

PSYCHIATRIC NEWS

PSYCHNEWS.ORG

ISSN 0033-2704

SEE STORY BELOW

10 Years Later, Virginia Tech Shooting Still Resonates on Campus

The psychiatrist on duty at the time of the tragedy recalls the event, the response, and the longer-term lessons learned for the university's mental health services. BY AARON LEVIN

Getty Images/Win McNamee

A decade after the shooting at Virginia Tech, mental health services at the university in Blacksburg, Va.—and at colleges around the country—are better prepared to care for students routinely as well as in emergencies.

During the April 16, 2007, incident, the gunman, Seung-Hui Cho, a university senior, killed 32 students and professors before killing himself.

Like everyone else on campus that

day, Joseph Friebe, M.D., the staff psychiatrist at Virginia Tech's Cook Counseling Center, was locked down until the incident was over.

"Everyone wanted to just do something and be helpful in some way, but in reality there was absolutely nothing that we could do," he told *Psychiatric News* a few weeks later. "Time moved very slowly."

Before the day was over, Friebe was on the phone with Edward Kantor,

M.D., his former residency training director at the University of Virginia and chair of the Disaster Committee of the Psychiatric Society of Virginia (PSV). Kantor, Friebe, and leaders of the PSV wanted to organize an appropriate response to the tragedy. One standard lesson of disaster psychiatry is strengthening local resources while discouraging well-meaning outsiders from parachuting in to the rescue. Kantor and

Friebe asked PSV members to volunteer their services, not in Blacksburg, but in their hometowns elsewhere in Virginia (and later, in surrounding states), where Virginia Tech students would be headed once the semester was over.

"We served as a coordinating buffer," recalled Kantor in an interview. "The event was over, and sometimes too much help coming in only perpetuated the trauma." *see Shooting on page 32*

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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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FROM THE PRESIDENT

Drinking Water From a Firehose

BY MARIA A. OQUENDO, M.D., PH.D.

As far as I was concerned, I had the year of serving as your president all sewn up. My penultimate act was to be in the lovely city of Adelaide in Australia in early May, where I was to represent APA at the Royal Australia New Zealand College of Psychiatrists (RANZCP) Biannual Meeting. After listening to the governor of South Australia talk about his commitment to mental health at the opening ceremony of the meeting, I was honored to describe the kinship between APA and RANZCP, both of which work closely with policymakers to make a difference for our patients. With that commitment behind me, I looked forward to enjoying the final stretch of my presidential year: the 2017 APA Annual Meeting in San Diego.

Nope! Of course not! So not sewn up! Because that is how the entire year has gone. Many plans in place; lots of intervention from the outside world. Naturally, there were all the planned activities: four Board

meetings, two Assembly Meetings, the Institute on Psychiatric Services in Washington, D.C., and two Corporate Advisory Council meetings of the APA Foundation, to mention just a few. But peppered among all those meetings were what I affectionately referred to as the “pop-up” events—meetings and issues that “popped up” all over the place, all the time. Clearly, this was no ceremonial job, no “smile for the camera” job; it was more like a “no rest for the weary” job. So, if you are thinking of running for president, put on your running shoes, and not just for the campaign! Because there is a lot to do and a lot to learn, at least that was so for me. But that is what made it so wonderful. While I worked harder than I could have ever predicted, I was surrounded by wonderful APA staff and APA members ready to teach, ready to advise, and ready to roll up their sleeves.

In my mind, the category of unexpected issues could be divided into three camps.

First, there were the press issues. This was a very busy year, not only because of all the action around health care on Capitol Hill and the general interest in mental health, but most urgently around the Goldwater Rule. Some of the press was eager to report on APA's rationale for it; others were simply looking to embarrass someone, in our case, APA. With the support of the excellent work of the Council on Communications and the fabulous APA Communications staff, I think we were able to keep APA's reputation pristine while speaking clearly about our ethical commitment to protecting our patients and the public from improper armchair diagnoses.

Next, there were the policy issues. From the visit with the commissioner of the Food and Drug Administration

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The new measure set addresses the importance of disclosing a dementia diagnosis to patients and, if possible, their primary caregiver.

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Institutions are rallying around international medical graduates, many of whom are recruited to fill psychiatry positions in underserved areas, leaders say.

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Interested in Expanding Your Practice?

Collaborative care continues to be an exciting area of growth and opportunity for psychiatrists. APA is offering free training under the Transforming Clinical Practice Initiative (TCPI) supported by a \$2.9 million, four-year federal grant. More information about the training is posted at www.psychiatry.org/TCPI.

New Dementia Measures Address Disclosure of Diagnosis to Patients

Patients with dementia and their caregivers want to be able to make realistic plans and thus do not want information about a diagnosis to be hidden from them. **BY MARK MORAN**

Updated quality measures for the care of patients with dementia, including a new measure to encourage disclosure of a diagnosis to patients and family members, have been published by a joint work group of APA and the American Academy of Neurology (AAN).

The document, "Updated Dementia Management Quality Measures," was written by a 26-member work group convened by the two associations and published this month in their respective journals, the *American Journal of Psychiatry* and *Neurology*. It covers nine broad areas of assessment, diagnosis, and treatment and may be adopted for future reporting in the Medicare Quality Payment Program; if so, the measurement set is also likely to be incorporated for use by psychiatrists and other clinicians participating in PsychPRO, APA's mental health registry.

"Driving improvement in clinical practice and care of dementia is the purpose of the new measures," psychiatrist Robert Roca, M.D., M.P.H., M.B.A., co-chair of the work group, told *Psychiatric News*. "The work group was formed for the purpose of updating quality measures that would be truly relevant to clinical practice and that would help align everyday clinical practice with guidelines for quality care."

Roca is vice president and medical director at Sheppard Pratt Health System and chair of the APA Council on Geriatric Psychiatry.

The nine broad areas addressed in the measure set are disclosure of diagnosis, education and support of caregivers, functional assessment, screening for behavioral and psychiatric symptoms, screening for safety concerns, screening for driving safety, advance care planning, screening for pain, and treatment of dementia. (A description of the measures is given in the box at right; specific metrics associated with each measure are in the *AJP* article.)

An especially important and potentially controversial addition to the set is the measure assessing the percentage of patients who are informed that they have been diagnosed with dementia.

"This may be the measure most likely to provoke the most discussion," Roca said. "Because we do not

currently have treatments that can definitively alter the course of dementia, clinicians are sometimes apprehensive about revealing a diagnosis of dementia because of the concern that patients will be very demoralized. In fact, the data show that people want to know the diagnosis and want to be able to make plans. Clinicians need not be afraid to take this subject up directly with patients and their caregivers. For the most part, people don't want this information hidden from them and want to be able to make appropriate plans."

Roca said the dialogue with a patient about a diagnosis of dementia may call especially for the skills of a psychiatrist. "People in the field will recognize that this is a conversation that needs to be opened with special sensitivity and that timing is crucial," he said.



Robert Roca, M.D., believes that psychiatrists may be especially equipped for the sensitive dialogue required when disclosing a dementia diagnosis to a patient and family members.

Other important changes to the measure set involve combining separate measures for screening and management of behavioral and psychiatric symptoms associated with dementia into one measure and a new

measure assessing pharmacologic treatment of dementia.

Roca told *Psychiatric News* that the new measures may be incorporated into the Medicare Quality Payment Program and PsychPRO.

APA Director of Research Philip Wang, M.D., M.P.H., said one of the benefits of PsychPRO is that it will allow APA to develop, test, and deploy new quality measures like the dementia measures.

"The multidisciplinary work group should be congratulated on its hard work to update these critically important quality measures and ensure they are clinically relevant," Wang told *Psychiatric News*. "Going forward, PsychPRO can also help in this process by allowing the field of psychiatry to develop, test, and deploy new quality measures that truly capture the value of psychiatric care."

PsychPRO was created by APA to assist members with quality reporting requirements as well as meeting the requirements for Maintenance of Certification by the American Board of Psychiatry and Neurology.

The original Dementia Management Quality Measurement Set was developed and published in 2013 by AAN as

see *Dementia* on page 37

New Measures Intended to Drive Improvement in Dementia Care

A 26-member work group of APA and the American Academy of Neurology developed a set of measures for the assessment, diagnosis, and treatment of dementia. They are as follows:

- **Disclosure of Dementia Diagnosis.** Percentage of patients with a diagnosis of a qualifying dementing disorder or disease whose diagnosis has been disclosed to them and, if available, their primary caregiver.
- **Education and Support of Caregivers for Patients With Dementia.** Percentage of patients with dementia whose caregiver(s) were provided with education on dementia disease management and health behavior changes and were referred to additional resources for support in the last 12 months.
- **Functional Status Assessment for Patients With Dementia.** Percentage of patients with dementia for whom an assessment of functional status was performed at least once in the last 12 months.
- **Screening and Management of Behavioral and Psychiatric Symptoms Associated With Dementia.** Percentage of patients with dementia for whom there was a documented screening for behavioral and psychiatric symptoms, including depression, and for whom, if screening positive, there was also documentation of recommendations for management in the last 12 months.
- **Safety Concern Screening and Follow-Up for Patients With Dementia.** Percentage of patients with dementia or their caregiver(s) for whom there was a documented safety screening in two domains of risk: dangerousness to self or others and environmental risks, and for whom, if screening positive, there was documentation they were provided with recommendations for their mitigation, which may include referral to other resources, in the last 12 months.
- **Driving Screening and Follow-Up for Patients With Dementia.** Percentage of patients with dementia for whom there was a documented screening for driving risks and for whom, if screening positive, there was also documentation they were informed of alternatives to driving in the last 12 months.
- **Advance Care Planning and Palliative Care Counseling for Patients With Dementia.** Percentage of patients who have an advance care plan or surrogate decision maker documented in the medical record (or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan); and percentage of patients' surrogate decision makers who received comprehensive counseling regarding ongoing palliation and symptom management, and end-of-life decisions within two years of initial diagnosis.
- **Pain Assessment and Follow-Up for Patients With Dementia.** Percentage of patients with dementia who underwent documented screening for pain symptoms at every visit and, if screening positive, also had a documentation of a follow-up plan.
- **Pharmacological Treatment of Dementia.** Percentage of patients with dementia or their caregivers with whom available guideline-appropriate pharmacological treatment options and nonpharmacological behavior and lifestyle modifications were discussed at least once in the last 12-month period.

Enforcement of Parity Law Broadens to Include New Areas of Insurer Violations

The APA Committee on Ethics says that clinicians can ethically inform a patient about opportunities to seek redress when insurance companies have denied or limited the patient's access to necessary care. BY MARK MORAN

The Mental Health Parity and Addictions Equity Act (MHPAEA) has been largely effective in eliminating discriminatory quantifiable treatment limits—outpatient visit or inpatient stay limits—for mental illness or substance use disorders.

But APA staff involved with enforcement of the parity law say that insurance companies have continued to find ways to limit access to care. At least one law firm that has aggressively pursued enforcement of the parity law insists there are wide areas of enforcement in which clinicians and/or patients may be plaintiffs in class-action lawsuits.

Prior authorization, utilization review practices requiring “step care” (the practice of requiring patients to try a lower-cost form of treatment

before being authorized for more expensive care), and other “nonquantifiable treatment limits” are still being used by insurance companies to restrict access to care, said Brian Hufford, J.D., an attorney with Zuckerman Spaeder LLP.

“Insurance companies are at war with the behavioral health community,” Hufford told *Psychiatric News*. “They want to keep down utilization as far as possible. The insurance companies have the upper hand because they control the dollars that pay for treatment. It's important that the mental health community realize that there are wide areas of violation of the parity law, and behavioral health providers and their patients need to be prepared to fight back to level the playing field.”

Irvin “Sam” Muszynski, J.D., APA's senior policy advisor and director of

parity enforcement and implementation, said that the encompassing problem is “network inadequacy”—health plan provider networks that have few mental health professionals available to treat patients. In some cases, health plans have been found to have “phantom networks” that may include physicians who are no longer accepting patients, have moved out of a geographic area, or—in some cases—are deceased.

