WWW.PSYCHNEWS.ORG | THE FIRST AND LAST WORD IN PSYCHIATRY | VOLUME 50, NUMBER 18, SEPTEMBER 18, 2015

PSYCHIATRIC NEWS

AMERICAN PSYCHIATRIC ASSOCIATION

ISSN 0033-2704

AP Photo/Steve Helber

WDBJ-TV7 meteorologist Leo Hirsbrunner (right) wipes his eyes as Kimberly McBroom and Steve Grant anchor the early morning newscast at the station in Roanoke, Va., on August 27, the day after reporter Alison Parker and cameraman Adam Ward were killed during a live broadcast. See story below.

National Strategy On HIV/AIDS Geared Toward Elimination of HIV

The new strategy emphasizes the need for collaborative care across multiple disciplines and the importance of psychosocial factors in the prevention of HIV/AIDS and in treatment of people living with the disease.

BY MARK MORAN

A newly revised national strategy on HIV/AIDS, released by the White House in July, outlines a detailed path toward an ambitious goal—the virtual elimination of HIV/AIDS in the United States.

"The National HIV/AIDS Strategy for the United States: Updated to 2020," developed by the Presidential Advisory Council on HIV/AIDS (PACHA), opens with the following vision statement: "The United States will become a place where new HIV infections are rare, and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity, or socioeconomic circumstance, will have unfettered access to high-quality, life-extending care, free from stigma and discrimination."

Importantly, the new strategy emphasizes the need for collaborative care across multiple disciplines, including attention to psychosocial factors in the prevention of HIV/AIDS and treatment of people living with HIV. This year, for the first time, a psychiatrist—Jeffrey Akman, M.D., dean of the School of Medicine and Health Sciences at George Washington University—was appointed

see **Strategy** on page 6

Deaths of Journalists Again Raise Concerns About Violence in Workplace

On-air television shootings in Virginia leave families, colleagues, and viewers grieving and wondering how such a tragedy could occur.

BY AARON LEVIN

The shooting deaths of two Virginia television journalists on August 26 went out over the air during a live broadcast, exposing viewers to real-life violence and trauma as it happened, and once again raising the purported connection between mental illness and violence.

WDBJ reporter Alison Parker and cameraman Adam Ward were interviewing economic development official Vicki Gardner in Smith Mountain Lake, Va., when a gunman identified as Vester Lee Flanagan attacked them. Parker and Ward were killed, and Gardner was injured.

Flanagan, who was fired from the station two years ago, uploaded his own video of the murders on social media and later killed himself after a police chase.

As family members, friends, and coworkers of the victims grieved over the two young people, viewers, especially children, also may have been traumatized by what they saw on live television. Each person affected needed to be approached individually if support was needed, said APA President Renée Binder, M.D., a professor of psychiatry at the University of California, San Francisco, in an interview.

"It is normal to have a reaction, such as anxiety or intrusive thoughts," said Binder. "People don't have to talk about it, but there should be no stigma in doing so if they wish."

In any work setting, an employee who seems unduly upset or threatening should be taken seriously by fellow workers, said Binder. At her home institution, a multidisciplinary team draw-

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Psychiatric News, ISSN 0033-2704, is published biweekly on the first and third Friday of each month by the American Psychiatric Association, 1000 Wilson Boulevard, Arlington, Va. 22209-3901. Periodicals postage paid at Arlington, Va., and additional mailing offices. Postmaster: send address changes to *Psychiatric News*, APA, Suite 1825, 1000 Wilson Boulevard, Arlington, Va. 22209-3901. Online version: ISSN 1559-1255.

SUBSCRIPTIONS
U.S.: individual, $134. International: APA member, $182; nonmember, $201. Single issues: U.S., $24; international, $41. Institutional subscriptions are tier priced. For site licensing and pricing information, call (800) 368-5777 or email institutions@psych.org.

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PROFESSIONAL NEWS

APA INSTITUTE

CLINICAL & RESEARCH NEWS

Mark Your Calendar Now for APA's Other Meeting Gem

APA's next major meeting is the IPS: The Mental Health Services Conference, which will be held October 8 to 11 at the Sheraton New York Hotel and Towers in New York City. This year's theme is "When Good Care Confronts Red Tape: Navigating the System for Our Patients and Our Practice."

Registration and other information about the meeting can be accessed at http://www.psychiatry.org/ips.

Departments

FROM THE PRESIDENT

The Time for Mental Health Reform Is Now!

During my career, I have frequently been contacted by family members who are trying to obtain care for their loved ones. I have heard stories of patients locking themselves in their rooms, or threatening suicide, or becoming agitated and threatening. Even with all of our treatment advances and our legislative successes such as the parity law, it is difficult to obtain mental health care that is accessible and affordable and has a continuum of services. Unfortunately, our mental health care system is still broken. Insurers are not giving our patients the care they deserve despite a federal law mandating equal coverage of mental health care. In addition, our jails and prisons have evolved into de facto mental health treatment facilities, and 22 veterans every day are dying by suicide.

Mental health reform is desperately needed. Fourteen million Americans suffer from serious mental illness, but 40 percent of them receive no treatment. Exacerbating the problem is that a number of those who do seek treatment encounter obstacles by their insurers, despite the mental health "parity" law that has been on the books since 2008. Research shows that 1 out of 5 adults experiences a mental health problem in a given year, which can be triggered by an unexpected job loss, a divorce, a physical illness, or any other major life event. Our health care system is not able to treat people when they most need it.

Finally, hope for a better day is emerging on Capitol Hill. There is bicameral and bipartisan support to fix some of the problems. Politicians are beginning to understand that mental health is of concern to all Americans.

In August, Sens. Chris Murphy (D-Conn.) and Bill Cassidy (R-La.) introduced the Mental Health Reform Act of 2015. The Senate legislation echoes the Helping Families in Mental Health Crisis Act (HR 2646), a comprehensive mental health bill reintroduced weeks earlier by U.S. Reps. Tim Murphy (R-Pa.) and Eddie Bernice Johnson (D-Texas). Both bills call for better coordination of federal mental health resources, stringent monitoring and enforcement of the existing mental health parity law, establishing a national plan to boost the mental health workforce, and increased research funding for the National Institute of Mental Health. If enacted, these provisions and others in the two bills will help patients and families struggling with serious mental illness (*Psychiatric News*, July 3 and September 4).

In February, Congress overwhelmingly passed the Clay Hunt Suicide Prevention for American Veterans (SAV) Act, which is intended to improve mental health care for veterans. The bill is named after Marine veteran Clay Hunt, who took his own life after serving in Iraq and Afghanistan. Hunt, a Purple Heart recipient, became an advocate for veterans on Capitol Hill after his service. Tragically, he shot himself in 2011 as he struggled with depression and posttraumatic stress disorder.

Under the legislation, a third party would conduct an annual evaluation of the VA's mental health and suicide prevention programs. The measure would further establish a three-year pilot program to pay for the education loans of psychiatrists who work at the VA for at least two years. It would also allow the VA to jointly carry out its suicide-prevention programs with nonprofits dedicated to promoting mental health.

The passage of the Clay Hunt legislation and the introduction of comprehensive mental health care reform in both the Senate and the House demonstrates that lawmakers on both sides of the aisle are coming together because they recognize it's time for a fundamental change. The treatment of mental illness is everyone's concern, and we need better systems to do so.

As these new bills move through Congress, we need to show our support. You will receive requests from APA to contact your members of Congress and urge them to vote for the bills. They want to know what their constituents want when determining how they will vote. Our nation's last big effort at comprehensive mental health reform was over 50 years ago, with President Kennedy's Community Mental Health Act in 1963. It's a new century, and it's vital that our political leaders seize this rare opportunity. Patients, families, and communities can't afford to wait any longer. PN

Psych News Launches New Psychopharmacology Newsletter

If you are an APA member, you should have received a new member benefit in your email box by now: *Psychiatric News PsychoPharm*. This e-newsletter is published on the first and third Fridays each month and features in-depth articles on new medications, FDA news, and more. See the latest issue at http://psychnews.psychiatryonline.org/topic/news-psychopharmacology. If you are not receiving the newsletter, you can also subscribe at this site.

PROFESSIONAL NEWS

Psychoanalysts to Offer 'Virtual' Rounds On Psychotherapy for ECPs

It is hoped that the program will attract early career psychiatrists in diverse geographical regions, including rural areas, where the need for psychotherapists is great.

BY MARK MORAN

Early career psychiatrists (ECPs) seeking additional training in psychotherapy may want to take advantage of a pilot program offered by seasoned psychotherapists and psychoanalysts to provide periodic online training in small-group "virtual" classrooms.

The pilot program, titled "Clinical Enhancement of Psychodynamic Skills: Psychotherapy Virtual Rounds," was developed by the American College of Psychoanalysts (ACP). It is slated to begin January 2016 and will be free of charge. (The program is supported by a grant from the Laughlin Trust.) The virtual rounds will be held twice a month for an hour and a half; exact days and times will be announced.

Participants need to use a computer with a microphone, camera, and high-speed internet access. Jessica Brown, M.D., a psychoanalyst in Washington, D.C., and Estelle Bender, M.D., of Columbia University, will each meet by videoconference with a group of six to eight ECPs, preferably with a wide geographic distribution. They will present cases and lead a discussion about psychotherapy theory and technique.

Norman Clemens, M.D., a psychoanalyst in Cleveland, a past speaker of the APA Assembly, and current president of the ACP Board of Regents, told *Psychiatric News* that the idea for the virtual rounds program grew out of the concerns among ACP members that psychotherapy was losing ground among psychiatrists—that the "psyche" was being dropped from psychiatry.

ECPs are a crucial group to reach out to because they may have received training in psychotherapy that is less intense than it once was, said Clemens. "These are psychiatrists who may be doing some psychotherapy but may want to learn more from a really seasoned therapist."

He also said that the pilot program is hoped to attract participants from a diverse geographic distribution and especially those living and working in rural areas, where there is a shortage of mental health professionals.

In an "Open Letter to Early Career Psychiatrists" published in the *Journal of Psychiatric Practice*, Clemens urged ECPs to seek out more training in psychotherapy and not let those skills be sacrificed to the demands of a health care marketplace that may make it difficult to practice psychotherapy.

"You were trained in psychotherapy—supportive, psychodynamic, and cognitive-behavioral—to a level of 'competence' as required by the Accreditation Council for Graduate Medical Education," Clemens wrote. "Unless you were in an extraordinary program, you know that competence at the PGY-4 level is not equivalent to proficiency. There is a lot of variability in programs, and few can provide the extent of patient experience that is required to be proficient in even one systematic treatment, such as cognitive-behavioral therapy or psychodynamic psychotherapy, as applied to a wide variety of patients. … There is much to learn in many fields to become a psychiatrist, which constricts the time available in residency for learning psychotherapy. It takes years to become a highly skilled and versatile psychotherapist, just as it takes years to become a mature surgeon.

Norman Clemens, M.D.

Cleveland-based psychoanalyst Norman Clemens, M.D., says early career psychiatrists have received ACGME-mandated training in psychotherapy but may desire more training from seasoned psychotherapists.

