issue in last month's appeal are three questions: whether United, as a third-party administrator on behalf of a self-insured company, can be held liable under the ERISA law or whether the self-insured employer must itself be named as the defendant; whether NYSPA as a professional member association has legal standing in the case to act on behalf of its members; and whether psychiatrists have legal standing to act on behalf of their patients who have an insurance-related claim under ERISA.

APA, in its amicus brief, focuses on the second and third questions, emphasizing that associations have traditionally been permitted to represent their members' interest in litigation that is consistent with the mission of the association and that psychiatrists should be able to represent the interest of their patients for two reasons: because they have an "assignment of interest" from the patient (referring to the reimbursement and other policies set by the insurer) and because the nature of mental illness, and the stigma that can surround it, may make it difficult or impossible for patients to act on their own behalf.

"Our argument is that in the narrow area of mental illness, because of stigma and because of the nature of the illness itself, patients may be unable to speak for themselves," Colleen Coyle, J.D., general counsel for APA, told *Psychiatric News*. "The special relationship between doctors and their patients allows them to represent the interest of individuals who otherwise, because of their illness, may be disinclined or unable to act for themselves."

In its brief, APA states: "Psychiatrists have third-party standing to assert claims on behalf of their patients because: they suffer injury themselves; they stand in a 'close relationship' with the patients on whose behalf they seek to litigate; and those patients face 'some hindrance to. . .asserting their own rights.' "

The district court, in its earlier ruling, held otherwise, in part because it determined that mental health and substance use disorder patients face "no hindrance to [their] ability to bring suit themselves."

In its response to that decision, APA states, "That determination fails to recognize that social stigma and the inherent incapacities associated with mental health and substance use disorders constitute a substantial and often insurmountable obstacle to patients' efforts to vindicate their own rights through litigation. These deterrent effects are supported by the scientific literature and have long been recognized by the courts. As a result, just as courts have recognized the third-party standing of nonpsychiatric doctors to litigate on behalf of patients, courts also have recognized the standing of psychiatrists to do the same."

Further, APA's brief states that "[p]rofessional associations of psychiatrists like appellant NYSPA and amicus APA in turn have associational standing on the basis of the standing of their psychiatrist members, because their members would otherwise have standing to sue in their own right; the interests they seek to protect are germane to the organization's purpose; and neither the claim asserted nor the relief requested requires the participation of individual members in the lawsuit."

APA and NYSPA are supported in the suit by the AMA, which also filed an amicus brief. The AMA brief states, "The complaint here alleges systematic violations of federal and state law. These violations have injured members of NYSPA and their patients. The patients suffer social stigmas and other obstacles preventing their remedying these violations except through the aid of their psychiatrists. Due to the pervasive nature of the violations, an association of psychiatrists can and should lead the legal effort to right those wrongs."

Also filing in support of NYSPA is the Department of Labor and former member of Congress Patrick Kennedy, one of the authors of the parity law. Both assert that Congress never intended third-party entities, such as an insurance company that is hired by self-insured companies—and that makes all decisions about employees' options for medical and mental health treatment—to be exempt from legal liability. PN