Patients need to come forward as witnesses or plaintiffs willing to testify that insurance company practices have hindered their access to care.

A study last year by researchers with the American Psychiatric Association Foundation found that the majority of network psychiatrists listed as practicing in the Washington, D.C., area in three major health plan networks were either not able to schedule an appointment or were not reachable at the telephone numbers listed for enrollees to call. The analysis revealed that close to a quarter of the phone numbers for the listed psychiatrists were nonworking numbers or were not associated with a return call. And only 14 percent of psychiatrists were able to schedule any appointment at all; in one plan, only 4 percent were able to schedule an outpatient appointment (*Psychiatric News*, June 17, 2016).

Similar studies being conducted across the country have yielded similar results, according to Muszynski.

Hufford and Muszynski said that an especially prominent problem that contributes to network inadequacy is the practice of discriminatory reimbursement for mental health.

“We hear constantly of inadequate provider networks resulting in patients being on extraordinarily long waiting lists or otherwise having great difficulties finding in-network providers,” Hufford said. “We think that a big cause of this problem is that reimbursement for behavioral health providers is so poor. If we can collect evidence of the fact that reimbursement for behavioral health is much more restrictive than it is for medical care, we believe this can serve as an important part of a parity law claim.”

Muszynski said that APA has engaged with state insurance commissioners and state attorneys general

about provider reimbursement for mental health, and the issue is beginning to attract the attention of insurance regulators. He and Hufford urge psychiatrists to contact APA or Zuckerman Spaeder about discriminatory reimbursement rates and other practices they believe may be limiting access to care in violation of the parity law.

But it's also critical, they said, for patients to come forward as witnesses or plaintiffs willing to testify that insurance company practices have hindered their access to care. The APA Ethics Committee, in response to a query from *Psychiatric News*,

released a statement saying clinicians can ethically inform patients about opportunities to litigate on the patient's behalf when insurance company practices have denied or limited the patient access to necessary care.

The committee statement noted that Section 7 and Section 9 of the *Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry* “encourage psychiatrists to participate in activities that improve public health and access to care.”

The committee statement also said, “It is not unethical for a psychiatrist to inform patients that there may be an opportunity for them to litigate claim denials on behalf of themselves and others who are discriminated against because they have a mental illness and to provide them with the information about how to inquire into this opportunity. It would not be appropriate, however, to force patients into following through or to attempt to influence their decisions.”

Zuckerman Spaeder has aggressively pursued litigation around parity violations. Most prominently, the law firm represented the New York State Psychiatric Association's (NYSPA) suit against UnitedHealth Group challenging a host of restrictions that NYSPA alleged that United had laced on mental health care. The suit alleged such problems as more restrictive internal coverage guidelines, higher evidentiary burdens for authorization of care, more stringent utilization review practices, refusal to pay claims during the appeal process, and applying less favorable reimbursement rates.

An August 2015 ruling by the U.S.

see **Parity** on page 18

Advertisement

Collaborative Effort Among Stakeholders Can Reduce Barriers to Clozapine Use

Challenges surrounding prescribing clozapine may seem intimidating to clinicians with little or no training in use of the drug, but working with primary care physicians and more experienced prescribers can reduce the burdens. **BY MARK MORAN**

To reduce barriers to clozapine use, prescribers should collaborate with primary care physicians to manage side effects that could emerge during treatment of patients with schizophrenia.

Additionally, prescribers should continually seek to improve their own knowledge base with lifelong learning on clozapine treatment. Less experienced prescribers should establish links with more experienced prescribers who can assist them in addressing issues that arise during clozapine treatment.

These were among the recommendations outlined in a recent white paper on the underuse of clozapine—an antipsychotic that remains underprescribed, despite proven efficacy for the treatment of refractory schizophrenia. The report, a publication of the National Association of State Mental Health Program Directors (NASMHPD), was presented as a poster at the International Congress on Schizophrenia Research in San Diego in March.

It is the result of a collaboration of multiple stakeholders and includes recommendations for psychiatric training programs and academic health centers, acute care and psychiatric hospitals, academic scientists and pharmaceutical research programs, local and state health authorities, payers, correctional systems, and providers of continuing education for health professionals.

“Our report provides recommendations to different key stakeholders about what they should be doing at a minimum,” co-author Deanna Kelly, Pharm.D., of the Maryland Psychiatric Research Center, told *Psychiatric News*. “The barriers to use are related to side effects associated with the drug and a lack of provider education. If everyone plays their part, these barriers are not as significant as they may seem. If access to clozapine is improved, millions of patients could benefit. In turn, their improved care would result in substantial cost savings to the entire health care system.”

Prescriber knowledge and comfort around the decision to use clozapine remains a significant barrier to care. In an interview with *Psychiatric News*, Brian Hepburn, M.D., executive director of NASMHPD, said individual clinicians may be intimidated by the

challenges associated with using clozapine, especially the requirement for routine blood monitoring for the risk of neutropenia (a severe reduction in a type of white blood cell).

Individual clinicians tend to overestimate patients’ unhappiness with many side effects of clozapine, including the frequency of blood draws and sedation, when in fact patients report less concern about these disadvantages. “[P]eople with schizophrenia have more favorable attitudes toward

to prescribing clozapine, or have little experience with it, collaborating with clinicians more comfortable using the medication. Telepsychiatry, for

patients receiving clozapine.

Among other recommendations in the report are the following:

- All acute care and psychiatric hospitals should have clozapine on their formularies as an essential medication and have policies and procedures to facilitate its safe and appropriate use.

KEY POINTS

There are several steps clinicians can take to overcome barriers to clozapine use:

- Establish links with primary care practices to assist in the management of side effects that may emerge during treatment with clozapine.
- Continually seek to improve their own knowledge base with lifelong learning on clozapine treatment.
- Collaborate with more experienced prescribers who can assist them in addressing issues that arise during clozapine treatment.

Bottom Line: Collaboration among physicians prescribing clozapine can help diminish burdens associated with using the drug and overcome barriers to underuse.



Deanna Kelly, Pharm.D., says clinicians tend to overestimate patient dissatisfaction with side effects associated with clozapine, as well as the risk of leukopenia.

clozapine treatment than prescribers expect,” the report stated.

Additionally, clinicians tend to overestimate the risk of neutropenia. “[O]ne study reports that about one-quarter of physicians think the risk is greater than 1 percent, when it is actually estimated to occur less than 0.8 percent of the time,” according to the paper. “Furthermore, approximately two-thirds of prescribers do not realize that the greatest risk for severe neutropenia occurs in the first 6 months of clozapine treatment.”

Hepburn said a principle recommendation for clinicians is the need to work together—those who are new

instance, can link clinicians working in rural, isolated areas to urban clozapine clinics where physicians have more experience with clozapine. “What’s important is to provide support to individual practitioners so that they don’t feel as though they are alone dealing with someone who is on clozapine,” he said.

Physicians report that a significant barrier to more widespread use of clozapine is the lack of experience during residency training. “This is critical, as physicians who have never prescribed clozapine are more likely to overestimate the significance of these challenges than current prescribers,” according to the report.

“Incorporating clozapine education in residency training to increase the knowledge of clozapine and comfort level of future prescribers would create a generation of future psychiatrists who have at least had some exposure to real-world clozapine prescribing.”

The NASMHPD white paper recommends that psychiatric residency and training programs include didactic instruction on the use of clozapine, a requirement to become certified under the FDA Clozapine REMS Program, clinical experience in treating and monitoring patients receiving clozapine, and participation in interdisciplinary teams that manage

• Clozapine should be a preferred medication on the pharmacy drug lists of all state Medicaid programs and pharmacy benefit/managed care programs contracting with state Medicaid programs, and on the formularies of Medicare prescription drug programs and other payers of pharmacy benefits.

• Academic centers, in consultation with state or local mental health authorities, should encourage interdisciplinary consultation centers for community providers such as psychiatric pharmacists or nurse practitioners involved in the management of patients receiving clozapine.

• Every public health system of care should have a system that provides ready access to clozapine, provides appropriate safety monitoring of patients receiving it, and encourages prescribers to consider its use when appropriate.

• Mental health authorities should consider establishing model programs for the initiation and monitoring of clozapine patients, and consider offering evidence-based recommendations for addressing metabolic and other emergent side effects. **PN**

“Clozapine Underutilization: Addressing the Barriers” is posted at http://www.nasmhpd.org/sites/default/files/Assessment%201_Clozapine%20Underutilization.pdf.



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Executive Orders Usher in Era of Uncertainty for IMGs, Program Directors

APA has joined other medical groups in expressing concern about the impact of the travel ban on patient care and resident training. **BY MARK MORAN**

White House executive orders barring immigration from certain countries, and a new climate of distrust of immigrants generally, has sown uncertainty among residents from other parts of the world and the directors of their residency training programs, say psychiatric educational leaders.

Though at press time the legal status of the March 6 executive order (EO)

barring immigration from six countries was in limbo after being blocked by district courts in Hawaii and Maryland, educational leaders who spoke with *Psychiatric News* said that the order has fostered unease among residents working in the United States, even those not from the countries directly affected by the EO. (The March 6 order temporarily suspended entry to the United States

of foreign nationals from Iran, Libya, Somalia, Sudan, Syria, and Yemen. A previous order on January 27 that was blocked by state courts also included people from Iraq.)

"Concern about entry to the United States for international medical graduates [IMGs], apart from the status of the executive order, has created a lot of uncertainty for trainees and direc-



Sandra DeJong, M.D., says that the anxiety felt by international trainees about travel to and from the United States comes at a time when there is a general concern about the emotional and physical well-being of physicians and trainees.

tors," Consuelo Cagande, M.D., chair of the IMG Caucus for the American Association of Directors of Psychiatric Residency Training (AADPRT), told *Psychiatric News*. "Trainees who are

here in the country face a lot of anxiety about returning to their home countries, for family or other reasons, because they cannot be sure they will be able to return or not be delayed." She is the psychiatry residency director at Cooper Medical School of Rowan University in Camden, N.J.

The IMG Caucus sponsored a special session on the subject of immigration at AADPRT's March meeting. During that meeting, Jacob Sperber, M.D., who chaired the special session, delivered a harsh judgment on what he characterized as the arbitrary and capricious nature of immigration enforcement, an unpredictability that preexisted the executive orders and has likely been made worse since.

Sperber's comments during the session reflected his own opinion, not that of AADPRT.

"The president's EO creates serious problems of access for immigrant physicians and their families from the countries of origin named in the EO," said Sperber, vice chair for education and training and the psychiatry residency director at Nassau University Medical Center in East Meadow, N.Y. "Their careers and family lives are at risk for disruption, and so are the training programs that have hired them in the established way. So is the health of the patients their training institutions would care for."

In comments later to *Psychiatric News*, he echoed Cagande's remarks *see Uncertainty on page 39*



VIEWPOINTS

We've Come a Long Way

BY JEFFREY LIEBERMAN, M.D.

On March 4, I attended my final Board of Trustees meeting of the American Psychiatric Association, the professional organization of which I have been a member for almost four decades. As I sat next to Dr. Altha Stewart, the new (and first African American) president-elect of APA; observed Dr. Maria Oquendo, the current (and first Latina) APA president, lead the proceedings; and listened while Dr. Saul Levin, APA CEO and medical director (an international medical graduate and gay man), presented his report to the Board, I was suffused with feelings of pride and satisfaction at the diversity of APA's leadership.

In 2012, I had been encouraged by colleagues to run for the APA presidency. This was a departure for me. Although I had participated in many APA roles and activities over the years, I had neither yearned for nor

sought a position in the highest echelon of leadership. However, as the chair of a major department of psychiatry and chief of the behavioral health services at our hospital, my frustration with our country's health policy and financing system had swelled and prompted me to activism.