"I have great respect and admiration for ECPs: your knowledge of psychiatry today is far broader and more current than mine could possibly be," Clemens concluded. "I write this in the hope that you have caught the spirit of skillful talking with patients wherever you work in the wild world of health care. Then, as a practitioner, an educator, a team leader, or an administrator, your skills will give patients the benefit of full-service psychiatry. I have written this and many other columns in this journal over the years because engaging in psychoanalysis and psychodynamic psychotherapy was the greatest source of challenge and professional satisfaction in my career as a psychiatrist." PN

To obtain more information or apply to the program, contact Patricia Troy at (410) 647-5002 or ptroy@nextwavegroup.net.

UW to Offer Fellowships to Train Psychiatrists in Integrated Care

The fellowships are part of a larger effort to improve access to psychiatric consultation in areas and settings where there is poor access now.

The University of Washington has been awarded funds by the state of Washington for a new integrated, evidence-based psychiatry training program to improve access to mental health care in Washington State.

As part of this program, the university's Department of Psychiatry and Behavioral Sciences will offer up to five positions a year in its Integrated Care Fellowship. The psychiatrists selected to participate will learn how to provide integrated care through delivery of consultation in primary care and other non-mental health settings, provision of telepsychiatry, and leadership to improve systems of care.

Gavin W. Sisk/University of Washington

Anna Ratzliff, M.D, Ph.D., director of the Integrated Care Training Program at the University of Washington, says the fellowships will focus on delivering population-based mental health care.

Anna Ratzliff, M.D, Ph.D., an associate professor of psychiatry and director of the Integrated Care Training Program at the University of Washington, said the one-year fellowship experience will focus on developing both clinical and leadership skills to deliver population-based mental health care.

"These new fellowships are focused on teaching skills in effective consultation, telepsychiatry, and team work rather than traditional office-based psychiatry that reaches only a relatively few number of patients," she told *Psychiatric News*. "The fellowships are part of a larger effort to substantially address a serious mental health workforce shortage and to improve access to psychiatry consultation in areas and settings where there is poor access now."

Applicants to the Integrated Care Fellowship must have completed an ACGME-accredited psychiatry residency training by the start date. They should submit the following materials by November 1: a personal statement discussing the candidate's reasons for wanting to participate in the Integrated Care Fellowship; a current curriculum vitae; a letter of recommendation from a residency director confirming satisfactory or expected completion of general psychiatry training and discussing overall performance in residency, clinical skills, interpersonal communication, professionalism, and teaching, research, or leadership activities; a letter of recommendation from any psychiatry subspecialty fellowship program the candidate has completed or is completing; two other letters of recommendation from faculty members with whom the candidate has worked during residency or fellowship; USMLE scores; and proof of medical licensure. PN

More information about the fellowship is available by contacting Ratzliff at annar22@uw.edu.

Board Approves Statement on Role in Reducing Physical Health Disparities

The statement is broadly worded to allow for a range of ways in which psychiatrists can be involved in the management of common medical conditions, depending on clinicians' competence, confidence, and training.

BY MARK MORAN

Attention to the common medical conditions that are often comorbid with mental illness is an essential component of psychiatric practice, according to a position statement approved by the APA Board of Trustees at its meeting in June in Washington, D.C.

This may include screening for common medical conditions, counseling patients to reduce preventable cardiovascular risk factors, taking steps to limit the harm that can come from use of psychotropic medications, monitoring the medical care being delivered by other medical providers, or engaging in management of some common medical conditions when warranted by the clinical situation and with appropriate support and training. The position statement further calls for education of psychiatrists and trainees in primary care skills and for funding for that education (see box).

The position statement was jointly written by members of APA's Work Group on Integrated Care and the Association of Medicine and Psychiatry (AMP). Before being approved by the Board, it was reviewed and supported by the APA Council on Health Care Systems and Financing, Council on Geriatric Psychiatry, Council on Psychosomatic Medicine, Council on Medical Education and Lifelong Learning, American Association of Community Psychiatrists, and Academy of Psychosomatic Medicine.

"Many patients with serious mental illness experience high rates of medical disorders, including tobacco-related pathology, obesity, hypertension, hyperlipidemia, and diabetes," said APA President Renée Binder, M.D. "The position statement approved by the Board of Trustees points out that psychiatrists have medical training that distinguishes us from other mental health disciplines. Psychiatrists can develop partnerships with primary care providers in order to improve the health status and medical care of their patients. They can also play a vital role by screening for common medical conditions, counseling patients to reduce preventable cardiovascular risk factors, and limiting harm that can come from use of psychotropic medications."

Lori Raney, M.D., notes that the position statement outlines specific steps that psychiatrists should be taking as part of the routine care they provide to their patients.

She added, "The position statement also supports the development of guidelines that clarify the clinical circumstances in which psychiatrists may become involved in the management of common medical disorders for a subset of their patients. And it asserts that APA will advocate for appropriate funding for training psychiatrists in primary care skills to work confidently and competently in a variety of settings."

Authors of the position statement who spoke with *Psychiatric News* say APA's endorsement of the need for psychiatrists to play a role in the care and management of patients with common medical conditions is crucial to the field and will promote further awareness, research, and training to fulfill the core tenets of the position statement.

Lori Raney, M.D., chair of the APA Work Group on Integrated Care, noted that for almost a decade it has been known that the lifespan of people with serious mental illness is 20 to 30 years shorter than that of the general population, exacerbated by a host of factors in the preceding decade including the introduction of second-generation antipsychotics.

"Although screening for some metabolic changes began in 2004 after the publication of new guidelines, this has not been sufficient to limit the continued morbidity and mortality," Raney said.

Raney said the statement draws on the pioneering work of psychiatrist Benjamin Druss, M.D., M.P.H., whose research has focused on health disparities among people with serious mental illness and who has published research from the Primary Care Access and Referral Study (PCARE) showing that a medical care management intervention for patients in community mental health centers improves rates of preventive care services and overall health outcomes.

"We are trained as physicians first and then as psychiatrists," said Raney. "The position statement encourages psychiatrists to take responsibility for the oversight of medical care for our patients and outlines specific things we should be doing as part of routine care. In certain situations in which psychiatrists are willing and feel competent, they can consider providing some basic treatment themselves. They should seek out additional training in treating common medical conditions if they feel they need it."

Raney said the Primary Care Skills for Psychiatrists course offered at APA's annual meeting and IPS: The Mental Health Services Conference (formerly known as the Institute on Psychiatric Services) has drawn an increasingly large attendance and is an important resource for clinicians seeking to sharpen their primary care skills.

Jeffrey Rado, M.D., incoming AMP president and a coauthor of the statement, emphasized that the statement is meant to incorporate a range of ways that psychiatrists can be involved in the management of medical conditions.

*see **Health Disparities** on page 28*

Statement Outlines Psychiatry's Role in Patients' Overall Health Care

APA and the Association of Medicine and Psychiatry (AMP) support the following tenets in a position statement on the role of psychiatrists in reducing physical health disparities in patients with mental illness:

- Screening for common medical conditions, counseling patients to reduce preventable cardiovascular risk factors, limiting harm that can come from use of psychotropic medications (including use of existing guidelines from APA and the American Diabetes Association), and monitoring the medical care being delivered by other medical providers are essential components of psychiatric practice.
- Psychiatrists should identify patients receiving no or suboptimal primary care and may intervene when most appropriate based on their identified competencies, local resources, and patient preferences for care. Co-management of common medical conditions when clinically necessary should be recognized as a potential component of the overall care of patients with mental illnesses (when this occurs, appropriate reimbursement should also be made).
- Appropriate primary care training in the treatment of common medical conditions, including the leading determinants of mortality in populations with serious mental illnesses, should be made available to psychiatrists seeking to better manage physical health conditions in patients with mental illnesses. Furthermore, APA and partner organizations such as the AMP should increase efforts to provide adequate training and clinical experience throughout the spectrum of medical education from residency and fellowship levels to continuing medical education for the psychiatric workforce.
- The scope of this endeavor should include development of measurable competencies in the screening for common medical disorders, knowledge of age and culturally appropriate disease prevention concepts, and current approaches to the treatment of common medical conditions.
- APA and AMP support the development of partnerships between primary care providers and psychiatrists to provide consultation and oversight in the management of chronic medical conditions in a variety of settings.
- APA and AMP support the development of guidelines that clarify the clinical circumstances in which psychiatrists may become involved in the management of common medical disorders for a subset of their patients.
- APA and AMP advocate for appropriate funding for training psychiatrists in primary care skills to work confidently and competently in a variety of settings, both traditional and nontraditional, such as in public mental health clinics and outreach services to immigrant and homeless populations.
- APA and AMP should continue to support the research, development, and wider implementation of integrated models of health care including outcome studies for psychiatrists treating the conditions contributing to increased mortality.

PROFESSIONAL NEWS

Advisory Council Member Offers Voice For Psychiatry in New HIV/AIDS Strategy

Psychiatrist Jeffrey Akman, M.D., said psychiatry brings a biopsychosocial perspective to the prevention of HIV/AIDS and the treatment of people with HIV in the recently revised national strategy on HIV/AIDS.

BY MARK MORAN

Psychiatrists are crucial in the prevention of HIV/AIDS and in the integrated, comprehensive care of patients with HIV/AIDS.

That's a message that psychiatrist Jeffrey Akman, M.D., brought to the Presidential Advisory Council on HIV/AIDS (PACHA), and it has been incorporated into the revised National Strategy on HIV/AIDS for the United States, released in July (see story on page 1). Akman, the first and only psychiatrist to serve on the council, is vice president for health affairs and dean of the School of Medicine and Health Sciences (SMHS) at George Washington University.

"I was able to be a voice for psychiatry and for mental health generally, and this was really important because there are multiple points in the newly released strategy that recognize the crucial role that mental health plays in HIV prevention and treatment," Akman told *Psychiatric News*. "Where I was most involved was with the notion of comprehensive care and how psychiatry can play a critical role in increasing access to comprehensive care and improving health outcomes.

"This includes screening for depression and other mental illnesses and bringing to prevention and treatment an awareness of the effects of stigma, trauma, and violence in HIV," Akman said. "The psychiatrist is an important part of the treatment team, and we bring a perspective on HIV/AIDS that reinforces the biopsychosocial model of care."

Jeffrey Akman, M.D.

Jeffrey Akman, M.D., says the national strategy released in July recognizes that psychiatry plays a critical role in increasing access to comprehensive care and improving health outcomes.

PACHA comprises 25 individuals from diverse backgrounds with a deep involvement in the prevention and treatment of HIV. Akman was nominated by APA to fill a vacancy on the council earlier this year and became a part of discussions at a critical time in the development of the revised strategy.

He has been involved in fighting the HIV epidemic for more than 30 years. "I started seeing patients with HIV in 1983, when the epidemic was just beginning, and it has remained an important part of my identity as a psychiatrist," he told *Psychiatric News*.

Akman was one of a group of physicians who created the field of HIV/AIDS psychiatry and served on APA's Commission on AIDS. Through funding by

*see **HIV** on page 17*

Strategy

continued from page 1

to PACHA (after being nominated for the position by APA) and served as a vital voice for the role of psychiatry in HIV/AIDS care in the development of the revised strategy (see story above).