As I look back on this experience five years later, I feel gratified by what we have been able to accomplish. As president-elect, I had encouraged Maria to run for APA office and was on the search committee that selected Saul to succeed Dr. Jay Scully as CEO and medical director, and then as APA president, officially welcomed and installed him in his position. Dr. Frank Brown, a Native American, was elected treasurer and then, after his term ended, I asked him to stay on the Board as the parliamentarian. When my term in office ended, I chaired, as is the tradition, the Nominating Committee that led to Altha's election as secretary and Maria's election as president.

Much has been accomplished in recent years during my tenure and that of my immediate predecessors (Drs. John Oldham and Dilip Jeste) and successors (Drs. Paul Summergrad and Renée Binder). We completed and launched the fifth edition of *DSM* and established it as a "living document" under the auspices of a steering committee that can integrate changes as occasioned by emergent scientific findings; finalized plans to return APA to the District of Columbia by building a new home in a prime location near the Capitol; augmented the permanent staff of APA; revamped APA's programs and enhanced its range of functions, focusing their emphases and orientation on the members of APA; and enhanced our relationship with the federal government to more effectively contribute to policy and legislation while advocating for increased psychiatric research funding and improving reimbursement of psychiatric services under Medicare. When insurance companies were not complying with the law, we initiated legal actions



Jeffrey Lieberman, M.D., is chair of psychiatry at Columbia University Medical Center and psychiatrist in chief of the New York Presbyterian Hospital. He is also a past president of APA and the author of *Shrinks: The Untold Story of Psychiatry* (Little Brown, 2015).

against them. Most recently we actively supported the Helping Families in Mental Health Crisis Act and 21st Century Cures Act. The latter has culminated in the first ever nominated psychiatrist—Dr. Elinore McCance-Katz—to the newly established position of Assistant Secretary of Mental Health and Substance Use in the Department of Health and Human Services. In addition, we have reversed the downward trend in APA membership for the first time in more than 10 years and seen the number of medical students entering postgraduate training in psychiatry increase by 5 percent this year.

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Risk Management Considerations If You're Thinking of Serving as a Medical Director

Before you sign on the dotted line, here are some questions to ask, issues to weigh, and pitfalls to be aware of. BY KRISTEN LAMBERT, J.D., M.S.W., L.I.C.S.W.

Lately we have been receiving an increase in calls from psychiatrists considering serving in the role of medical director of clinics, office practices, and inpatient and outpatient programs. There are unique liability risks when both practicing in the role as psychiatrist and acting as a medical director. These are some of the issues to consider:

- **Contractual considerations:**

Before considering whether to serve in the role of medical director, the agency/clinic likely will present you with a contract for terms of employment and how your role will be structured within the practice. Keep in mind that the contract is likely designed to protect the business and not necessarily you personally. Prior to signing and accepting the terms, you should consult and obtain advice from an attorney who has experience analyzing employment contracts for physicians. Once you sign the contract, it will likely be more difficult to

alter your role, and there may be provisions within the contract that could impact you significantly.

- **Supervision of staff and compliance with state regulations:**

As the medical director, you may likely be in the role of ultimate supervisor at the agency. You also may be the collaborating physician/supervising physician for other psychiatrists, nurse practitioners, or physician assistants. It is important to know what your responsibilities are both within your employment contract but also what your statutory obligations are within your state. Know whether you are expected to meet with those you supervise and be aware of who the clinic employs and what type of oversight they may require.

It is not uncommon for medical directors to be included in lawsuits if there is an adverse outcome involving a professional within the clinic even if the medical director had no direct involvement with the patient. However, whether there is



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liability for the alleged issue will depend on a number of factors.

- **Ensuring that the clinic's policies and procedures are in compliance with regulations and are adhered to:**

One of the first things you should do as medical director is review the clinic's policies and procedures. Here are a few considerations:

- Do they need to be updated?
- How often are they reviewed?
- Are they in compliance with state and federal laws?
- Do you have a designated person who reviews the policies and procedures on a specific timeframe or when there is a significant change in practice/state regulations?

- **Recognizing situations in which your interests may diverge from the clinic's interests:** What should you do if things go awry? It is important to recognize when your interests differ from the clinic's interests—for example, if you are uncomfortable with billing, administrative, or prescribing practices. If something occurs that is of concern, you should obtain legal or risk management advice on how to best address the situation. It is always advisable to obtain advice as soon as possible to avoid issues that could potentially impact your licensure or place you at risk for a lawsuit or board of medicine complaint. **PN**

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However, it is the election of our recent series of presidents (and officers) culminating in Altha's election that I cherish most of all, as it represents, in my opinion, the heart and soul of APA as an organization that is mission driven as well as inclusive, compassionate, and socially aware.

APA is dedicated to the advancement of psychiatric medicine for the care of patients with mental disorders. At the same time, its members are heterogeneous and composed of multiple constituencies defined not only by clinical focus and professional discipline (for example, clinicians, academics, researchers, and administrators working in the public and private sectors and specialists in such areas as adult, child and adolescent, geriatric, addiction, and consultation-liaison psychiatry), but also age, gender, race, ethnicity, nationality, and sexual orientation. Throughout its history, APA's leadership has variably represented these constituencies in a way that reflects the evolution and directions

of the field and our society.

From 1844 to 1985, the presidents of APA were white men drawn mostly from academic medical centers and universities, with substantial representation of public sector, community psychiatrists. However, in the 1970s, the leadership began to more and more reflect private practitioners and deemphasize the community psychiatrists working in the public sector. In a related trend, the leadership of state mental hospitals and departments of mental health was ceded to nonpsychiatric mental health disciplines, reflecting psychiatry's retreat from the public health arena.

At the same time, APA began to fragment into silos with the formation of subspecialty organizations and special interest groups and caucuses. As APA became more subspecialized and factionalized, it paid a price in its cohesiveness and effectiveness as a professional organization.

But then in 1985, Dr. Carol Nadelson, the first woman president, was elected, followed by Dr. Elissa Benedek in 1990 and Dr. Mary Jane

England in 1995. With the "glass ceiling" broken in the last decades of the 20th century, nine women have been elected president of APA in the first 17 years of the 21st century.

The first Hispanic psychiatrist, Dr. Rod Muñoz, was elected president in 1998, followed in 2006 by Dr. Pedro Ruiz. In 2012, Dr. Dilip Jeste was the first Asian Indian elected President. Unfortunately, we may never know when the first gay psychiatrist was elected to the APA presidency due to the historic social stigma and fear of disclosure of sexual orientation and identity that prevailed until very recently.

While this lineage of APA leadership may have reflected the social standards and biases of American society and the medical profession during those periods, it certainly did not accurately reflect the APA membership or the patients whom they served. In this regard, however, APA was no different than other medical subspecialties and the United States at large.

The extent to which the situation has

changed can be seen in the succession in APA leadership positions of previously underrepresented minorities—women, Hispanic, black, Asian, gay. Indeed, to look around the room at the Board members was to see an impressive display of talent and dedication to APA's mission and diversity of leadership (clinicians and administrators from the private and public sectors, academics, researchers, men, women, young, old, Asian, black, Hispanic, white, gay, straight, not to mention geographic regions) that more fully reflects our membership and patient populations.

I believe these auspicious events reflect the growth of APA and its capacity for self-examination and renewal, which bode well for its future. Indeed, given what is in our power to control, the field of psychiatry and APA are on a roll. As I sat through the final moments of the Board meeting, I couldn't help but feel proud of what APA has accomplished and in doing so reaffirming its commitment to its sacred values and mission. **PN**

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Survey Finds Poor Compliance With Guidelines For Monitoring SGAs in Kids

Less than 20 percent of the child psychiatrists surveyed said they adhere to recommendations to routinely monitor the fasting blood glucose and lipid levels, body mass index, and abnormal involuntary movements of children on second-generation antipsychotics. BY MARK MORAN

Few child psychiatrists monitor children treated with second-generation antipsychotics (SGAs) in accordance with treatment guidelines, even though most are aware of those guidelines and agree with them, according to a survey published April 17 in *Psychiatric Services in Advance*.

"The low rate of monitoring, despite high levels of awareness of and agreement with the need to monitor, suggests that obstacles interfere with adopting these guidelines," Jennifer McLaren, M.D., of Dartmouth-Hitchcock Medical Center and colleagues wrote. The findings of the survey suggest family resistance to monitoring may be one such barrier to compliance.

Youth treated with SGAs are known to be at a greater risk of weight gain, developing type 2 diabetes, and elevated cholesterol. In 2004, APA and the American Diabetes Association published guidelines on screening and monitoring of patients on SGAs, which were endorsed by the American Academy of Child and Adolescent Psychiatry (AACAP) in 2011. The guidelines specify routine monitoring of fasting blood glucose, fasting lipid profiles, body mass index (BMI), and abnormal involuntary movements (AIMs) prior to and periodically after initiating SGAs.

McLaren and colleagues sent the survey to 4,144 working email addresses of child psychiatrists throughout the United States who were registered members of AACAP, excluding psychiatrists in training, between December 2012 and February 2013.

Of the 1,314 psychiatrists who responded, over 95 percent reported they were aware of the guidelines for monitoring children and adolescents on SGAs. Fewer respondents said they agreed with the recommendations—agreement rates ranged from 69 percent for fasting lipids to 80 percent for glucose, 89 percent for AIMs, and 91 percent for BMI monitoring. Less than 20 percent of those surveyed said they had adopted and adhered to the SGA monitoring guidelines.

Additional analysis revealed that psychiatrists who were in academic practice had greater monitoring of glucose, lipids, BMI, and AIMs. In contrast, a physician's length of time in practice was inversely related to monitoring glucose, lipids, and BMI. Many of the psychiatrists surveyed (82 percent) reported that parents who forget to obtain laboratory tests were a barrier to obtaining fasting glucose and lipids. Other commonly cited barriers were parental resistance (52 percent) and children's refusal to obtain the tests (63 percent).

"Potential interventions to improve

adoption include education with audit and feedback directed at specific providers who have not adopted recommended monitoring practices, monitoring reminder systems, and family education to improve knowledge and attitudes about monitoring," the authors wrote.

David Rettew, M.D., an associate professor of psychiatry at the University of Vermont who reviewed the report for *Psychiatric News*, said previous studies have found similar results, but the findings of the current survey are especially striking.

"What is a little surprising is that in the past these low numbers have come from reports that have actually looked objectively at whether these lab tests have been ordered," he told *Psychiatric News*. Moreover, he said the results come from a voluntary self-report where presumably people might overreport compliance with the recommendations, and those who are not compliant would be less likely to respond.

(Rettew was co-author of a 2015 report in *Pediatrics* that found that prescribing patterns of antipsychotic medications for children and adolescents follow best practice guidelines approximately one-half of the time. Lack of adherence to

guidelines was in most cases related to lack of metabolic monitoring, Rettew said, mirroring results from the present study.)

Rettew said the association of compliance with use of an electronic medical record (EMR) suggests that this might be one vehicle to improve monitoring. "Physicians who have EMRs tend to be bombarded with automatic messages that often have little clinical utility, but here is an area where an electronic alert could be very useful," he said. "I know in my own practice that having a message tell me that a particular patient is overdue for lab testing could be quite helpful, but right now that doesn't happen."

He said family resistance to lab monitoring found in the new study mirrors the experience of clinicians in practice. "Nobody likes getting their blood drawn but for some kids it can spark major anxiety and outbursts," he said. "This presents a difficult dilemma for the treating clinician and it is important that patients and families be fully informed of the risks." **PN**

■ "Monitoring of Patients on Second Generation Antipsychotics: A National Survey of Child Psychiatrists" is posted at <http://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201500553>.

Advertisement

Promise and Reality of Genomics: Link to Schizophrenia Involves Lots of Unknowns

Hundreds of possible gene mutations may act alone or with each other to determine phenotypic expression of schizophrenia. BY MARK MORAN

Better treatments for schizophrenia rely on a more complete understanding of how genetic mutations alter the activity of neural circuits in patients with the disease.

That's the message National Institute of Mental Health (NIMH) Director Joshua Gordon, M.D., delivered to researchers and clinicians during a plenary lecture at the International Congress of Schizophrenia Research in San Diego in March.

Gordon said the path forward for genomics and schizophrenia, though promising, is extraordinarily daunting: hundreds of potential gene mutations act through the same complex chain—genes to molecules to cells to circuits to behavior—resulting in a diversity of possible phenotypes. This wide range of phenotypes accounts for what has traditionally been called the “heterogeneity” of schizophrenia.

“There is the promise of genetics, and there is the reality,” Gordon said at the meeting. “The reality is that there are hundreds of genes that contribute to subsyndromal or syndromal schizophrenia, and each one of these mutations has a very small effect size. There is a lot of biology [between the mutation and the phenotypic expression of disease] that we don't understand. When you throw in environmental influences, it makes the complexity picture completely non-linear.”

Gordon gave an example of how genetics contribute to understanding the differential phenotypic expression of schizophrenia based on his own work at Columbia University and the New York Psychiatric Institute prior to his becoming director of NIMH.

He and colleagues focused on the 22q11 microdeletion, a tiny mutation in a portion of chromosome 22 known to be associated with schizophrenia and cognitive deficits. They found that mice bred with the 22q11 microdeletion took longer to learn a working memory task than those that did not have the mutation.

Additional analyses suggested that the working memory impairments in the mice appear to be due to disrupted communication between the hippocampus and the prefrontal cortex, where spatial information is encoded in memory. Even further, Gordon and



NIMH Director Joshua Gordon, M.D., says extremely large study cohorts are necessary to help prioritize targets for genetic research in schizophrenia.

his long-time collaborator Joseph Gogos, M.D., Ph.D., were able to elucidate neurochemical abnormalities in the development of axons (the threadlike fibers from a neuron that transmit information to another neuron), which appear to account for disrupted communication between the hippocampus and prefrontal cortex.

Gordon said this work illustrates how genetic mutations and the various behavioral phenotypes associated with schizophrenia can be linked to offer a more complete understanding of the neurobiology of the disorder. In this case, one phenotypic expression (impaired working memory) is associated with a genetic mutation

(22q11) that is linked to cells and neural networks specifically associated with disrupted communication of information between two brain structures (the hippocampus and prefrontal cortex).

Yet as elegant as it appears, Gordon said it almost certainly oversimplifies the true picture of what happens in schizophrenia. “The bigger problem is that it represents only a portion of what we know about schizophrenia genetics,” Gordon said, with hundreds of other possible gene mutations that may act alone or in concert with each other to determine phenotypic expression.

What is necessary and what Gordon said he and other researchers

hope to find is “critical convergence” of research findings—“where some significant amount of schizophrenia is explained by one common convergent pathophysiology.”

For that, he said, it will be necessary to collect data on extremely large population cohorts to link genomics to phenotypes.

That's an enormous undertaking. Gordon said he has appointed the Workgroup on Genomics of the National Advisory Mental Health Council and charged it with answering the following questions:

- What are the best strategies for prioritizing genetic signals/genes for functional analyses?
- What are the best experimental and computational tools for investigating genetic risk factors?
- How can NIMH leverage diverse population-based cohorts to enable large-scale genomic discovery?
- How should dimensional phenotypes be used to further elucidate the genetic architecture of mental disorders?

In the meantime, Gordon suggested the way forward toward better treatment of patients with schizophrenia is to leverage developing integrated care networks to make the treatments that exist—antipsychotic medication and evidence-based psychosocial therapies—available to patients in primary care.

“But I deeply believe that in order to truly transform the efficacy of drug treatment for schizophrenia we need to understand the neurobiology of the disease,” he said. **PN**

Parity

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Court of Appeals for the Second Circuit recognized that NYSPA could represent its members and their patients in pressing a claim under the MHPAEA through “associational standing.” Also, the court decision (overruling a lower court) recognized that United could be sued even when it acted not as the insurer but as the administrator of a self-insured plan. This means that the carriers are at risk under MHPAEA whenever they exercise discretion in the administration of benefits and employees do not have to sue their employer (as United argued) to recover benefits (*Psychiatric News*, October 16, 2015).

The firm is currently pursuing a case in New York state against UnitedHealth, claiming the insurance company restricts coverage of nutritional counseling for patients with

anorexia in violation of the parity law.

Hufford said since passage of the parity law—and regulations issued by the government requiring strict interpretation of parity rules—insurance companies have become more creative in finding ways to keep utilization low.

That's a message APA shared last year with the White House Task Force on Parity, appointed by then President Barack Obama. When the task force's report was released last October, among its recommendations was that the federal government work with the National Association of Insurance Commissioners and states to develop a standardized template that states could use to help assess parity compliance.

Hufford noted, however, that some insurance practices are difficult to litigate under the parity law, which requires a comparison of insurance company practices across the mental health/substance use and medical/

surgical areas of coverage. For that reason, he said, the firm is turning to charging insurance companies with failure of fiduciary responsibility under ERISA (Employee Retirement Income Security Act).

“Insurance companies are applying hidden internal guidelines that allow them to be more restrictive of mental health care,” Hufford said. “It's important that people in the behavioral health community—providers and patients—understand that they don't have to take it lying down, and there are ways to fight back.” **PN**

APA members interested in learning more about opportunities for seeking redress of parity violations should contact Muszynski at imus@psych.org. A poster created by APA that spells out patients' rights under the parity law and outlines steps to take when they believe their rights have been violated is posted at www.psychiatry.org/psychiatrists/practice/parity.

Hallucinations Can Be Marker For Variety of Psychiatric Disorders in Youth

Understanding the experience of hallucinations among children and adolescents can help clinicians and researchers better understand the trajectory of individuals deemed to be at risk. **BY MARK MORAN**

Auditory or other hallucinations are not uncommon in childhood and adolescence, are most often transitory, and do not necessarily indicate that later onset of psychosis is inevitable.

However, hallucinations experienced at multiple points in adolescence are an indicator of persistence of symptoms and appear to be associated with a significantly higher risk of a variety of mental illnesses later in life—not only psychosis—as well as with suicidality.

Those were among the take-away messages from several speakers at the International Congress of Schizophrenia Research in San Diego in March.

A World Health Organization (WHO) survey of more than 31,000 adults found that the lifetime prevalence of any hallucination was 5.2 percent. Of those reporting hallucination, 32 percent said they experienced hallucination just once, and another 32 percent said they experienced hallucinations between two and five times.

Persistence of such experiences is a risk factor for later onset of disorders. James Scott, M.D., Ph.D., an affiliate associate professor at the University of Queensland Centre for Clinical Research, Australia, reported results from the Mater-University of Queensland Study of Pregnancy (MUSP). This study analyzed data on the mental health outcomes of individuals aged 30 to 33 who had filled out the Youth Self-Report Questionnaire at ages 14 and 21 and individuals who reported never having experienced hallucinations.

A total of 455 participants (12.9 percent of the sample) self-reported having hallucinations at age 14 but not at age 21, and 140 (4 percent) self-reported hallucinations at both 14 and 21. These individuals were compared with 490 controls who reported no history of hallucinations at either time point.

Lifetime diagnoses of mental disorders were ascertained by the Structured Clinical Interview for DSM Disorders (DSM IV-TR), and suicidal behavior was measured by self-report. Scott and colleagues also identified participants not engaged in education or employment (NEET) using the Activity and Participation Questionnaire



Ian Kelleher, M.D., Ph.D., says physicians should ask children and adolescents about hallucinations, as they may be reluctant to report them, and parents may not know about them.

(APQ6). Quality of life was measured using the Assessment of Quality of Life (AQoL) scale.

Those with hallucinations at both 14 and 21 years had close to nine times the chance of having a psychotic disorder by 30 years of age, 2.3 times the chance of having a substance use disorder, and 3.6 times the chance of having an eating disorder. Moreover, those who reported hallucinations at both time points had more than seven times the risk of any lifetime suicide attempt. They were also more likely to be unemployed or not engaged in training and four times as likely to have poor quality of life, Scott reported.

Scott said adolescent experience of hallucinations calls for a thorough mental health assessment, including for present or past trauma, suicidal ideation, and substance use. But equally important is the message that most adolescent experience of hallucination is transitory.

“When there is no evidence of current psychosis, advice and reassurance are called for along with follow-up to determine whether hallucinations continue,” he said. “Most adolescents who experience hallucination are not going to progress to psychosis, and most don’t develop schizophrenia. But it’s really important

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Advertisement

Patient Attitudes Toward 'At Risk' Status May Affect Treatment, Outcome

Much work remains to be done in developing anti-stigma strategies that could be part of a clinical high-risk intervention. **BY MARK MORAN**

What is the effect on a young person of being told—by teachers, peers, family members, or clinicians—that he or she is “at risk” of psychosis or schizophrenia?

What kind of experiences does that young person bring to treatment in early intervention programs? How do those experiences affect treatment adherence and recovery? And how can the movement toward early identification and intervention incorporate strategies to address the potential stigma attached to being “at risk”?

Those are some of the questions being explored in research by Lawrence Yang, Ph.D., an associate professor of social and behavioral sciences at New York University; Larry Seidman, Ph.D., a professor of psychology in the Department of Psychiatry at Harvard Medical School; and William McFarlane, M.D., professor of psychiatry at Maine Medical College. Seidman is the principal investigator of the high-risk intervention program at Beth Israel Deaconess Medical Center (affiliated with Harvard Medical School), which is part of the North American Prodrome Longitudinal Study (NAPLS), a consortium of nine sites compiling longitudinal data on individuals deemed to be at clinical high risk (CHR) for psychosis.

Their study, “Predictors of Being ‘Most Impacted’ by Psychosis in Self-Identity Among Individuals at Clinical High-Risk for Psychosis,” is looking at factors affecting stigma and self-identity among 120 individuals being treated at three early identification/intervention sites—Beth Israel Deaconess Medical Center, the Portland Identification and Early Referral Program (PIER) in Portland, Maine, and Columbia University/New York Psychiatric State Institute in New York. (The last two are not a part of the NAPLS consortium.)

Yang presented baseline data from the study at the International Congress on Schizophrenia Research in San Diego in March. Notably, close to two-thirds of the sample (n=63) had been told that they were at risk for psychosis or schizophrenia.

Perhaps most significant for future research and intervention strategies, the factor that is most predictive of individuals’ considering themselves

“most impacted” by psychosis is being told that they are at risk for psychosis/schizophrenia. That is, being labeled by others (as opposed to what individuals identified as high risk might think of themselves) appears to be a critical factor in self-identity and one that elevates the impact of the label of “at-risk for psychosis/schizophrenia.”

(Yang and Seidman explained that “impactfulness,” in the context of the survey, refers to whether the designation of “at risk” affected how the individual thinks about himself or herself and the need to make changes or adjustments in response to a label.)

“For clinicians working in specialty clinics for individuals identified as high-risk patients, it’s important to gauge with whom they have been in contact and what those individuals might have told them,” Yang told *Psychiatric News* at the Congress. “The patient may bring those ideas and attitudes into treatment. Clinicians should be aware of that and prepared to offer some psychoedu-



Lawrence Yang, Ph.D. (left), and Larry Seidman, Ph.D., say clinicians can help dispel misconceptions about being “at risk” for psychosis—such as the idea that it means psychosis or schizophrenia is inevitable.

cation around those issues.”

Seidman said the research points to the fact that the subjective experience of being at risk is largely a black box: How does that experience affect participation in treatment and recovery? And can how early intervention programs use this knowledge to address stigma as a part of treatment?

“There’s a real need for greater understanding on the part of clinicians about the variety of ways people think about these symptoms, and there is a lot of work to be done in developing anti-stigma strategies that could be part of the clinical high-risk intervention strategy,” he said.

Hallucinations

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ant to avoid cannabis use.”