The revised strategy includes four broad goals: reducing new HIV infections, increasing access to care and improving health outcomes for people living with HIV, reducing HIV-related health disparities and health inequities, and achieving a more coordinated response to the HIV epidemic.

For the goal of increasing access to care and improving health outcomes, the revised strategy emphasizes that an expansion of the workforce to include the entire continuum of care will be vital.

"Developing models of competent care that treat the whole person, as well as the virus, is crucial," the strategy states. "People living with HIV—after being diagnosed, entering the health care system, and being prescribed treatment—require supports to remain engaged in care. A culturally competent and skilled workforce is vital to this effort and includes a range of providers. … Key priorities for improving outcomes along the care continuum include expanding the workforce by engaging and training nontraditional providers and expanding proven models of team-based, patient-centered care that facilitate ongoing engagement in care."

The national strategy is a revision of the document released in 2010. Since that time, the strategy document notes that there have been a number of developments that require a significant "rethinking" of the approach to HIV/AIDS. These include, notably, the passage of the Affordable Care Act as well as groundbreaking work by the National Institutes of Health (NIH). One of NIH's initiatives is the HIV Prevention Trials Network study, which *Science* magazine called the scientific breakthrough of 2011 and which demonstrated that early treatment for HIV reduces the risk of onward transmission by 96 percent while simultaneously improving health outcomes.

Additionally, the period since 2010 has seen the introduction of pre-exposure prophylaxis (PrEP), a biomedical prevention tool that helps people reduce their risk of HIV infection by taking a daily pill. Based on evidence from multiple clinical trials released from 2011 to 2013, the Food and Drug Administration approved PrEP in 2012, and in 2014 the U.S. Public Health Service issued clinical practice guidelines for PrEP.

"These and other accomplishments have resulted in important gains toward targets for increasing the percentage of persons living with HIV who know their status, are linked to care, and have achieved viral suppression, as well as reducing death rates," according to the strategy. "Despite this progress, the level of infection is stable overall. While declines in diagnoses have occurred for women, persons who inject drugs, and heterosexuals, the epidemic among gay and bisexual men remains severe, with increases in new diagnoses. Achieving the goals of the strategy will require intensified efforts for this population in order to realize the greatest impact."

Each of the four goals in the national strategy includes specific steps required to reach the goal, measurable indicators of progress, and explicit policy actions that are required at the federal, state, and community levels. For instance, the goal of reducing HIV infections includes the following specific steps:

- **Intensify HIV prevention efforts in communities where HIV is most heavily concentrated.**

- **Expand efforts to prevent HIV infection using evidence-based approaches.**

- **Educate all Americans with easily accessible, scientifically accurate information about HIV risks, prevention, and transmission.**

Indicators of progress for those steps include increasing the percentage of people living with HIV who know their seropositive status to at least 90 percent, reducing the number of new diagnoses by at least 25 percent, and reducing the percentage of young gay and bisexual men who have engaged in HIV-risk behaviors by at least 10 percent.

Each of the steps and indicators is accompanied by specific policy actions. For instance, the step toward intensifying prevention efforts in communities where HIV is most heavily concentrated includes the following policy actions:

- **Allocate public funding consistent with the geographic distribution of the epidemic.** "Governments at all levels should ensure that HIV prevention funding is allocated to grantees according to the latest epidemiological data so that funds reach areas with the highest burden of disease."

- **Focus on high-risk populations.** "Federal agencies should ensure that funding to state and local health departments and community-based organizations is allocated according to the epidemiological profile within the jurisdiction and is directed to high-risk populations accordingly."

- **Maintain HIV prevention efforts in populations at risk but with a low national burden of HIV.** "Federal, state, tribal, and local agencies should make the best use of surveillance and other appropriate data, including the HIV care continuum, to characterize the burden of disease and apply high-impact prevention strategies for populations such as Asian Americans, Native Hawaiians and other Pacific Islanders, American Indians, and Alaska Natives." PN

"The National Strategy on HIV/AIDS for the United States: Updated to 2020" is posted at https://www.aids.gov/federal-resources/national-hiv-aids-strategy/nhas-update.pdf.

APA INSTITUTE

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N.Y. Insiders Divulge Secrets For Budget-Friendly Dining

BY SERENA YUAN VOLPP, M.D., AND JOSHUA BEREZIN, M.D.

Compromising on price does not mean compromising on a range of outstanding eateries during your visit to New York.

You may have heard that sometimes the sky is the only limit when it comes to spending money to dine well in New York City—a $450 dinner at Masa, anyone? Don't forget to add the tip! Since most of us attending IPS: The Mental Health Services Conference are not on corporate expense accounts, we decided to recommend some places on the far-less-expensive end of the spectrum.

For the "foodies" out there, ny.eater.com, grubstreet.com, and chowhound.com have plenty of lists and opinions on the best eats in the city. Here are a few of our suggestions for a good meal that won't consume the better part of a paycheck.

The area around the headquarters hotel (the Sheraton New York on Seventh Avenue at 52nd Street) is adjacent to the Times Square/Broadway theater district, and, as such, is a tourist mecca with lots of places to eat. But first, a caution—for those who were looking forward to paying $19.99 for a hot pastrami sandwich at the famed Carnegie Deli, stay tuned—the restaurant was shut down in April due to the discovery that it was not paying for all of the gas it was using, and its status come October is unknown. But food lovers, never fear—go west. There are multitudes of excellent restaurants in the gentrified Hell's Kitchen neighborhood a couple blocks west of the Sheraton. Among the delicious choices in this area are several great Thai places, including Pure Thai Cookhouse on Ninth Avenue between 50th and 51st streets (www.purethaishophouse.com) and Wondee Siam (www.wondeesiam2.com) on Ninth Avenue between 52nd and 53rd streets.

Noodle lovers, you are in luck as well. Ippudo, thought by many locals to offer the best ramen in the city, has opened a branch called Ippudo Westside on 51st Street between Eighth and Ninth avenues (www.ippudony.com). And if your taste buds are craving tasty but no-frills Mexican cuisine, head for Tehuitzingo on 10th Avenue between 47th and 48th streets (www.tehuitzingo.net), where the owners serve wonderful tacos and tortas from the back of their small bodega. For those times when a slice or two of pizza is just the ticket, Don Antonio on 50th Street between Eighth and Ninth avenues may be just what you are looking for (www.donantoniopizza.com/ny-home).

Are you interested in venturing further afield? Of course the dining choices in the surrounding neighborhoods are endless, and you get to sample spots often frequented by more locals than tourists. Smorgasburg (which famed chef Mario Batali summarized as "the single greatest thing I've ever seen gastronomically in New York City") is a weekly market of roughly 100 food carts, selling everything from burgers with fried Ramen noodles to buns to vegan Banh Mi (www.smorgasburg.com). You will not leave hungry. It's in the Williamsburg section of Brooklyn on Saturdays and in Brooklyn Bridge Park on Sundays, with both locations operating from 11 a.m. to 6 p.m. If such culinary variety piques your interest, there are a couple of food courts that are essentially smaller, indoor versions of the same concept, with Brookfield Place near the World Trade Center (www.brookfieldplaceny.com) and Gotham West Market near Times Square (www.gothamwestmarket.com) as standouts.

> **REGISTER NOW!**
>
> Register now for IPS: The Mental Health Services Conference at www.psychiatry.org/IPS.

But what if your agenda is so full that you don't want to take time for a full meal? There are literally thousands of places to grab a quick—and very tasty—bite to eat. One of our favorites is Taim at 222 Waverly Place in the West Village section of historic Greenwich Village, which draws those in the know for its excellent falafel (www.taimfalafelcom). It was founded by a husband and wife who missed the street food of their native Tel Aviv. There's also the ubiquitous Shake Shack, which started as a local chain but is starting to branch out to locations outside of New York. Chain or not, its burgers and shakes are outstanding, and it has a vegetarian option that is just as good. There is a location on Eighth Avenue in the Theater District and several others throughout Manhattan. For those craving a more unique burger experience, Burger Joint in the hotel Le Parker Meridien at 119 West 56th Street is often on the list of best burgers in the city, and finding the restaurant (behind a curtain in the lobby) makes you feel like you've discovered a hidden gem (www.burgerjoint.nyc).

Manhattan's Chinatown is another obvious place to go for good deals on fabulous food. One of our favorites for dim sum is Golden Unicorn at 18 East Broadway (www.goldenunicornrestaurant.com). You might also want to check out Indian restaurants on Lexington Avenue around 28th Street. There are some great inexpensive options like Haandi at 113 Lexington Avenue (no website) and some exceptional lunch buffets such as the one at Dhaba at 108 Lexington Avenue (www.dhabaindiancuisinenyc.com), both of which will be a good fit for all budgets.

If Korean cuisine is tempting you, head for the block of West 32nd Street between Fifth and Sixth avenues, where Woorijip Authentic Korean Food (www.woorimjip.com) and BCD Tofu House (www.bcdtofu.com) are excellent places to start.

Many New York visitors will plan to visit the 9/11 memorial or take the elevator to the top of the new One World Trade Center skyscraper in lower Manhattan. While dining options are not great in that area, a wonderful, though somewhat pricey, meal can be had at North End Grill in Battery Park at the southern tip of Manhattan (www.northendgrillonyc.com). If you are visiting the Tenement Museum on Orchard Street on the Lower East Side, you will discover several top-notch choices nearby. Russ & Daughters, at 179 East Houston Street, has specialized in smoked fish since 1914 and recently opened a café on Orchard Street literally steps from the Tenement Museum (www.russanddaughters.com). One new standout in the neighborhood is Kiki's, at 130 Division Street (no website), which serves excellent Greek fare in a congenial setting. For those struck by a craving for a high-carb snack, Kossar's Bialys at 367 Grand Street (www.kossarsbialys.com) and Doughnut Plant, at 379 Grand Street (www.doughnutplant.com), are sure to please.

These are just a few of the many budget-friendly options that we can recommend. Your New York friends will doubtlessly have their own lists, and you are likely to stumble across intriguing places as you wander this fascinating city. Keep in mind that it's nearly impossible to leave this food-crazed mecca without eating well! PN

Serena Yuan Volpp, M.D., is associate director of the New York University (NYU) Public Psychiatry Fellowship. Joshua Berezin, M.D., is a clinical associate professor of psychiatry at NYU.

FROM THE EXPERTS

Recognizing When Food Restriction Has Little to Do With Weight

BY B. TIMOTHY WALSH, M.D., AND EVELYN ATTIA, M.D.

An 11-year-old girl came to our clinic, accompanied by her mother, after being referred by her pediatrician. The mother explained that the girl had always been a picky eater and avoided foods with thick textures, such as mashed potatoes, and foods that had strong smells, such as chicken soup. The girl's restrictive eating and general food avoidance had worsened during the current school year, as she began middle school and needed to eat more of her meals independently.

The girl denied any concerns about her body shape or weight and insisted that her only motivation for limiting her intake related to "how the food feels." The pediatrician became worried about the girl's growth as her Body Mass Index (BMI) fell from the 10th percentile at age 9 to the 5th percentile for her age.