Scott was joined at the symposium by Ian Kelleher, M.D., Ph.D., who discussed the relationship between hallucinations and suicide—especially whether the relationship is mediated by the strong relationship between borderline personality disorder (BPD) and suicide. Kelleher is a research lecturer at the Royal College of Surgeons in Ireland.

Kelleher reported data that was published in the March 2017 editions of the *British Journal of Psychiatry* and *Acta Psychiatrica Scandinavica* on a nationally representative sample of individuals from the 2007 Adult Psychiatric Morbidity Study of British households. Participants were assessed for common mental disorders, BPD (clinical and subclinical), suicidal behavior, and auditory and visual hallucinations.

He and colleagues found that approximately 4 percent of the total sample (n=323) reported hallucinations. These experiences were associated with increased odds of suicide attempts across the board—whether it be in individuals with BPD, individuals with a common mental disorder, individuals without a common mental disorder, or individuals with neither a common mental disorder nor BPD.

Kelleher said the results suggest that the relationship between hallucinations and suicide is not driven by association with BPD and that experience of hallucinations is associated not only with psychosis, but also with several common mental disorders. “Hallucinations should be regarded as trans-diagnostic markers for a variety of mental illnesses,” he said.

He said that the high prevalence of hallucination among children and adolescents and the association with multiple disorders and suicide call for

Surprisingly, while a third of the sample rated themselves “most impacted” by the “risk” label for psychosis/schizophrenia, two-thirds rated themselves most impacted by other, nonpsychotic condition labels—especially anxiety and depression.

Yang and Seidman suggested that the finding relates to the fact that nearly all individuals being treated in high-risk clinics have a long history of wrestling with mental health problems and may be likely to subsume information about their risk for psychosis into that history of other problems.

Moreover, they said, young people are likely to be subjectively more concerned with concrete problems in their daily lives—school work and being able to function in social situations—than with a future risk of psychosis. “The subjective complaints of high-risk patients are likely to be about cognitive problems—‘I can’t think, I can’t concentrate, I can’t do my schoolwork,’” Seidman said.

Further research on self-identity and stigma among the CHR population may prove crucial. Concerns about stigma and false-positives were important factors in debates about whether to include criteria for “clinical high risk syndrome” in the main text of *DSM-5*. While these criteria identifying individuals at clinical high risk can reliably predict conversion to acute psychosis approximately 30 percent of the time, many youth will never convert but will continue to have sub-syndromal symptoms. Much recent research revolves around how to refine prediction of outcome among

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greater clinical attention to the subject.

“A huge number of people have these experiences, and hallucinations in adolescence are most commonly transient,” he said. “Very few people talk about them, and parents are often unaware of their children’s experience of hallucinations. When people look online for information, the only thing they are pointed to is psychosis and schizophrenia, and people are frightened by that. But it’s important to realize that hallucinations can occur across a wide range of mental illnesses, not just psychosis.” **PN**

More information about discussions at ICOSR is posted at https://academic.oup.com/schizophreniabulletin/article-abstract/43/suppl_1/S8/3075362/6-2-Course-of-Auditory-Hallucinations-From?redirectedFrom=fulltext. “Psychotic Experiences and Suicide Attempt Risk in Common Mental Disorders and Borderline Personality Disorder” is posted at <http://onlinelibrary.wiley.com/doi/10.1111/acps.12693/abstract>.



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National Academies Issues Report on Health Effects Of Cannabis

The first NASEM report on this subject in 18 years concludes that cannabinoids have some medical benefits, but cannabis use poses several long-term health and safety risks. BY NICK ZAGORSKI

Earlier this year, the National Academies of Science, Engineering, and Medicine (NASEM) released a report on the health effects of cannabis and cannabinoids. This report—which features some 100 conclusions related to the health effects of recreational and therapeutic use of the drug and related products—offers the most comprehensive analysis of available evidence since 1999.

“For years, the landscape of marijuana use has been rapidly shifting as more and more states are legalizing cannabis for the treatment of medical conditions and recreational use,” Marie McCormick, M.D., Sc.D., chair of the 16-person committee who wrote the report, said in a press statement. “As laws and policies continue to change, research must also.”

As such, in addition to offering conclusions on the health effects of cannabis, the committee included

in the report four broad recommendations to improve cannabis-related research moving forward. The recommendations included strategies to tackle existing research gaps, improve existing research standards and benchmarks, strengthen federal and state-based public health surveillance, and address regulatory barriers.

“The new report is based on reviews of research on both the cannabis plant itself and its constituents, but its conclusions are substantially similar to the 1999 report,” Nora Volkow, M.D., director of the National Institute on Drug Abuse (NIDA), wrote on her blog following the release of the report.

“While cannabis use, particularly smoked cannabis, poses some long-term health and safety risks, there is evidence that cannabis or cannabinoids can treat certain medical

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How Strong Is Link Between Cannabis Use, Mental Health Effects?

Among the nearly 100 conclusions about the therapeutic benefits and risks of cannabis/cannabinoid use made by the National Academies were numerous findings in the mental health arena. Below are the conclusions that have at least moderate evidence (that is, enough data to make general conclusions, but with enough risk of chance, bias, or confounding factors to not rule out other explanations).

There are enough data to draw firm conclusions of the following, with a limited risk of other explanations due to chance, bias, or confounding factors:

- Cannabis use is associated with the development of schizophrenia and other psychoses.

- Starting cannabis use earlier in life increases the risk of problem cannabis use.

- Stimulant use in teenagers with attention-deficit/hyperactivity disorder (ADHD) is not a risk factor for problem cannabis use.

There is moderate evidence of the following:

- Cannabis use increases symptoms of mania and hypomania in people with bipolar disorder.
- Cannabis use is associated with an increased risk of developing depression, and depression is a risk factor for developing problem cannabis use.

- Cannabis use is associated with increased incidences of suicidal ideation, attempts, and completion.

- Regular cannabis use is associated with an increased incidence of social anxiety disorder.

- Anxiety disorders, personality disorders, and bipolar disorder are not risk factors for problem cannabis use.

- Adolescent ADHD is not a risk factor for problem cannabis use.

- Problem cannabis use is associated with increased severity of PTSD symptoms.

‘Night Owl’ Schedule Linked to Depression in Type 2 Diabetes

The study provides further evidence that good sleep hygiene is an important component to maintaining health for people with diabetes. BY JOANN BLAKE

Patients with type 2 diabetes who are night owls are more likely to report symptoms of depression than early birds, who follow early-to-bed, early-to-rise sleep routines, according to a study presented at the annual meeting of the Endocrine Society in Orlando, Fla., last month.

Patients with type 2 diabetes are already known to be at a greater risk for depression than the general population. Previous studies have shown that untreated depression can lead to adverse patient outcomes involving diabetes self-care, blood glucose control, and complications of diabetes, said lead investigator Sirimon Reutrakul, M.D., an associate professor at

Mahidol University Faculty of Medicine, in Bangkok, Thailand.

Diabetics with a “later or evening chronotype,” a preference to go to bed late and wake up late, tend to experience more symptoms of depression than those with the disease who turn in early and wake up early, an “early or morning chronotype.” A chronotype is the tendency, possibly from a genetic-environment interaction, for an individual to sleep at certain times during a 24-hour period. Previous studies have also found higher rates of depression among night owls in the general population.

These findings, said Reutrakul, support an association between circadian system regulation and psychological functioning in patients with type 2 diabetes. She emphasized, though, that this research does not prove cause and effect.

“We need to further explore a combination of interventions that help with

circadian timing, such as light therapy and melatonin,” she said. “Learning more about the relationship between depression and circadian functioning might help us figure out strategies to improve physical and mental health for patients with diabetes.”

Because geographic location may influence chronotypes (with a greater morning preference near the equator), the investigators studied diabetic patients in Chicago and Thailand. Chronotype was assessed using the Morningness-Eveningness in the Thailand group. Depressive symptoms were evaluated by the Center for Epidemiologic Studies Depression scale (CES-D). Sleep quality was determined using the Pittsburgh Sleep Quality Index (PSQI). Demographics, diabetes history, and complications were collected. HbA1c values were retrieved from medical records.

Researchers found that the “later phenotype” was significantly

associated with higher CES-D scores. This finding remained constant even after the researchers adjusted for sleep quality, age, sex, ethnicity, insulin use, PSQI score, and other factors that could affect depression.

The U.S. group consisted of 194 patients, and 70 percent were women. Of the 282 patients in the Thai group, 67 percent were women. Chicago patients answered the questionnaires between February and early April; patients in Thailand, where there is little seasonal weather variation, participated throughout the year.

The study, “Later Chronotype Is Associated With Greater Depressive Symptoms in Type 2 Diabetes Patients: A Study in Two Different Ethnic Cohorts,” was funded by Rush University Medical Center in Chicago, the Endocrine Society of Thailand, Mahidol University Faculty of Medicine, and Faculty of Medicine Ramathibodi Hospital in Bangkok. **PN**

How Are 'SuperAgers' Different From the Rest of Us?

Studying the brains of elderly adults whose episodic memory ability is at least as good as that of middle-age adults could provide clues about healthy aging. **BY JOANN BLAKE**

It is well known that as most people get older, it can take longer to process information and remember everyday details—changes thought to be associated with normal age-related cortical atrophy. For a rare group of elderly adults, however, memory remains as sharp as that of adults decades younger.

Researchers at Northwestern University are studying adults 80 years and older whose episodic memory ability is as good as that of average middle-age adults—known as SuperAgers—in hopes of better understanding how the brain ages.

The program's most recent study, led by Emily Rogalski, M.D., an associate professor and director of Neuroimaging for the Cognitive Neurology and Alzheimer's Disease Center, suggests that the brains of SuperAgers



do not age as rapidly as those of other elderly adults. The study was published April 4 in the *Journal of the American Medical Association*.

To be included in the study, SuperAgers were required to score as well as adults aged 50 to 65 on a memory test and at least "average-for-age" on other cognitive tests. Participants were also required to have had

structural MRIs at two consecutive study visits about 18 months apart and a stable cognitive status.

Researchers measured changes in the brain cortex thickness of 24 SuperAgers and 12 cognitively average elderly people, with similar levels of education, for 18 months. Although both groups suffered brain volume loss due to aging, the average cognitive elderly group experienced a loss more than twice that of SuperAgers—over 2.2 percent compared with 1.1 percent for SuperAgers.

From a visual standpoint, the cortices of the SuperAgers looked "less worn" than their average 80-year-old peers and were similar to those of people in their 50s and 60s, said Rogalski.

Were the brains of "SuperAgers" endowed with a thicker outer layer to begin with? Since the research was done at age 80 and not at age 20, Rogalski said that question can be answered

only indirectly. "When we evaluated the rate of atrophy, we saw the SuperAgers are on a different trajectory path altogether."

SuperAgers also outperformed the other elderly participants in episodic memory tests at the first visit and again 18 months later.

"Finding the factors involved in successful aging could help people live long and well," said Rogalski. "If we're going to live longer, we want to make sure that longevity doesn't outpace the health span."

The study was funded by grants from the National Institutes of Health, including the Alzheimer's Disease Core Center, the National Institute on Aging, and National Institute of Neurological Disorders and Stroke; and the Davee Foundation. **PN**

2 An abstract of "Rates of Cortical Atrophy in Adults 80 years and Older with Superior vs. Average Episodic Memory" is posted at <http://jama.network.com/journals/jama/fullarticle/2614177>.



ETHICS CORNER

When Being Human Is a Boundary Crossing

BY CLAIRE ZILBER, M.D.

"Many people are so overwhelmed by the intensity and intimacy of the therapeutic relationship that they experience an otherwise inconsequential gesture or statement as a full-fledged romance or romantic intrusion."

—O.B. Caudill, quoted by Thomas Gutheil and Archie Brodsky, Preventing Boundary Violations in Clinical Practice

After a busy day in the office, a psychiatrist goes home to have dinner with her family. At 8 p.m., when the kids are settled into doing their homework, she returns a call from a patient from earlier in the day. To the doctor, this is merely an issue of time management. For the patient, it could seem like unusual behavior and be interpreted as a sign that the patient is either very special or very troublesome to the doctor.

Rising from her chair at the end of a session, a patient stumbles and loses her balance. The psychiatrist reflexively catches the patient's elbow to steady her and leads her to the door with this support. This chivalrous gesture could leave the patient feeling either grateful to the doctor, romantically aroused, or intruded upon, depending on the patient.

Like many subtle boundary crossings, these examples demonstrate ways in which a psychiatrist may view his or her behavior as innocuous or helpful while a patient might perceive it as confusing, frightening, unwanted,

or seductive. The psychiatrist may remain oblivious to the effect of his or her behavior unless the patient is brave enough to discuss what happened, which temporarily shifts to the patient the responsibility for managing the therapeutic relationship, a function ordinarily assumed by the psychiatrist.

Left unaddressed, the tension from these rifts in the therapeutic relationship occasionally lead patients to initiate a complaint to an ethics committee or a licensing board. A single hug initiated by a psychiatrist in celebration of a patient's achievement, an exchange of a photograph of the psychiatrist so the patient can have a transitional object, or frequent phone contact outside of regularly scheduled sessions, while potentially therapeutic, can at times be perceived by the patient—and regulatory authorities—as inappropriate.

How might a psychiatrist behave in the fairly human ways in the above illustrations while fulfilling the expectation that his or her behavior not disrupt the treatment? Any time a

psychiatrist's behavior varies from its usual course, the psychiatrist should consider discussing it. As is often stated in residency training, "It's not what you say (or do), it's what you say (or do) next." It may be useful to run through the following steps each time professional behavior falls outside the norm.

- **Reflect on what happened.**

How was this behavior different from the usual? Is there something about this particular patient that elicited unusual behavior? Is there something going on in the psychiatrist's life that is shifting him or her away from standard practice? What are the ways the patient might perceive and respond to this departure from the norm?

- **Consider consultation.** If the transference or countertransference feels unusual or intense, supervision may be beneficial. If the psychiatrist is vulnerable because of a life crisis, psychotherapy may be helpful. Seeking guidance, even if it's just for reassurance, is always a good idea.

- **Acknowledge the boundary crossing to the patient as a way of inviting discussion.** This might happen right away at the moment of the unusual behavior, such as, "I know I'm calling later than usual. I

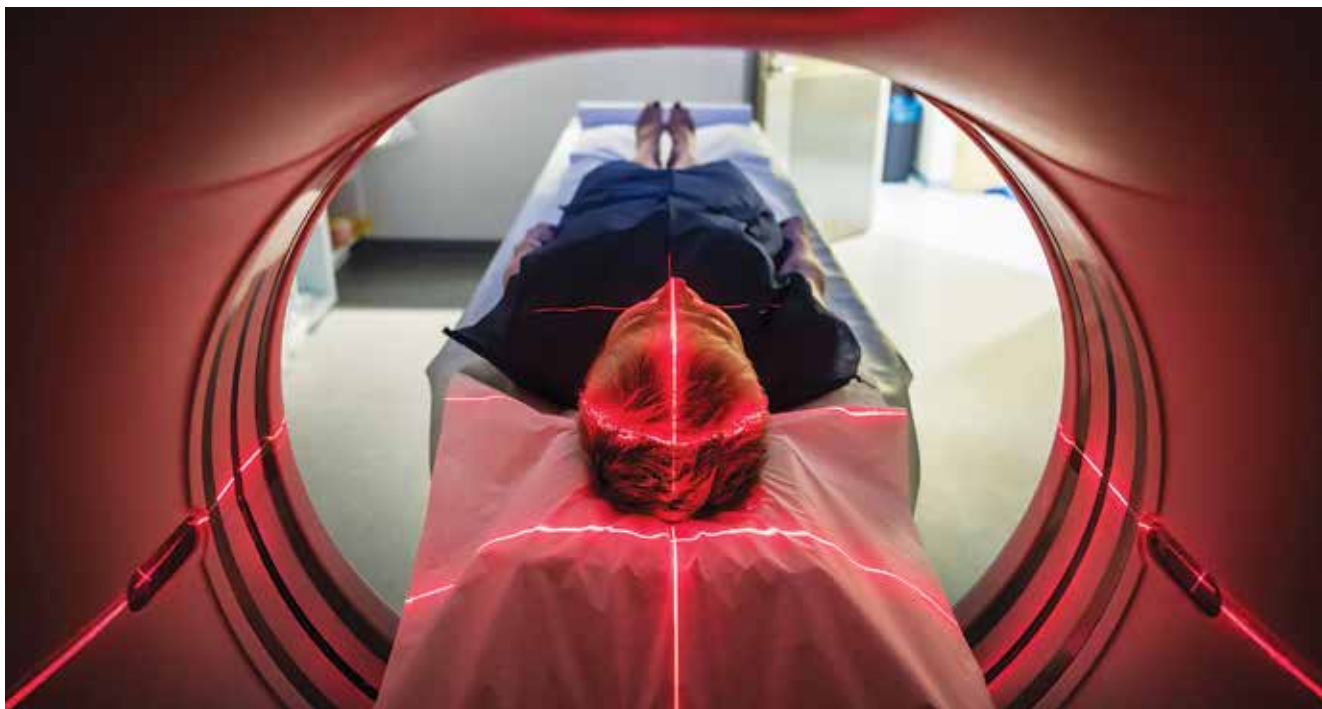


Claire Zilber, M.D., is chair of the Ethics Committee of the Colorado Psychiatric Society, a corresponding member of APA's Ethics Committee, and a private practitioner in Denver.

sometimes return calls in the evening so I can have dinner with my family." Or it might happen in the next session or several sessions later if consultation is required.

- **Apologize if the patient expresses discomfort as a result of your behavior and invite further exploration.** "I'm sorry that when I grabbed your elbow, it felt patronizing to you. Are there other times when you have felt patronized by me or by others?"

Psychiatrists are not automatons. It is inevitable that at times a psychiatrist's behavior will surprise or upset a patient when it differs from expectations of how the profession behaves. Employing one's observing ego to preempt departures from the norm when possible, reflecting on what precipitated a boundary crossing, seeking consultation, and discussing the interaction with the patient, including an apology if appropriate, allow the psychiatrist to reestablish his or her professionalism and restores equilibrium in the treatment relationship. **PN**



iStock/Johnny Greig

Imaging Advances Could Aid Prediction Of Outcome in High-Risk Patients

Findings from imaging that could aid in prediction are converging around differences in glutamate and dopamine activation in three crucial areas of the brain. **BY MARK MORAN**

Brain imaging is revealing differences between individuals at high risk for psychosis that will help clinicians distinguish those who are likely to progress to acute psychosis, those whose symptoms will remain subsyndromal, and those who may recover.

Among patients with existing psychosis, these advances may also help distinguish those who will respond to antipsychotic treatment from those who will not, said Phillip McGuire, M.D., a professor of psychiatry and cognitive neuroscience at Kings College, London. He presented a plenary lecture at the International Congress of Schizophrenia Research in San Diego in March.

Specifically, McGuire said imaging advances point to important differences among patients in a triad of brain regions—the hippocampus, mid-brain region, and striatal cingulate region—and neurochemical differences in dopamine and glutamate activation in those regions. The hope is that imaging results, along with other relevant predictive data (demographics, family history, etc.) could be analyzed in a handheld device allowing a clinician to make determinations about risk stratification at the patient's presentation.

The findings can also help facilitate the development of alternative treatments for those who do not respond to existing treatments, he said.

McGuire noted that advances are

being made in predicting outcome using other strategies—including peripheral biomarkers and clinical/demographic predictor tools—but he focused his remarks on neuroimaging.

“Neuroimaging has been quite successful at a group level in differentiating individuals who are clinically identical but are likely to have different outcomes,” he said. “These are not trivial differences, but clinically significant differences, in outcome. One of the major research efforts now is to translate these findings into tools that can be used in clinical practice. That is the goal over the next five or 10 years. Once these tools have been developed, we would like to be able to develop alternative treatments for different stratified groups.”

The neuroimaging findings are important because they can help resolve a critical problem in the identification and treatment of at-risk individuals: How can clinicians better predict who, among those deemed at clinical high risk, will actually convert to acute psychosis?

The last decade and a half has seen an enormous focus on early identification of patients at clinical high risk, resulting in criteria that were included in Section 3 of *DSM-5*. Those criteria encompass such factors as family history, social withdrawal, deficits in function, and attenuated psychotic symptoms. The criteria can reliably predict progression to psychosis approximately 30 percent



Mark Moran

“If we had predictive biomarkers, we could intervene more selectively ... with a lighter touch in patients who may not convert to psychosis or who might even spontaneously recover,” says Phillip McGuire, M.D.

of the time, but a sizable portion of at-risk individuals will have persistent subsyndromal symptoms without developing psychosis, or may even spontaneously recover.

But which patients will fall into which category, and how can clinicians avoid the problem of false-positives? Moreover, with the exception of clozapine, existing antipsychotic treatments have relied for decades on dopamine blockade even though a significant number of patients with psychosis do not respond to D2 antipsychotic antagonists.

“This is not an academic issue but is grounded in real clinical practice,” McGuire said. “A key problem in the management of clinical high-risk

psychosis is that it is very difficult to predict clinical outcome on the basis of clinical presentation alone. If we had predictive biomarkers, we could intervene more selectively—perhaps more assertively in patients we were confident would have a psychotic disorder and with a lighter touch in patients who may not convert to psychosis or who might even spontaneously recover.

“In patients with established psychosis, we know that antipsychotics will work in two-thirds of patients, but for up to a third the response will be disappointing.”

McGuire provided an overview of neuronal imaging as it pertains to risk stratification over the last 15 years, beginning with MRI findings showing that the subset of CHR patients who develop psychosis have a smaller hippocampus and higher levels of resting-state activity in the mid-brain, hippocampus, and basal ganglia. Imaging has also shown elevated glutamate in the hippocampus among those who develop psychosis.

“The important concept here is that at the clinical level, these individuals are indistinguishable, but at the imaging level, there are important differences,” he said.

Neurochemical abnormalities regarding treatment response that have been found using imaging have been especially revealing, particularly with regard to dopamine activity, long regarded as a common factor in schizophrenia. McGuire said patients who respond to treatment show classically elevated levels of striatal dopamine function; however, in those who don't respond, glutamate is elevated while dopamine function is comparable to that of controls.

“Conceptually this is important because it is the first evidence that the psychotic population is heterogeneous in terms of neurochemistry,” McGuire said, and it points to the need for alternative forms of antipsychotic treatment.

Ultimately, McGuire said the goal is to translate these findings into usable tools in the clinical setting. “A key consideration is that all of these findings are at the group level revealing mean differences between one group and another,” he said. “In clinical practice, you have to make a decision about the patient sitting in front of you. The challenge is to develop a test powerful enough to work with data from a single individual.

“The real deliverable goal is not a scientific paper describing mean differences but a tool that clinicians can use in practice—such as an iPad device that would allow a clinician to enter data from an individual patient and get a readout regarding the patient's likely outcome.” **PN**

Advertisement

Advertisement

Brain Scans May Indicate Optimal Treatment for Depression

The degree of resting-state functional connectivity between brain regions involved in mood regulation hinted at depression patients most likely to respond to CBT or antidepressants. BY JOANN BLAKE

Brain-based measures used in emerging research may help psychiatrists to personalize treatments for patients with major depressive disorder (MDD).

As it stands now—apart from weighing a wide-ranging set of symptoms or patient preference—psychiatrists often resort to a trial-and-error process, according to Helen Mayberg, M.D., a professor of psychiatry, neurology, and radiology at Emory University School of Medicine.

“We’re all looking for markers that will move us toward precision treatment, like our colleagues in cancer research who took the same stance and turned the field upside down,” she said.