Upon physical exam, the girl was found to have sinus bradycardia, with a heart rate of 52 beats per minute, and was hypotensive, with blood pressure of 92/60 mm Hg.

The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*) introduced avoidant/restrictive food intake disorder (ARFID) into the category of feeding and eating disorders. ARFID is a diagnosis that aims to clarify and expand a little used pediatric diagnosis listed in *DSM-IV* called feeding disorder of infancy or early childhood. ARFID describes individuals whose significant food avoidance or restriction does not result from excessive concerns about body shape or weight. Rather, it is characterized by avoidant or restrictive eating behavior due to decreased interest toward food or eating, the sensory characteristics of food, and/or concern about aversive consequences of eating, such as vomiting.

ARFID's eating behavioral disturbances are associated with persistent failure to meet appropriate nutritional and/or energy needs, including significant weight loss or failure to achieve expected growth in children, significant nutritional deficiency, dependence on nutritional supplements, and/or marked interference with psychosocial functioning. The disturbance is not better explained by lack of available food or by a culturally sanctioned practice and may not be present during the course of anorexia nervosa or bulimia nervosa. If ARFID occurs in the context of another condition or disorder, the severity of the eating disorder exceeds that routinely associated with the condition and warrants additional clinical attention.


Since the publication of *DSM-5*, ARFID has begun to receive research attention from pediatricians, adolescent medicine specialists, and mental health clinicians. ARFID affects children and adolescents most commonly but may affect individuals across the lifespan. Children who present with ARFID tend to be younger than those with anorexia nervosa or bulimia nervosa. Individuals with ARFID are low weight, on average, but less so than those with anorexia nervosa. While clinical samples include more females than males, the gender imbalance is less extreme than that seen in anorexia nervosa.

Due to its recent introduction into *DSM-5*, less is known about treatment for ARFID than for the other eating disorders. However, commonly, weight restoration and nutritional rehabilitation are emphasized, with behaviorally focused treatments recommended. Individuals who have fear of choking or vomiting that contributes to restrictive eating might benefit from anxiety-based treatments, such as exposure therapy and response prevention. Individuals who have difficulty tolerating sensory aspects of food may also benefit from exposure and other behavioral strategies.

The Eating Disorders Assessment for *DSM-5* (EDA-5) is a new tool to guide the assessment of feeding and eating disorders according to the *DSM-5* criteria. This semi-structured interview is available at no cost at www.eda5.org. The use of this tool combined with a clinically useful discussion about evaluating and treating individuals with eating problems and formal eating disorders is thoroughly presented in *Handbook of Assessment and Treatment of Eating Disorders*, scheduled for publication by American Psychiatric Association Press in the fall. PN

B. Timothy Walsh, M.D., is a professor of psychiatry at the Columbia University Medical Center and director of the Division of Clinical Therapeutics at the New York State Psychiatric Institute. Evelyn Attia, M.D., is a professor of psychiatry at Columbia University Medical Center and Weill Cornell Medical College and director of the Center for Eating Disorders at New York-Presbyterian Hospital.

The Eating Disorder Assessment for *DSM-5* is posted at www.eda5.org.

Join APA's New 'Find a Psychiatrist' Database

APA is offering a new member benefit for psychiatrists practicing in the United States and Canada. They are invited to join a new database on APA's website that will enable individuals seeking psychiatric care to locate psychiatrists practicing in their area. To join the database, go to http://apps.psychiatry.org/optinfap/Login.aspx. To review the functionality of the database, go to http://finder.psychiatry.org.

VIEWPOINTS

Calling Women Psychiatrists: Here's an Organization Just for You

BY MARY BARBER, M.D.

Greetings from the Association of Women Psychiatrists (AWP)! What is AWP, you may ask? I'd love to tell you about our group of amazing, inspiring women.

AWP is an independent organization of women psychiatrists and male supporters. We meet concurrently with APA at APA's annual meeting, and we work closely with APA and the APA Women's Caucus. Our membership is small—just under 150—but we are mighty. Our annual membership meeting is always a room full of former and current APA officers and other accomplished women psychiatrists, as well as early career psychiatrists already making their mark on our field.

Small but mighty. Despite our size and small budget, we are able to do the following each year:

- Give awards to outstanding women and supportive men in psychiatry.
- Give a cash award to a community organization working to improve women's mental health.
- Sponsor an annual APA award and lecture, the Alexandra Symonds Award.
- Sponsor international women psychiatrists to come to the United States.
- Sponsor U.S. women psychiatrists to travel internationally to work, study, and undertake projects.
- Provide mentors at the APA women's networking lunch, in partnership with the APA Women's Caucus.

In short, we are an awesome group of high-powered, motivated women in psychiatry. Like women in general, we work hard and accomplish a lot with very limited resources.

AWP provides a tremendous opportunity for mentorship, support, networking, and building a lifelong circle of colleagues and friends.

If you are intrigued by the list above, come check us out at the next annual meeting. Or email me and ask questions. If you have enjoyed a Symonds lecture or mentorship at the networking lunch, support our organization so that these events can continue.

As AWP president, and as someone who has been fed and inspired by the women I've met at AWP, I would love to see this small organization grow and reach more of us. PN

Mary Barber, M.D., is president of the Association of Women Psychiatrists.

You can join AWP at http://associationofwomenpsychiatrists.com/register.aspx.

CLINICAL & RESEARCH NEWS

Older Adults Are More Likely to Receive Prescriptions for Depression, Anxiety

Per capita, adults aged 65 and over were prescribed these medications at around twice the rate of younger adults. Seniors also received fewer psychotherapy visits on average.

BY NICK ZAGORSKI

Adults aged 65 and over are receiving prescriptions for some psychiatric medications at more than twice the rate of younger adults—though they're less likely to be getting these prescriptions from a psychiatrist, according to a study published July 29 in the *Journal of the American Geriatrics Society*.

"The big worry used to be that seniors were not being treated enough for mental health issues," said Donovan Maust, M.D., a geriatric psychiatrist at the University of Michigan who led this study.

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"Now, the results suggest that psychotropic medication is becoming pervasive among older adults."

Maust and his colleagues at Michigan and the Veterans Administration Ann Arbor Healthcare System examined outpatient data from 2007 to 2010 that was obtained from the Centers for Disease Control and Prevention's National Ambulatory Medical Care Survey.

They found that on a per capita basis, older adults (aged 65 and older) received a mental health–related diagnosis at about the same rate as younger adults (aged 21 to 64). However, older adults had around 121 medical visits annually per 100 people that resulted in the prescription or renewal of a psychotropic medication compared with a rate of 57 such visits per 100 people per year for younger adults.

Among seniors, only 4 percent of the visits that resulted in a prescription for a psychotropic medication were with a psychiatrist compared with 17 percent in younger adults.

There was no real difference in the rates of prescriptions of stimulants, mood stabilizers, or antipsychotics between the two groups; antidepressants and anti-anxiety medications, though, were prescribed roughly twice as much for older adults.

Maust believes that many of the prescriptions for antidepressants and anxiolytics are likely for mild cases of depression and anxiety that could be more safely treated with psychotherapy. According to the study data, older adults had a lower rate of therapy-related visits than their younger peers (4.3 annual visits per 100 people compared with 6.8).

"This pattern of resorting to psychotropic medications instead of expert psychiatric care and specifically the use of psychotherapy for older adults with mental illnesses reflects, at least in part, both the prevalent ageism and a tendency for a quick fix with medications," said Dilip Jeste, M.D., former APA president and Distinguished Professor of Psychiatry and Neurosciences at the University of California, San Diego.

"There is a commonly held belief, even among primary care physicians, that older adults do not respond to psychosocial interventions. The literature actually shows that appropriate psychotherapeutic management is useful in older adults, and that overuse of medications may cause more harm than good, given the high risk of pharmacokinetic and pharmacodynamic changes associated with aging," Jeste continued.

Interestingly, 20 percent of the psychotherapy visits attended by older adults were handled by a primary care

*see **Prescriptions** on page 28*

Key Points

Researchers analyzed more than 100,000 visits to office-based physicians in the United States from 2007 to 2010 and compared the prevalence of visits related to mental health (for example, visit to a psychiatrist or any visit resulting in a psychotropic prescription) between older (65 and up) and younger adults.

- Older and younger adults had a similar number of annual visits resulting in a mental health diagnosis (32.01 and 28.12 visits per 100 people, respectively).
- Older adults were more than twice as likely to receive a new or refilled psychotropic prescription (121.14 versus 56.77).
- Older adults were less likely to visit a psychiatrist (6.32 vs. 11.82) or receive psychotherapy (4.34 versus 6.78).

Bottom Line: On a per-population basis, older adults receive less care from psychiatrists, less psychotherapy for mental health issues, and a far higher number of psychotropic prescriptions than younger adults.

CLINICAL & RESEARCH NEWS

FDA Approves First Treatment for Sexual Desire Disorder in Women

The medication will feature a boxed warning to highlight the risk of severe hypotension and loss of consciousness in patients who drink alcohol with the medication and in those who use moderate to strong CYP3A4 inhibitors.

BY VABREN WATTS

AP Photo/Allen G. Breed

The Food and Drug Administration (FDA) last month approved Addyi (flibanserin) to treat acquired, generalized hypoactive sexual desire disorder (HSDD) in premenopausal women. The medication is the first FDA-approved treatment for sexual desire disorders in men or women.

"The problems associated with low sexual desire are commonly seen in psychiatric practice and may be comorbid with many psychiatric disorders, especially anxiety and mood disorders," said Robert Segraves, Ph.D., M.S., a professor emeritus of psychiatry at Case Western Reserve University and a member of the Sexual and Gender Identity Disorders Work Group for *DSM-III*, *DSM-IV*, and *DSM-5*. "For the first time, an approved medication can be prescribed for this disorder," he told *Psychiatric News*.

Addyi—a serotonin 1A receptor agonist and serotonin 2A receptor antagonist—was rejected twice by the FDA in the past five years after the agency concluded the drug was ineffective and carried too high a risk for side effects. After the setbacks, Sprout Pharmaceuticals, manufacturers of Addyi, along with multiple women's activist groups launched a campaign against the FDA for being discriminatory toward sexual health products for women that led to a petition of more than 60,000 signatures. After a third submission of data supporting Addyi's effectiveness, the drug was approved.

Addyi's effectiveness was evaluated in three 24-week randomized, double-blind, placebo-controlled trials in approximately 2,400 premenopausal women with acquired, generalized HSDD. The average age of the trial participants was 36 years, with an average duration of HSDD of approximately five years. The participants took either an

see **Addyi** on page 27

CLINICAL & RESEARCH NEWS

Adults Need 7 or More Hours of Sleep Every Night

A review of the literature by a panel of sleep experts finds sleeping less than seven hours per night is associated with an increased risk of depression, suicidal ideation, and many other health problems.

BY LYNNE LAMBERG

To promote optimal health, adults aged 18 to 60 years should sleep seven or more hours per night, a panel of leading sleep experts has concluded. The recommendations, based on a review of thousands of studies assessing the effects of different sleep durations on mental and physical health, were published last month in the journal *Sleep* and the *Journal of Clinical Sleep Medicine*.