While previous studies suggest psychotherapy and antidepressants in combination improve remission rates in MDD patients, the cost and time associated with this combination therapy can serve as barriers for some.

Mayberg together with Broadie Dunlop, M.D., director of the Emory Mood and Anxiety Disorder Program and W. Edward Craighead, Ph.D., a professor of psychiatry and behavioral science at Emory, set out to see if they could identify brain signatures capable of predicting how MDD patients receiving cognitive-behavioral therapy (CBT) or an antidepressant medication would respond.

Using functional MRI (fMRI), the researchers assessed the resting-state functional connectivity between the subcallosal cingulate cortex (SCC) and three other brain regions—the dorsal midbrain, the ventrolateral prefrontal cortex and anterior insula, and the ventromedial prefrontal cortex—in 122 patients with depression.

The patients, none of whom had received previous treatment for depression, were then randomly assigned to receive 12 weeks of CBT or treatment with one of two antidepressant medications: escitalopram or duloxetine. CBT consisted of 16 individual sessions, 50 minutes each. No placebo was used, and patients who did not remit after 12 weeks with a single treatment were offered combination treatment for an additional 12 weeks (CBT was added to medication nonremitters and escitalopram was added to CBT nonremitters).

Of the 122 participants, 58 achieved remission at weeks 10 and 12 (defined as a HAM-D score of ≤ 7), and 24 had treatment failure (defined as a <30 percent reduction from baseline HAM-D score at week 12). A total of 40 patients had intermediate outcomes.

Overall, patients with positive connections (greater functional connectivity) between the SCC and other regions examined were significantly more likely to achieve remission with CBT, while those with negative or absent connectivity were likely to remit to medication. Conversely, patients with positive connections did not remit when medications were used, and those with negative or absent connectivity did not remit to CBT. Some patients fell into a middle “gray zone,” which did not suggest a specific treatment.

Precision medicine should involve the prediction of both the desired outcome (remission) and the most undesired outcome (treatment failure), the study authors noted. “Severe consequences for choosing the ‘wrong’ treatment underscore the need for biomarkers predictive of both remission and treatment failure,” they wrote.

These emerging findings should help shape the prescribing patterns of clinicians, said Mayberg.



Helen Mayberg, M.D., says that research suggests there is a group of people who should not be prescribed an antidepressant because of their specific neural circuitry. Neuroimaging may one day help identify these individuals.

“A person who seeks out help from a psychiatrist and receives treatment is likely to get a first-line SSRI. If that doesn’t make the person better, the clinician should not assume the patient needs more drugs,” she said. “This research suggests trying psychotherapy instead. There is clearly a group of people who should never use a drug to get well.”

From a practical standpoint, Mayberg believes it is premature to advocate that brain scans be used now to determine the best treatments for depression

patients in clinics because of cost and other considerations. Still, her findings in this area demonstrate the way imaging technology today may one day be used to personalize therapy for patients with MDD. (Another imaging study by Mayberg and colleagues, published in 2013, found evidence to suggest that using positron emission tomography [PET] to measure blood glucose in depressed patients might help predict response to CBT and escitalopram.)

Brain-based measures of major depression “may provide a basis for possible future algorithms for triaging subjects to the appropriate treatment, likely as a component within a multivariate approach to prediction,” the authors concluded.

This research, which appeared March 24 in *AJP in Advance*, was supported in part by the National Institutes of Health. Eli Lilly and Forest Laboratories donated the study medications, escitalopram and duloxetine, respectively, but were otherwise uninvolved in the study. **PN**

“Functional Connectivity of the Subcallosal Cingulate Cortex and Differential Outcomes to Treatment with Cognitive-Behavioral Therapy or Antidepressant Medication for Major Depressive Disorder” is posted at <http://ajp.psychiatryonline.org/doi/abs/10.1176/appi.ajp.2016.16050518>. Mayberg’s 2013 study, “Toward a Neuroimaging Treatment Selection Biomarker for Major Depressive Disorder” is posted at <http://jamanetwork.com/journals/jamapsychiatry/fullarticle/1696349>.

CBT, Antidepressants Are Equally Effective In Treatment-Naïve Patients

Patients with depression who are given their preferred treatment may be more likely to stick with the therapy. BY VABREN WATTS

Current guidelines for treating major depressive disorder (MDD) recommend that clinicians consider both the clinical features of the disorder and patient preference when choosing the initial form of treatment. A study published in *AJP in Advance* in March suggests that while antidepressants and psychotherapy appear to be equally effective in treatment-naïve MDD patients, those matched with their preferred treatment may be more likely to complete therapy.

“These results suggest that patients who receive their preferred treatment may invest more fully in their treatment, which makes the finding that preference does not affect improvement all the more striking,” Boadie

Dunlop, M.D., director of the Mood and Anxiety Disorders Program at Emory University School of Medicine, and colleagues wrote. “This discrepancy implies that biological or psychosocial factors are stronger determinants of treatment efficacy than patient preference.”

The study was a part of the Predictors of Remission in Depression to Individual and Combined Treatments (PRE-DICT) trial that aimed to identify biological and psychological factors predictive of treatment outcomes in major depressive disorder in adults who had never previously received treatment for a mood disorder (see story above).

The researchers randomly assigned 344 adults aged 18 to 65 with moderate MDD (mean baseline Hamilton Depression Rating Scale [HAM-D] score of 19.8) to 12 weeks of escitalopram (10-20 mg/day), duloxetine (30-60 mg/day), or cognitive-behavioral therapy (CBT, 16 50-minute sessions).

Prior to randomization, patients indicated whether they preferred pharmacotherapy, CBT, or had no preference. Patients were evaluated at weeks 1 through 6, and again at weeks 8, 10, and 12.

The authors found that the mean estimated overall decreases in HAM-D score from baseline to week 12 did not significantly differ between treatments (CBT: 10.2; escitalopram: 11.1; duloxetine: 11.2). Additionally, remission rates did not significantly differ between treatment arms (CBT: 41.9 percent; escitalopram: 46.7 percent; duloxetine: 54.7 percent).

Of the 225 patients who expressed a treatment preference, 107 were matched to their preferred treatment and 118 were mismatched. Patients who were matched with their preferred treatment were significantly more likely to complete the trial than those who were not matched with preferred treatment (82.2

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Low-Cost Reminders Fail to Improve Medication Adherence

Improvements in medication adherence occurred in a small percentage of study participants, regardless of whether they received a reminder device by mail or not.

BY NICK ZAGORSKI

Suboptimal medication adherence is a significant problem in psychiatry and throughout the health care system. Simple and inexpensive options to remind patients to take their medications daily are widely available, but can

continued from facing page

percent vs. 67.8 percent, respectively). However, patients matched to their preferred treatment were not found to be more likely to achieve remission.

"Asking patients about their treatment preference, and exploring the basis for their preference, can help build the therapeutic alliance, even if the clinician's final treatment recommendation does not align with the patient's preference," Dunlop told *Psychiatric News*.

While the "findings about patients' preferences do not warrant a change in current practice," he said he believes advances in biomarkers will allow mental health professionals to "take a more definitive stance when recommending a specific form of treatment for an individual patient."

The study was supported by the National Institutes of Health. **PN**

■ "Effects of Patient Preferences on Outcomes in the Predictors of Remission in Depression to Individual and Combined Treatments (PREdict) Study" is posted at <http://ajp.psychiatryonline.org/doi/abs/10.1176/appi.ajp.2016.16050517>.

such simple reminders improve adherence?

A large-scale clinical trial published February 27 in *JAMA Internal Medicine* suggests reminder devices alone may not be enough to improve adherence in patients who have a history of not taking their medications.

This study, named the Randomized Evaluation to Measure Improvements in Nonadherence (REMIND) trial, was carried out by a joint team of investigators from Brigham and Women's Hospital in Boston and CVS Health. The researchers enrolled 53,480 participants aged 18 to 64 whose prescriptions were managed by CVS and compared three low-cost adherence devices: a standard pillbox, a pill bottle with seven daily toggles that can be flipped between no/yes positions, and a pill bottle cap with a digital timer displaying the time elapsed since last medication.

The participants, which included 15,948 people taking antidepressants, were all chosen based on a 12-month prescription history of suboptimal adherence. They were randomized to receive one of the three devices in the mail—along with instructions and a number to call for assistance—or no device. Over the next 12 months, the researchers measured medication adherence



using pharmacy claims data.

At study's end, the investigators found no discernable difference between medication adherence in the groups that received any of the interventions and those in the control group. In each study arm, about 15 percent of the participants became optimally adherent to their prescribed treatments (taking 80 percent of their doses or more) during the follow-up period. These findings held true for the patient cohort overall as well as among patients taking only antidepressants or medications for cardiovascular disease. Reminders also failed to improve adherence in patients taking medications that required multiple doses per day.

"Influencing adherence through simple, easy-to-implement, and affordable interventions offers intriguing potential as a public health approach to solving [nonadherence]," Ian Kronish, M.D., M.P.H., and Nathalie Moise, M.D., of Columbia

University wrote in a related editorial. "Unfortunately, the authors found that providing patients with these devices alone was not the answer to nonadherence."

Lead study author Niteesh Choudhry, M.D., Ph.D., the founding executive director of Brigham and Women's Center for Healthcare Delivery Sciences, said more research is needed to understand why the devices alone were not enough to improve medication adherence.

"Our results could imply that these devices do not help, but it could also be that forgetfulness is not a major reason for chronic nonadherence in our study population," he told *Psychiatric News*. "These simple reminders may be more suited for people who are fairly compliant and just need a little extra nudge to be fully adherent," Choudhry said. Such reminders may also be useful to older adults where forgetfulness may be more common, he said.

In an effort to make the trial as reflective as real-world conditions as possible, Choudhry and colleagues deliberately did not coordinate the mailing of devices and instructions with prescription refills. As a result, he said, patients may have had trouble transitioning to the device in the middle of a prescription fill or may have not used them at all if their medication refill had lapsed.

"Such real-world testing is important," Choudhry said. "You run a greater risk of negative results, but the potential generalizability of the findings is a trade-off one should be willing to make."

Even though these reminders may not be a widespread solution for nonadherence, Choudhry does not think his study's results suggest such devices should be dismissed. They are inexpensive, simple to use, and have no drawbacks such as making adherence worse, he said. Additionally, it's possible the devices increase patient safety.

"What we did not capture, nor could we capture, in our analysis was did these devices make pill-taking safer? Did it prevent double dosing, for example? That is another important consideration that would make these devices worthwhile even if adherence stays the same."

The REMIND trial was supported by a grant from CVS Health. **PN**

■ An abstract of "Effect of Reminder Devices on Medication Adherence: The REMIND Randomized Clinical Trial" is posted at <http://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2605527>. The related editorial, "In Search of a 'Magic Pill' for Medication Nonadherence," is posted at <http://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2605523>.

MH Issues in Cancer Survivors Persist Long After Treatment Ends

People with cancer benefit from empathic care that helps them deal with the uncertainties with which they may always struggle.
BY CAROL SORGEN

By 2026 there will be more than 20 million cancer survivors, an increase of more than 4 million in 10 years, according to the National Cancer Institute. It goes without saying that, for the most part, these growing numbers of cancer survivors are, first and foremost, thankful to be alive. But long after treatment has ended and the patients' exams report NED (no evidence of disease), a cancer survivor is never really "cancer free."

"When a cancer patient completes treatment, everyone expects him to return to life as it was before cancer," says Alan Hsu, M.D., an assistant clinical professor of psychiatry at Moores Cancer Center at the UC San Diego Health. "But he is not the same person." Whether the patient was receiving psychiatric care before cancer, psychosocial post-cancer issues arise—including anxiety, depression, fear of recurrence, cognitive impairment, body image issues, and fear of intimacy—that often call for professional help.

Hsu frequently sees survivors after they no longer need to see their oncologist. "They're often more anxious and depressed than they were while undergoing treatment," Hsu told

Psychiatric News. "They think that they should feel better, but they don't, and it's important for them to know that that's perfectly normal."