"It would be a mistake for people to think they need only seven hours of sleep per night," Nathaniel Watson, M.D., a professor of neurology at the University of Washington, Seattle, and co-director of its sleep medicine center, told *Psychiatric News*. "Most adults need seven hours at a minimum," he said. Watson, currently president of the American Academy of Sleep Medicine (AASM), chaired the 15-member panel of sleep specialists selected by AASM and the Sleep Research Society.

More than one-third of the U.S. adult population reports sleeping less than seven hours on average in a 24-hour period, according to the Centers for Disease Control and Prevention (CDC).

The panel found that sleeping less than seven hours per night is associated with increased rates of adverse health outcomes, including weight gain, obesity, diabetes, hypertension, heart disease, stroke, depression, and an increased risk of early death. Averaging less than seven hours of sleep per night also may impair immune function, increase pain, hinder daytime concentration and performance, and boost errors and accidents.

The sleep experts reached their conclusions after examining 5,314 scientific articles published in English on the relationship between sleep duration and health. The group winnowed the list down to 311 papers on the basis of study design, participant number, and other specifications, and divided these into nine categories addressing specific health outcomes.

The panel focused on adults aged 18 to 60 years because epidemiological studies show that this group averages less sleep per night than younger and older age groups do. Older adults also are more likely to have medical disorders that may confound associations between sleep duration and health outcomes.

After reviewing all of the papers, panel members weighed the strength of evidence supporting a recommendation for nightly sleep durations less than five hours, between five and 10 hours, and more than 10 hours. They focused on nightly sleep durations that increased in one-hour increments because most epidemiologic and experimental studies they examined used these amounts.

In the mental health category, the research on the relationship between sleep duration and psychiatric health included observational, experimental, and treatment intervention studies. In these studies, the threshold for self-reported short sleep varied from five to seven hours. Investigators found that short sleep duration was associated with an increased risk of depression, suicidal ideation, and psychological distress.

Although the panel did not recommend an upper limit for nightly sleep, the experts did note that young adults, people recovering from a sleep debt, and people who are ill may need more than nine hours of sleep per night.

The panel's recommendation addresses nightly sleep, but omits napping, which was not included in most of the epidemiologic studies that were reviewed. Watson noted that shift workers and others with irregular schedules who cannot always sleep at night should aim for at least seven hours of sleep per 24-hour period.

Sleep duration is only one measure of sleep, the panel noted. Sleep timing, quality, day-to-day variability, and sleep disorders also affect health outcomes.

Because sleep needs vary from person to person, Watson recommended that individuals determine the length of nightly sleep they need by going to bed each night when sleepy and waking without an alarm clock for two to three weeks. "When people get as much sleep as they need," he said, "they feel more alert and energized. They think more clearly and feel more patient. Many aspects of performance improve. People report both better mood and higher quality of life."

Funding for the review came from the National Healthy Sleep Awareness Project, a partnership between AASM, the Sleep Research Society, and the CDC, to promote the nation's sleep health. PN

"Joint Consensus Statement of the American Academy of Sleep Medicine and Sleep Research Society on the Recommended Amount of Sleep for a Healthy Adult: Methodology and Discussion" is posted at http://dx.doi.org/10.5665/sleep.4886 and http://dx.doi.org/10.5664/jcsm.4950.

Early Start Times at U.S. Schools May Cause Teens to Lose Sleep

Students with depression, anxiety, and other mental disorders may be vulnerable to the stress of chronic sleep loss, which can lead to a worsening of symptoms.

BY LYNNE LAMBERG

The nation's schools start too early for most teenagers, according to researchers at the Centers for Disease Control and Prevention (CDC) and U.S. Department of Education.

The average start time of U.S. public middle and high schools is 8:03 a.m., the researchers reported in the August 7 *Morbidity and Mortality Weekly Report.*

Only 17.7 percent of public middle and high schools in the United States start at 8:30 a.m. or later, as the American Academy of Pediatrics (AAP) recommended in a policy statement issued in 2014.

Early school start times are out of sync with the adolescent biological clock, which prompts teenagers not to become sleepy until 11 p.m. or later and to sleep until 8 a.m. or later. Most adolescents need 8.5 to 9.5 hours of sleep for full alertness. Two-thirds of high school students, however, usually sleep less than eight hours on school nights.

Previous studies show insufficient sleep increases adolescents' risks for poorer classroom performance, depression, excess weight, inactivity, and use of alcohol, tobacco, and illicit drugs. It also boosts risks for sports injuries and drowsy-driving crashes.

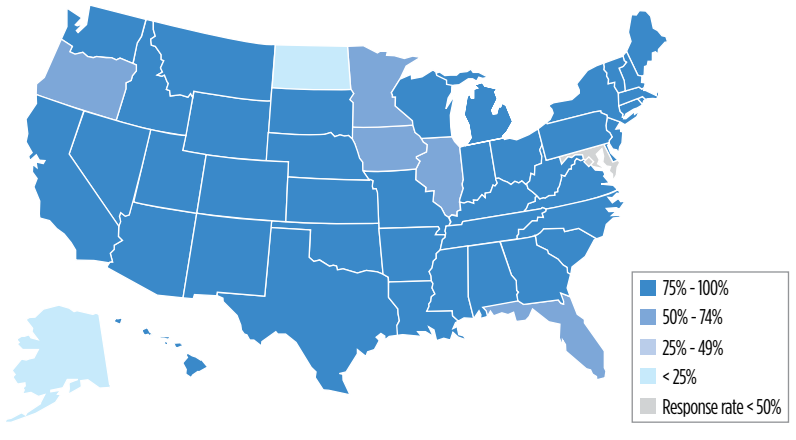
To assess state-specific distributions of public middle and high school start times, Anne Wheaton, Ph.D., an epidemiologist in the CDC's Division of Population Health, and colleagues analyzed data from about 8,000 public middle, high, and combined schools in the United States that responded to the Department of Education's 2011-12 Schools and Staffing Survey. These schools are representative of an estimated 39,700 U.S. public schools with a total enrollment of more than 26 million students.

School start times varied considerably by state. No schools in Hawaii, Mississippi, or Wyoming started at 8:30 a.m.

*see **Sleep** on facing page*

Early School Start Times May Be Out of Sync With Kids' Biological Clock

In 2011, most U.S. public middle and high schools across the country started the school day before 8:30 a.m.—the time the American Academy of Pediatrics recommends is the earliest that adolescents should start classes. The map shows the percentage of schools in each state that start at 8:30 a.m. or earlier.



Source: U.S. Department of Education, National Center for Education Statistics, Schools and Staffing Survey, public school data file, 2011–12.

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Sleep

continued from facing page

or later, while more than 75 percent of schools in Alaska and North Dakota did so. Students in Louisiana schools had the earliest average start time, with classes beginning at 7:40 a.m. In 42 states, at least 75 percent of schools started before 8:30 a.m. To make these early starts, students in some states must rise before 5 a.m. and board school buses at 6 a.m. or earlier.

"Among the possible public health interventions for increasing sufficient sleep among adolescents," Wheaton's team said, "delaying school start times has the potential for the greatest population impact." School start times typically are set locally by school districts or individual schools.

In the three years since the information cited in the CDC report was collected, schools in a few communities have shifted to later start times, but most schools still start too early, Judith Owens, M.D., director of sleep medicine at Boston Children's Hospital and chair of AAP's Adolescent Sleep Working Group, told *Psychiatric News*. Planning and implementing start time changes may take years, she said.

Assuring that adolescents obtain sufficient sleep has particular import for psychiatrists, she noted. In students with depression, anxiety, and other mental disorders, the stress of chronic sleep loss can increase both symptoms and severity. "Psychiatrists," she asserted, "can be powerful voices of advocacy for healthier school start times in their communities." PN

"School Start Times for Middle School and High School Students—United States, 2011–12 School Year" is posted at http://www.cdc.gov/mmwr/pdf/wk/mm6430.pdf.

HIV

continued from page 6

the National Institutes of Health (NIH) and as president of the National Lesbian and Gay Health Association, he helped lead national efforts related to HIV/AIDS education for health professionals. His efforts related to HIV/AIDS in the District of Columbia are extensive and have included service on the Mayor of the District of Columbia's Commission on HIV/AIDS and on multiple nonprofit boards including Whitman Walker Health (where he served as president). He also serves as a member of the Oversight Committee of the NIH-funded District of Columbia Center for AIDS Research and as a founding board member of the George Washington SMHS Rodham Institute, whose mission is dedicated to achieving health equity in the Washington, D.C., community.

Akman emphasized that the revised strategy is one that calls for action at every level of government, with explicit guidance reaching down to the community. "This is intended to be a national strategy, not a federal government strategy," he said. "The federal government has a role, but so do states and local communities."

The strategy is visionary and ambitious, but achievable, Akman said. And he emphasized that psychiatry will be essential to seeing its goals and objectives realized.

"Ultimately, our goal is an AIDS-free generation, and our perspective is that this will not be possible without psychiatry at the table," he said. PN

Nominations Invited for APA's 2016 Election

Do you know an APA member whose interests and expertise would make him or her a good candidate for APA office? If so, please submit the member's full name and the office for which he or she is being nominated to election@psych.org. Nominations are being sought for the following offices:

- President-Elect
- Treasurer
- Trustee-at-Large
- Area 3 and 6 Trustees
- Resident-Fellow Member Trustee-Elect

The deadline for nominations is October 1. More information on the national elections process and eligibility information is at http://www.psychiatry.org/psychiatrists/awards-leadership-opportunities/leadership-opportunities/election-information.

How to Diagnose and Treat Disruptive Mood Dysregulation Disorder

Studies suggest that approximately 1 to 3 percent of children under the age of 10 display symptoms of disruptive dysregulation mood disorder.

BY VABREN WATTS

DSM-5 includes the addition of a new diagnosis, disruptive mood dysregulation disorder (DMDD). Now that DMDD is viewed as a distinct mental health condition, Ellen Leibenluft, M.D., chief of the Section on Bipolar Spectrum Disorders at the National Institute of Mental Health and a member of the *DSM-5* Work Group on Childhood Disorders, believes that it is important for psychiatrists to know the history behind the disorder and how to properly diagnose and treat the condition.

According to Leibenluft, DMDD was added to *DSM* to provide a more accurate diagnosis for children who present with severe and chronic irritability.

"Many children with DMDD were receiving a diagnosis of pediatric bipolar disorder due to the irritability that they were presenting," Leibenluft explained during an interview with *Psychiatric News*. She said that it was once commonly accepted by psychiatrists that episodes of extreme irritability in children with DMDD was a manifestation of mania or elation that is seen in adults with the bipolar disorder. "But when my research group and other researchers observed that these children did not display manic episodes into adulthood, it became difficult to think of them as having bipolar disorder," Leibenluft said. "Instead, these children were at risk of having unipolar depression and anxiety disorder."

With substantial evidence showing phenotypical differences between children with bipolar disorder and children with DMDD, in addition to evidence that distinguished familial history of mental illness between both groups, the *DSM-5* Work Group on Childhood Disorders thought it was necessary to lay a foundation for DMDD as a standalone diagnosis in *DSM-5*, according to Leibenluft.

To be considered for a DMDD diag-

National Institute of Mental Health

Ellen Leibenluft, M.D., says that psychiatrists must be aware that the language used to diagnose depression, such as chronic and persistent sadness, is similar to such language used to diagnose children with DMDD as it relates to chronic and persistent irritability.

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nosis in accordance with *DSM-5* criteria, children must present symptoms before the age of 10, but should not be diagnosed before the age of 6 or after age 18. Symptoms—which must be present for at least one year prior to diagnosis—include the following:

- Three or more severe temper tantrums a week that are inappropriate for the situation and the child's age.

- Persistent irritability or angry moods between tantrums without sustained periods of relief.

- No evidence of mania or hypomania.

According to Leibenluft, some symptoms of DMDD overlap with other mental disorders, in particular oppositional defiant disorder (ODD).

"Usually you want some kind of distinction between diagnoses," said Leibenluft, who noted that children with DMDD experience psychiatric symptoms that are just as severe as those with bipolar disorder in terms of impairment, number of medications, and psychiatric hospitalizations. "These are a really sick group of kids. The feeling was that even though DMDD is not that distinct from ODD, symptoms for DMDD were severe enough for the disorder to have its own standalone diagnosis."

Other psychiatric disorders that are commonly linked to DMDD diagnosis include attention-deficit/hyperactivity disorder (ADHD) and anxiety disorder.

*see **DMDD** on page 27*

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Depression, Anxiety May Reduce Effectiveness of Opioids for Back Pain

Higher levels of depression or anxiety resulted in less pain improvement, more side effects, and more drug misuse among patients taking opioids for chronic lower back pain.

BY NICK ZAGORSKI

Chronic physical pain and mental anguish are inextricably linked. For those experiencing long-term pain, the constant physical discomfort combined with the inability to go to work or carry out other daily routines can lead to the development of symptoms of depression or anxiety. Similarly, for many people dealing with depression, there is a greater risk of short-term pain becoming chronic.

While there has been a lot of research into the relationship between pain and mental disorders, less is known about

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how a patient's mental state may influence his or her response to opioid therapy—a common but potentially risky pain medication given its addictive properties.

Ajay Wasan, M.D., a professor of psychiatry and anesthesiology at the University of Pittsburgh School of Medicine, recently led a study that provided some of the first prospective data on how chronic pain patients (those experiencing pain for more than 12 weeks) with depression or anxiety respond to opioid treatment. His team's work was published July 3 in *Anesthesiology*.

For the study, the researchers enrolled 81 chronic lower back pain patients with either low, moderate, or high depressive or anxiety symptoms and monitored their use of either morphine or oxycodone therapy over a six-month period. About 75 percent of the patients in the study developed depression as a result of their pain, but there were also those with preexisting issues.

All patients also underwent physical exams and MRI scans to confirm that the presence of damaged discs contributed to their pain.

A total of 24 participants with high depression or anxiety symptoms and 24 with low symptoms completed the study; seven participants in the moderate group also completed the trial, though the small size of this group made statistical analysis difficult.

University of Pittsburgh Medical Center

Patients diagnosed with chronic pain should be screened for depression and anxiety as soon as possible, according to Ajay Wasan, M.D.

The patients with high depression or anxiety symptoms found much less relief from the opioids, reporting about a 21 percent improvement in back pain (as self-reported using a daily electronic diary) compared with a 39 percent improvement reported by the low symptom group. This difference occurred despite the high anxiety and depression symptom group receiving a higher average daily dose of painkillers.

These patients also showed higher levels of opioid abuse (39 percent versus 8 percent) and more frequent and intense side effects from the medication compared with patients with low levels of depression and anxiety.

"This is a small prospective study, but I think it's also definitive, when you consider how it fits in well with all the other data we have on chronic pain and depression," Wasan told *Psychiatric News*. "And it really suggests that anyone diagnosed with chronic pain should be screened for depression and anxiety as soon as possible and before prescribing any opioids.

"At the same time, psychiatrists should be more proactive with their patients as well and not dismiss or undervalue any complaints related to pain," he said. "The pain they are reporting is likely very real."

Wasan did not suggest that opioids be prohibited in people with depression, but did note that there are likely better options. Serotonin-norepinephrine reuptake inhibitors (SNRIs), for example, are considered effective frontline treatments for both pain and depression and might be a more appropriate choice, he said.

see ***Opioids*** *on page 28*

Study to Answer What Comes Next When MDD Patients Don't Respond

VAST-D will provide valuable information about difficult-to-treat depression in a predominantly male population, including a relatively high proportion with comorbidities such as substance and alcohol use disorders and PTSD.

MY MARK MORAN

An ongoing study at more than 30 Veterans Administration (VA) medical centers will help provide clinicians with critical information about the best "next step" when patients with major depressive disorder (MDD) fail to respond to an initial antidepressant treatment.

The VA Augmentation and Switching Treatments for Improving Depression Outcomes (VAST-D) study is a multi-site, prospective, randomized clinical trial of outpatients with non-psychotic MDD. According to a paper describing the study's rationale and design in *Psychiatric Research* (August 5), the study enrolled 1,522 veterans (approximately 50 subjects at each of 30 to 35 participating VA medical centers) including both men and women with a diversity of ethnic/racial and socioeconomic backgrounds. Participants were randomized to switching or augmenting arms of the study. Treatment arms included randomization to either switching to bupropion-sustained release (bupropion-SR) alone, augmenting current antidepressant therapy with bupropion-SR, or augmenting current antidepressant treatment with aripiprazole. Follow-up on the last subject will be completed in October.

Somaia Mohamed, M.D., Ph.D.

Somaia Mohamed, M.D., Ph.D., says hybrid efficacy-effectiveness studies like VAST-D are designed to answer practical treatment questions in the setting of real-world practice.

The primary outcome for the VAST-D study is remission of depressive symptoms, defined by a score of 5 on the Quick Inventory of Depressive Symptomatology (QIDS-C16) for two consecutive visits during the 12 weeks of the acute treatment phase. Key secondary outcomes are response at the end of acute and continuation treatment, defined as 50 percent improvement from baseline on the QIDS-C16 and, as a separate response measure, a score of 1 or 2 indicating "much improved" or "very much improved" on the Clinical Global Impressions (CGI) Improvement Scale; percent change on the QIDS-C16 from baseline to end of acute and continuation treatment; and relapse, defined as having a QIDS-C16 score of greater than 11 after remission or during the continuation treatment.

Somaia Mohamed, M.D., Ph.D., a co-principal investigator in the study, noted in comments to *Psychiatric News* that MDD is among the most disabling and widespread of mental disorders, causing as much or more functional impairment as chronic heart disease.

"Unfortunately, most research on antidepressant therapies is conducted by drug companies to win FDA marketing approval and compares new medications with placebo in short-term trials of about six weeks," continued Mohamed, an associate clinical professor of psychiatry at Yale University School of Medicine. "What is really needed is research that compares approved medications over longer periods of time. These studies are often called hybrid efficacy-effectiveness studies because they use rigorous research methods and are designed to answer practical treatment questions in the setting of real-world practice. Only these kinds of studies can guide real-world clinical decision making in which the decision is almost never 'should I use a medication or not?', but rather 'which medication will give the most long-term benefit for this particular patient?' The field called comparative-effectiveness research has been developed to address this need throughout medicine."

Mohamed said that VAST-D is unique in that it compares three FDA-approved treatment strategies to be used after a patient has already failed to benefit from a first treatment attempt. "It uniquely addresses a question of urgent practical relevance: what to do as a next-step therapy for major affective disorder," she said. "In addition, it examines benefits over a far longer period than most clinical trials of antidepressants. For statistical reasons, such studies require many patients (1,500 in the case of VAST-D), and many clinics must be involved."

She added that VAST-D results will provide an empirical basis for practice guidelines, replacing clinical consensus.

Michael Thase, M.D., an expert on depression and antidepressant treatment and one of the participating investigators at the Philadelphia VA Medical Center, said VAST-D is important because it follows on the findings of the Sequenced Treatment Alternatives to Relieve Depression (STAR*D) trial. He is a professor of psychiatry at the Perelman School of Medicine at the University of Pennsylvania.

"VAST-D compares one of the better adjunctive treatment options studied in STAR*D—namely, adding the antidepressant bupropion to ongoing therapy with an SSRI or SNRI—with the most widely used strategy of the past decade, namely, adding the second-generation antipsychotic aripiprazole to ongoing antidepressant therapy," Thase told *Psychiatric News*. "Because VAST-D is being conducted in VA clinics, it will provide valuable and needed information about difficult-to-treat depression in a predominantly male population, including a relatively high proportion with comorbidities such as substance and alcohol use disorders and PTSD."

The VAST-D study is being supported by the U.S. Department of Veterans Affairs. PN

"The VA Augmentation and Switching Treatments for Improving Depression Outcomes (VAST-D) Study: Rationale and Design Considerations" is posted at http://www.psyjournal.com/article/S0165-1781(15)00556-9/abstract.

JOURNAL DIGEST

BY VABREN WATTS AND NICK ZAGORSKI

sciencepics/Shutterstock

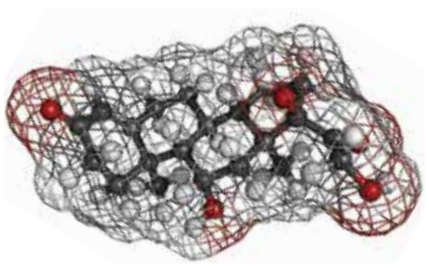
Urinary Metabolites May Help Differentiate BD From MDD

To develop a potentially more objective test for diagnosing bipolar depression (BD), a research team from Chongqing Medical University in China used various chromatography tools to profile the urine samples from 76 patients with major depressive disorder (MDD), 43 patients with BD, and 126 controls to identify any distinct metabolite patterns among these groups.

They uncovered a panel of six urinary metabolites that could serve as biomarkers: propionate, formate, 2,3-dihydroxybutanoic acid, 2,4-dihydroxypyrimidine, phenylalanine, and β-alanine. They tested this panel on a second group of 50 MDD and 28 BD patients and found they could distinguish the two conditions with about 90 percent accuracy.

Though preliminary, these findings do point to the validity of using metabolite profiling as a method of diagnosing mental disorders. The study was published in the *Journal of Proteome Research*.

Chen J, Zhou C, Liu Z, et al. Divergent Urinary Metabolic Phenotypes Between Major Depressive Disorder and Bipolar Disorder Identified by a Combined GC-MS and NMR Spectroscopic Metabonomic Approach. J Proteome Res. Aug 7, 2015; 14(8): 3382-9. http://pubs.acs.org/doi/abs/10.1021/acs.jproteome.5b00434



molekuul.be/Shutterstock

Cortisol Can Reduce Cravings In Some Drug Users

Stress has been found to increase cravings and is a risk factor for drug addiction or relapse. A new clinical study appearing in *Translational Psychiatry* tested whether the stress hormone cortisol might influence drug craving in people recovering from heroin addiction.

A total of 29 patients in a heroin-assisted treatment program were randomly divided to receive either 20 mg of oral cortisol or placebo 105 minutes prior to their daily drug administration, and their craving levels were measured at periodic intervals.

Cortisol was found to significantly reduce cravings in those patients who received a low dose of daily heroin (up to 305 mg), but it had no effect on medium- and high-dose patients. Cortisol also showed no effects on secondary outcomes of anxiety, anger, and withdrawal symptoms.

The study authors suggested that future studies should search for the factors that may influence cortisol's effects on craving and whether the drug reduces cravings and relapse in drug-abstinent patients.

Walter M, Bentz D, Schicktanz N, et al. Effects of Cortisol Administration on Craving in Heroin Addicts. Transl Psychiatry. Jul 28, 2015; 5: e610. http://www.nature.com/tp/journal/v5/n7/full/tp2015101a.html

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Elevated Glutamate Receptors Found In Women With Depression

A post-mortem analysis of brain tissue suggests that women with depression may have higher levels of several genes that regulate the neurotransmitter glutamate than women without depression. Three other glutamate-related genes were also found to be elevated in depressed patients—male and female—who had died by suicide.

Monsheel Sodhi, Ph.D., at the University of Illinois at Chicago and her colleagues examined a large cohort of brain tissue samples and identified higher expression levels of eight genes (GRIN1, GRIN2A-D, GRIA2-4, GRIK1-2, GRM1, GRM4, GRM5, and GRM7) in the dorsolateral prefrontal cortex in women with major depressive disorder compared with control females. Men and women with depression who died by suicide had elevated levels of GRIN2B, GRIK3, and GRM2 expression.

The higher elevation of glutamate expression in women may help to explain why women have a higher risk of suicide than men. The findings also help to explain why ketamine—which inhibits the glutamate-binding NMDA receptor—can rapidly eliminate depression symptoms.

As this study uncovered a wide range of glutamate receptors that may play a role in depression, it suggests that other agents besides ketamine might also have uses as rapid-onset antidepressants.

This study was published in *Molecular Psychiatry*.

Gray A, Hyde T, Deep-Soboslay A et al. Sex Differences in Glutamate ReceptorGene Expression in Major Depression and Suicide. Mol Psychiatry. July 14, 2015 [Epub ahead of print]. http://www.nature.com/mp/journal/vaop/ncurrent/abs/mp201591a.html

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Teens With Healthy Attitudes May Protect Others From Depression

Teens with healthy attitudes may have the potential to ward off depression in their friends, according to study published in *Proceedings of the Royal Society B*.

Researchers from Warwick Medical School and University of Manchester in the United Kingdom gathered data from more than 2,000 U.S. high school students enrolled in the National Longitudinal Study of Adolescent to Adult Health to examine how the moods of teenagers influence the moods of their closest friends. Individuals were classified as either having depressive symptoms (low mood) or not being depressed (healthy mood), based on the Center for Epidemiologic Studies Depression Scale. Methods for detecting how the teens' moods influenced each other were modeled after methods used to track the spread of infectious diseases.

According to the model, adolescents who have five or more friends with healthy mood were 50 percent less likely to become depressed over a six- to 12-month period than their counterparts with no friends with healthy mood. Having 10 friends with healthy attitudes doubled the probability of recovering from depressive symptoms compared with adolescents with three friends with healthy attitudes.

"It could be that having a stronger social network is an effective way to treat depression," Thomas House, Ph.D, M.D., a coauthor and a senior lecturer in applied mathematics at Manchester, said in a press release.

Hill E, Griffiths F, and House T. Spreading of Healthy Mood in Adolescent Social Networks. Proc Biol Sci. 2015; 282(1813). http://rspb.royalsocietypublishing.org/content/282/1813/20151180

John Gomez/Shutterstock

Military Women Are at No Greater Risk of Developing PTSD Than Men

While past research on gender differences in the onset of post-traumatic stress disorder (PTSD) among U.S. veterans has been mixed, a recent study by the departments of Defense and Veterans Affairs suggests that women in the military are at no greater risk of developing PTSD than their male counterparts who experience similar traumatic events.

The study included more than 2,300 pairs of men and women in the military who were matched based on an array of variables—including combat exposure, alcohol misuse, depression, and sexual assault—and surveyed on PTSD symptoms over an average time span of seven years (from 2001 to 2008). All participants had been deployed at least once to Iraq or Afghanistan and did not show signs of PTSD at the study's initiation. Outcome measures included a positive screen for PTSD and symptom severity scores measured by the PTSD Patient Checklist-Civilian Version.

The results, published in the *Journal of Psychiatric Research*, showed that 6.7 percent of women and 6.1 percent of men developed PTSD—a difference that was not statistically significant. There was also no difference in the severity of PTSD symptoms among men and women who developed the disorder.

According to the authors, the current study suggests that gender alone is not an indicator of PTSD risk.

Jacobson I, Donoho C, Crum-Cianflone N, et al. Longitudinal Assessment of Gender Differences in the Development of PTSD Among U.S. Military Personnel Deployed in Support of the Operations in Iraq and Afghanistan. J Psychiatr Res. 2015; 68:30-6. http://linkinghub.elsevier.com/retrieve/pii/S0022-3956(15)00167-3

see ***Journal Digest*** *on page 29*

MED CHECK

BY VABREN WATTS

FDA Approves New Injection Site for Abilify Maintena

In July, the Food and Drug Administration (FDA) approved injection of ***Abilify Maintena*** **(*aripiprazole*)** in the deltoid arm muscle. Health care providers will now have the option to administer the long-acting injectable antipsychotic in the gluteal or deltoid muscle when treating patients with schizophrenia.

The approval of the deltoid as an injection site was based on two studies involving a total of 178 patients with schizophrenia aged 18 to 64 who were selected to receive a 400 mg injection of Abilify Maintena in the gluteal muscle or the deltoid muscle. The studies compared the safety, tolerability, and pharmacokinetics of Abilify Maintena administered in the deltoid muscle with that of having the drug administered in the gluteal muscle. Safety and effectiveness of the drug between the two injection sites were found to be comparable.

Abilify Maintena is a D2 partial agonist administered to patients once a month. It was originally approved by the FDA for only gluteal injection in February 2013. Label changes incorporating deltoid administration for Abilify Maintena are scheduled to take place in the fall.

FDA Issues Warning Over Brintellix, Brilinta Confusion

On July 30, the FDA issued a warning to health care professionals and patients concerning reports of confusion between the antidepressant ***Brintellix*** (***vortioxetine***) and the anti-blood clotting medication ***Brilinta*** (***ticagrelor***), which has resulted in the wrong medication being prescribed or dispensed.

The FDA has determined that the main reason for the confusion between the two medications—with extremely different indications—is the similarity in the marketed names of the drugs. While the selective serotonin reuptake inhibitor Brintellix is used to treat major depressive disorder, Brilinta is an antiplatelet, anti-blood clotting medication that is used to lower the risk of recurrent heart attacks or death from a heart problem after a heart attack or severe chest pain.

To reduce the risk of name confusion, the FDA recommends that health care professionals include the generic name of the medication (e.g., vortioxetine) in addition to the brand name and the indication for use when prescribing the medication. The FDA also recommends that patients check their prescriptions to ensure that the correct medication was dispensed.

At the time of the FDA announcement, no reports regarding the name confusion had indicated that any patients had ingested the wrong medication; however, reports of prescribing and dispensing errors continue, according to the agency.

FDA to Review Cognitive Claims Linked to Brintellix

Last month, the FDA agreed to review a Supplemental New Drug Application (sNDA) submitted by H. Lundbeck A/S and Takeda Pharmaceutical Company regarding the benefits of ***Brintellix*** (***vortioxetine***) as it relates to the drug's ability to reduce cognitive dysfunction in adults with major depressive disorder (MDD). The companies are hoping to have these claims added to the label of the selective serotonin reuptake inhibitor next year.

The sNDA is primarily based on the FOCUS and CONNECT studies, which were specifically designed to examine the effect of Brintellix on certain aspects of cognitive function in adult patients with MDD. The CONNECT study showed

that Brintellix had a competitive advantage in reducing cognitive dysfunction in MDD patients over Eli Lilly and Co.'s antidepressant ***Cymbalta*** (***duloxetine***).

The FDA will review all submitted data supporting the cognitive benefits for Brintellix and decide if a label change is warranted by March 28, 2016.

According to previous studies, cognitive symptoms were reported by patients with MDD up to 94 percent of the time during major depressive episodes.

Lilly's Alzheimer's Drug Found To Delay Disease Progression

People with mild Alzheimer's disease who took Eli Lilly and Co.'s drug ***solanezumab*** earlier in the course of their disease saw benefits compared with patients who start the medication later on, according to data presented by the company at the 2015 Alzheimer's Association International Conference in held in Washington, D.C., in July.

The study included 1,300 patients with mild-to-moderate symptoms of Alzheimer's disease, who were randomly given solanezumab intravenously (400 mg/month) or placebo for 18 months. After this period, all patients, including those who initially took placebo, were administered solanezumab (400 mg/month).

At the end of the first half of the study, those taking solanezumab performed significantly better on cognitive and daily functional assessments—Alzheimer's Disease Assessment Scale Cognitive subscale and Alzheimer's

*see **Med Check** on page 26*

Med Check

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Disease Cooperative Study–Activities of Daily Living functional scale, respectively—than those who took placebo.

Two years later, the cognitive differences between the two groups remained despite the fact both groups had received treatment with solanezumab for at least two years.

Lilly plans to confirm these findings with follow-up trials.

Roche Revives Alzheimer's Drug For Another Phase 3 Endeavor

Roche Pharmaceuticals has plans to once again test its Alzheimer's treatment ***gantenerumab***, which failed in an initial phase 3 trial near the end of 2014. The drug is an antibody designed to rid the brain of beta-amyloid proteins, which form plaques that many researchers believe are at the center of Alzheimer's disease.

In an interview with Reuters, a spokesperson for Roche said the company has moved beyond its previous clinical failures with the antibody and is currently "developing novel approaches to implement higher doses" of gantenerumab for new phase 3 trials to be carried out in patients with Alzheimer's.

Roche said that it has requested feedback from global regulators on its plans for new studies, but the company is not disclosing when these studies will be initiated. PN

DMDD

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Leibenluft said that when symptoms of these comorbid psychiatric diagnoses are present in patients with DMDD, treatment options for DMDD must be carefully selected by physicians.

Although antipsychotic treatment has been used in some children with DMDD, the question remains if antipsychotics should be used as a first-line treatment, she noted.

"If you view the children as having comorbid bipolar disorder, then the answer would be 'yes,'" Leibenluft answered. "If you view the child as having comorbid ADHD, then you may want to put them on a treatment with a stimulant," she added. According to Leibenluft, a fair amount of literature shows that stimulant use in children with ADHD with severe irritability does help decrease irritability.

"At this point, we do not have sufficient data from clinical trials on treatments for DMDD yet. But drawing on the literature, comorbidities, and clinical presentations in these children, doctors can receive some form of guidance for treating patients with DMDD," Leibenluft concluded. PN

A Disruptive Mood Dysregulation Disorder fact sheet is posted at http://www.dsm5.org/Documents/Disruptive%20Mood%20Dysregulation%20Disorder%20Fact%20Sheet.pdf. An interview with Ellen Leibenluft, M.D., is posted at http://www.psychnews.org/update/audio/Leibenluft_PP8a1.mp3.

Addyi

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oral 100 mg dose of Addyi or placebo at bedtime.

Across the three trials, women taking Addyi were 10 percent more likely to report at follow-up meaningful improvements in past-month sexual event satisfaction or sexual desire than women being treated with placebo. On average, treatment with Addyi increased the number of satisfying sexual events by 0.5 to 1 additional event per month over placebo. The most common adverse reactions associated with the use of Addyi included dizziness, somnolence, and dry mouth. The mechanism by which Addyi improves sexual desire is currently unknown.

The FDA approved Addyi with a boxed warning to highlight the risk of severe hypotension and loss of consciousness (syncope) in patients who drink alcohol during treatment with Addyi and in those who use moderate to strong CYP3A4 inhibitors that interfere with the breakdown of the medication. The newly approved drug is also contraindicated for those with liver disease.

Because of the increased risk of severe hypotension and syncope due to the interaction between Addyi and alcohol, the FDA is requiring all prescribers of Addyi to enroll and complete training in a risk evaluation and mitigation strategy (REMS), which includes elements to assure safe use. Certified prescribers must counsel patients using a Patient-Provider Agreement Form about the increased risk of severe hypotension and syncope and about the importance of not drinking alcohol during treatment with Addyi. Only REMS-certified pharmacies will be allowed to dispense Addyi from a certified prescriber.

Segraves told *Psychiatric News* that he is hopeful that the approval of Addyi will lead to a renewed interest in human sexuality among psychiatrists and clinical psychologists, and spur more research into ways that low sexual desire can be treated.

The tentative marketing release date for Addyi is October 17, according to Sprout Pharmaceuticals. PN

Violence

continued from page 1

ing on university police, legal experts, psychiatrists, human resources, faculty affairs, and the dean of students office collectively evaluates all available information when such cases arise.

"It's better to do this as a group," she said. "It's hard for an individual to decide alone what to do."

In any organization, employee assistance programs may also be a source of help for an employee who is under stress or is reacting to some tragedy, she said.

The Virginia incident was especially troubling for other workers in the news media. Journalists face danger covering wars, disasters, and crime that can affect their own mental health, but the incident in Virginia touched a special nerve.

"Many news professionals I know were deeply rattled by this terrible event," said Bruce Shapiro, executive director of the Dart Center for Journalism and Trauma, a project of the Columbia University Graduate School of Journalism. The center trains journalists to prepare for and cope with reporting on violence, conflict, and tragedy.

"For one thing, our workplace is wherever we open our notebook or take out a microphone or plant a camera, and this reminded us of just how vulnerable that makes us to work-inspired violence, whether from a disturbed former colleague or a stranger," said Shapiro in an interview. "At the same time, many journalists reacted with sympathy and solidarity with our colleagues in Virginia. Locally in Roanoke, the main competitor station to the victims' employer even offered to cover the day's events for the grieving staff."

The killer was described as "troubled," and court documents in an employment-related lawsuit delineated a history of behavioral problems while he worked at the station.

"Most mental illness is treatable if you get to the sufferer . . . in this case we did not," WDBJ's General Manager Jeff Marks said at a memorial service for the two newspeople in Roanoke on August 30.

However, the rush, once again, to associate violence with mental illness concerned some psychiatrists.

Liza Gold, M.D.

"You want people who are angry and disgruntled to get help, but you don't want them to think that if they seek help, they'll be considered crazy," said forensic psychiatrist Liza Gold, M.D., arguing against society's stereotyping of mental illness.

People with mental illness are more often victims of crimes than perpetrators.

"When people with mental illness commit gun violence, they usually kill themselves more often than they kill anybody else," forensic psychiatrist Liza Gold, M.D., told *Psychiatric News.*

"Mental illness is not the most significant risk factor in whether people become violent and commit these acts," said Gold, who is in private practice in Arlington, Va., and is a clinical professor of psychiatry at Georgetown University School of Medicine. "Too many people automatically assume that if someone is angry, violent, and dangerous, then they must be mentally ill. That is the nature of the negative stereotyping of people with mental illness in our society and it's just not accurate." PN

The American Psychiatric Association Foundation's Partnership for Workplace Mental Health has more information on employer-employee mental health at http://www.workplacementalhealth.org/. The Dart Center's "Trauma in the Newsroom: Tips for Managers" is posted at http://dartcenter.org/content/trauma-in-newsroom-for-news-managers#.VeSkJU3D_yc.

Health Disparities

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"We intended the statement to be very broad in terms of what role a psychiatrist might play, from helping to co-manage conditions, screening for those conditions, or simply helping to coordinate care with a primary care clinician," Rado told *Psychiatric News.* "The statement doesn't say that every single psychiatrist should be doing all of these things. It depends on the setting they are working in and their level of competence and confidence and training."

Gavin W. Sisk/University of Washington

Eric Vanderlip, M.D., says the position statement approved by the Board puts APA's imprimatur on a call for psychiatrists to play a role in the management of common medical conditions that accompany mental illness.

The Association of Medicine and Psychiatry is an interdisciplinary clinical and scientific group that promotes high-quality patient care for those with combined illness, develops guidelines for services and training experiences specifically designed to address the problems of these patients, and fosters basic and clinical research in this area. Rado says many members are double-boarded in primary care and psychiatry, but some are psychiatrists who are interested in the interface between medicine and psychiatry.

Erik Vanderlip, M.D., also a coauthor, emphasized the immense value of the APA imprimatur. "The position statement is a call to action to psychiatrists to remember our medical roots and recognize that the epidemic of health problems among people with serious mental illness is still happening and that we have a role in addressing these problems," he told *Psychiatric News.* "It gives psychiatrists the permission from APA—the leading policymaking body on the standards of care for psychiatry—to expand the scope of their practice and to take responsibility for the physical health conditions of their patients." PN

The text of the Position Statement on the Role of Psychiatrists in Reducing Physical Health Disparities in Patients With Mental Illness is posted in APA's Policy Finder at http://apps.psychiatry.org/pdfs/position-statement-role-of-psychiatrists.pdf.

Prescriptions

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doctor—more than twice as high as that seen in younger adults.

"It's encouraging that primary care physicians are trying to help provide psychotherapy, but realistically we can't ask them to do that with everything else that they have going on," Maust told *Psychiatric News.*

Maust suggested that if social workers were trained to conduct brief psychotherapy courses, they might be able to help fill in this gap. Additionally, seniors who may be reluctant to see a psychiatrist might be more willing to consider psychotherapy with a social worker, he said.

Psychiatrists can still play a role to help reduce this high rate of medicine usage, though. "Ultimately, the push for collaborative care is an important one," Maust said. "Psychiatrists could serve as consultants at a care center, work with primary care doctors to oversee a group of patients, and provide their expertise without disrupting the doctor-patient relationship."

The work was funded with support from the National Institute on Aging, the American Federation for Aging Research, the John A. Hartford Foundation, and the Atlantic Philanthropies. PN

An abstract of "Mental Health Care Delivered to Younger and Older Adults by Office-Based Physicians Nationally" is posted at http://onlinelibrary.wiley.com/doi/10.1111/jgs.13494/abstract.

Opioids

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In this study, all the participants did report improvements in their mood symptoms by the conclusion, with the high depression group reporting the highest gains of about 31 percent improvement. However, this result was still lower than the 50 percent mood improvement typically used as the cutoff of successful treatment.

"Whatever the exact route, the key message is that we want to treat the depression or anxiety in patients experiencing pain right away, which will make opioids safer and more effective if they are needed.

"It may even be possible that by being attentive and intervening early on, we can prevent the transitioning of acute pain into chronic pain," said Wasan, who is hoping to answer that very question in one of his upcoming clinical studies.

It's a critical question to address, as chronic back pain is a tremendous burden in the United States. According to the National Institute of Neurological Disorders and Stroke, about 80 percent of adults will experience low back pain at some point in their lives, and one in five of these cases will become chronic. PN

An abstract of "Psychiatric Comorbidity Is Associated Prospectively With Diminished Opioid Analgesia and Increased Opioid Misuse in Patients With Chronic Low Back Pain" is posted at http://anesthesiology.pubs.asahq.org/article.aspx?articleid=2396642.

Journal Digest

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Nine Modifiable Risk Factors May Contribute to Alzheimer's

Recent analysis by researchers at the University of California, San Francisco, highlights nine modifiable risks that may contribute to Alzheimer's disease.

Out of almost 17,000 articles, the researchers focused their analysis on 323 articles that identified 93 different potential risks for Alzheimer's disease in more than 5,000 people.

Nine risk factors, including obesity, current smoking, carotid artery narrowing, type 2 diabetes, high levels of homocysteine, depression, high blood pressure, frailty, and low educational attainment were associated with Alzheimer's disease. In contrast, estrogen, statins, antihypertensive medications, and non-steroidal anti-inflammatory drugs as well as dietary exposures to folate, vitamin E, vitamin C, and coffee served as protective factors against the onset of Alzheimer's disease.

The researchers noted that though no definitive conclusions can be drawn about cause and effect, the findings suggest that preventive strategies targeting diet, prescription drugs, body chemistry, mental health, underlying disease, and lifestyle may serve as beneficial tools in helping to curb the number of new cases of Alzheimer's disease.

Xu W, Tan L, Wang H, et al. Meta-Analysis of Modifiable Risk Factors for Alzheimer's Disease. J Neurol Neurosurg Psychiatry. 2015; pii: jnnp-2015-310548. doi: 10.1136/jnnp-2015-310548. [Epub ahead of print] http://jnnp.bmj.com/content/early/2015/07/27/jnnp-2015-310548

Roman Rybaleov/Shutterstock

Young Adults Perceive Hookah, E-Cigarettes as Safer Than Cigarettes

A new study published in *Health Education & Behavior* shows that people under the age of 25 believe that vaporized nicotine products, such as hookah and electronic cigarettes, are safer than conventional cigarettes.

For the study, the researchers collected data from almost 3,000 smoking and nonsmoking young adults aged 18 to 34. They found that approximately 58 percent of all respondents believed e-cigarettes to be less risky than cigarettes, while 25 percent reported hookah to be less risky than cigarettes. In comparison, 14 percent rated cigars and 7 percent rated smokeless tobacco as less risky.

When separating perceptions by age group, the researchers found that 62.1 percent of the participants aged 18 to 24 perceived e-cigarettes as less risky than cigarettes compared with 54.6 percent of 25 to 34 year olds perceiving e-cigarettes to be less risky. In addition, 32.7 percent of those aged 18 to 24 believed hookah to be less risky than cigarettes compared with 18.5 percent of participants aged 25 to 34.

The researchers noted that discrepancies in perceptions among the two age groups may be associated with different advertising messages the groups are exposed to, and in the case of e-cigarettes, a possible inclination for younger people to attribute more positive feelings toward newer products. PN

Wackowski O, Delnevo C. Young Adults' Risk Perceptions of Various Tobacco Products Relative to Cigarettes: Results From the National Young Adult Health Survey. Health Education & Behavior. August 24, 2015 [Epub ahead of print]. http://heb.sagepub.com/content/early/2015/08/21/1090198115599988.full