According to the Centers for

Disease Control and Prevention, 10 percent of cancer survivors report that they have poor mental health, compared with only 6 percent of adults who have not had cancer. Mental health problems among cancer survivors can lead them to forego healthy lifestyle choices such as improved diet and physical activity. Less than one-third of survivors who
see Cancer Survivors on page 33

One Survivor's Story

As both a cancer survivor and a journalist, writing the article on cancer survivorship holds a special significance for me.

When I was diagnosed with breast cancer 10 years ago, my fear was not that I was going to die—my own mother had gone through breast cancer twice (before ultimately dying of unrelated lung cancer). My fear was how my life was going to change. Despite the fact that I write frequently on health care, I'm a tad, shall we say, on the health-phobic side. I knew enough about cancer (in fact, at the time I was the editor of a breast cancer newsletter) to know that the rest of my life would be filled with many more doctors' visits than I'd like and that with every symptom that arose, I'd be gripped by panic.

Once I got through the initial diagnosis and treatment planning, I settled down to some extent. I was assured by all the doctors that the cancer was early stage. I planned out the calendar and figured I'd be done by Christmas and back to my life. Just a bump in the road of life, I told myself.

Unfortunately, that all flew out the window, and I learned firsthand about cancer being a "roller coaster ride," as social worker Jill Kaplan said. Diagnosis, testing, even surgery all went fine. But after one chemo session, my colon ruptured. Severe, life-threatening complications landed me in the hospital for two months, followed by additional surgeries including a temporary colostomy, radiation therapy, and yet more surgeries including, a year and a half later, a colostomy reversal.

Once I was more or less back on my feet—almost two years later—a psychiatrist I knew asked me what I had learned from the experience. I blithely responded that I wasn't sure anything significantly had changed, other than that I had managed to survive. As the years have gone by, however, I see now how naïve I was. While every day I'm reminded that I'm a cancer survivor, as I take my daily pill (only for six more months!), every day I am also thankful for my health. But along with the gratitude have come difficult emotions and experiences. With every routine mammogram and MRI, I suffer from "scanxiety." I'm pretty much resigned to the fact that this will never go away, and I just get through it as best I can.

I saw both a psychiatrist and an oncology social worker, both of whom were an enormous help to me, but what I now know is that the ramifications of cancer extend far behind the initial diagnosis and treatment. They may be ongoing, they may change over time, and they may come when you least expect them.

From my standpoint as a cancer survivor, however, I'd like to echo those I interviewed for this article: Prescribe medication when needed. But go deeper, even if someone is only there for a prescription. See that person for who she was before cancer and for who she is now. Help her accept that she may not be the same. And help her realize that's OK.

—Carol Sorgen



FROM THE EXPERTS

Support or Settle?

BY RICHARD MAKOVER, M.D.

Any experienced supervisor will recognize the red flag in the following exchange:

Trainee: My patient is stuck. She comes in every week with the same problems as always. We're not getting anywhere.

Supervisor: What's your treatment approach?

Trainee: Well, I was doing CBT, but it wasn't working, so now I'm providing support.

This common supervisory issue—the therapy is making little progress, but the therapist continues to "provide support"—signals that the trainee's therapy is in serious trouble. The decision to utilize "supportive" measures when another approach has been unsuccessful, when providing support becomes a fallback position, or when

the therapist simply does not know what else to do usually means that the work is at an impasse and will ultimately fail. The problem, then, is that this kind of "support" is not supportive therapy, but rather no therapy.

True supportive psychotherapy is a legitimate treatment that has become an important element of the training process. It provides a response to the growing demands of third-party payers for cost-containment and of the mental health care community for more efficient, time-limited ways to stretch scarce resources. Supportive therapy borrows from other modalities and may include expressive, directive, and experiential techniques combined with a heavy dependence on the therapeutic alliance. It may now be the most frequently used modality. (See, for example, "The Nuts and Bolts of Supportive Psychotherapy" by Arnold Winston, *Psychiatric News*, June 15, 2012).

Supportive psychotherapy is a prime example of eclectic

psychotherapy. As an amalgam of other therapeutic approaches, with no specific techniques of its own, it sometimes seems designed not so much to make patients better as instead to prevent them from getting worse. It may be most useful with two, widely different sets of patients: essentially healthy individuals temporarily overwhelmed by stressful circumstances and chronically ill patients with poor coping skills. For the former, it can provide the stability that allows the patient's natural healing to occur and, for the latter, it can strengthen weak defenses and teach better coping skills. It may be employed in combination with medication management to bolster compliance and reduce comorbid illness. In light of its many applications, supportive therapy might be considered a nonspecific, that is to say, a broad-spectrum treatment.

But what about our trainee who is "providing support"? If another approach falls short, is this alternative a positive, helpful choice? No, it isn't.



Richard Makover, M.D., is a lecturer in psychiatry at Yale School of Medicine. He is the author of *Treatment Planning for Psychotherapists: A Practical Guide to*

Better Outcomes, Third Edition, from APA Publishing. APA members may purchase the book at a discount at www.appi.org/Treatment_Planning_for_Psychotherapists_Third_Edition.

When a therapist falls back on support not knowing what else to do or settles for support in lieu of continuing to work on the problems for which the patient sought treatment, bad things happen. The patient drops out of treatment or continues to meet without any further improvement. Money and time permitting, this interminable but ineffective arrangement can go on and on, sometimes for years. Sessions begin to revolve around day-to-day problems, with the occasional intercurrent crisis to ostensibly justify

see Experts on page 39

Poor Communities Have Fewer Options For Mental Health Care

The distribution of mental health treatment resources varies by communities' socioeconomic status. BY DEBORAH COHEN

Whether a person with mental illness ever seeks professional help often depends on a variety of factors, including the cost of care and available resources in his or her community.

A study appearing in the May issue of *JAMA Psychiatry* found that while 70 percent of the U.S. population lives in communities where specialty mental health treatment is available, the distribution of mental health treatment resources varied significantly by the socioeconomic status of the community. While office-based practices of mental health professionals are more likely to be located in higher-income areas, mental health clinics are more common in lower-income communities.

"These findings build on prior workforce research examining the distribution of mental health

professional shortage areas across U.S. counties," Janet Cummings, Ph.D., of Emory University, and colleagues wrote. "The present study adds depth to our understanding of the distribution of mental health treatment resources by examining two mental health systems that serve different clientele." These systems include specialty community mental health clinics (which often take Medicaid and offer payment assistance) and solo and small-group practices of psychiatrists and therapists.

For the study, Cummings and colleagues analyzed the distribution of specialty outpatient mental health treatment clinics and office-based practices, across 32,000 U.S. communities.

The researchers identified 7,700 specialty mental health treatment centers providing outpatient services using the Substance Abuse and Mental Health Services Administration

(SAMHSA) Behavioral Health Treatment Services Locator. From the 2013 U.S. Census Bureau County Business Patterns data, they identified 11,165 psychiatrist office practices and 20,290 nonphysician (therapist) mental health professional practices. Median household incomes were used to assess community-level socioeconomic status.


The analysis revealed that nearly twice as many communities in the highest income quartile of median household income (43 percent) had specialty mental health treatment resources compared with communities in the lowest income quartile (23 percent).

More than three times as many communities in the highest income quartile had a psychiatrist practice compared with the lowest quartile (25 percent versus 8 percent). Similarly, more than 35 percent of the communities in the highest income quartile had therapist practices compared with 13 percent of communities in the lowest income quartile.

In contrast, about 16.5 percent of the communities in the lowest income quartile and 13 percent of communities in the highest income quartile had outpatient mental health facilities.

Although the researchers identified the number of mental health treatment facilities and practices located in many communities, they noted the data do not provide information about their treatment capacity or waiting times.

"[M]ental health treatment facilities—which are more likely to serve vulnerable populations—are the backbone of the outpatient specialty mental health care infrastructure that exist in local low-income and rural areas," Cummings and colleagues concluded. "To the extent that gaps in geographic accessibility to mental health treatment resources exist in vulnerable communities, policymakers may consider bolstering resources for expanded behavioral health care services in other safety-net facilities." **PN**

 An abstract of "Geographic Access to Specialty Mental Health Care Across High- and Low-Income US Communities" is posted at <http://jamanetwork.com/journals/jamapsychiatry/fullarticle/2616167>.

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JOURNAL DIGEST

BY NICK ZAGORSKI



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Women Benefit More From Meditation Than Men

College-aged women who completed a 12-week, university-based meditation training program experienced greater mood improvements than men in the same program, reported a study published in *Frontiers in Psychology*.

The findings suggest that gender-specific modifications to mindfulness programs may be necessary to maximize their efficacy.

For this study, 41 male and 36 female undergraduates at Brown University took a 12-week academic course with meditation training components, including "meditation labs." All the students filled out questionnaires at the beginning and the end of the program that assessed their mood (using the Positive and Negative Affect Scale), mindfulness, and self-compassion.

At program's end, the average negative affect score for women dropped

from 21.11 to 18.67, whereas the score for men rose nonsignificantly from 19.10 to 19.80. While both groups showed improvements in measures of nonreactivity, nonjudgment, and self-compassion, women increased more than men on these mindfulness domains.

"Improved affect in women was related to improved mindfulness and self-compassion skills, which involved specific subscales for approaching experience and emotions with non-reactivity, being less self-critical and more kind with themselves, and over-identifying less with emotions," the authors wrote.

Rojiani R, Santoyo J, Rahrig H et al. Women Benefit More Than Men in Response to College-Based Meditation Training. *Front Psychol.* April 20, 2017. [Epub ahead of Print] <http://journal.frontiersin.org/article/10.3389/fpsyg.2017.00551/full>



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Alcohol Misuse May Affect Brains of Women, Men Differently

Neuroimaging studies have demonstrated that the reward network of the brain is smaller in men with alcohol use disorder (AUD) than those without AUD, but little is known of whether the same is true in women with AUD.

A study published in *Psychiatry Research Neuroimaging* found that the volume of the reward region of the brains of women with a history of AUD was larger than those without such a history.

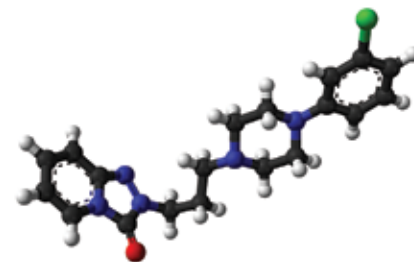
Gordon Harris, Ph.D., of Harvard Medical School and colleagues analyzed and compared the MRI scans of 30 men and 30 women with a history of an AUD with those of controls. Participants with a history of AUD had been abstinent at least four weeks.

Regions of the brain's reward system—including the amygdala, hippocampus, and nucleus accumbens—were on average 4.4 percent larger in women with a history of AUD than those without. When the researchers compared the volume of these regions in men with a history of alcohol use disorder with that of men without this history, they found these regions were 4.1 percent smaller in men with a history of AUD.

The authors noted that there is no way of knowing from the trial whether these differences in volume preceded or resulted from the alcohol use.

"Our findings suggest that it might be helpful to consider gender-specific approaches to treatment for alcoholism," Harris said in a press release.

Sawyer K, Oscar-Berman M, Barthelemy O, et al. Gender Dimorphism of Brain Reward System Volumes in Alcoholism. *Psychiatry Res.* May 2017; 263:15-25. [http://www.psyn-journal.com/article/S0925-4927\(16\)30191-3/abstract](http://www.psyn-journal.com/article/S0925-4927(16)30191-3/abstract)



Benjah-bmm27

Trazodone Slows Neurodegeneration In Mouse Models

The antidepressant trazodone can slow the progression of neurodegenerative disease in mouse models, reports a study from investigators in the United Kingdom.

The researchers screened more than 1,000 drugs previously shown to be safe in humans in search of compounds that target the eIF2 α -P signaling pathway. This pathway controls how fast proteins get made in cells and is overactive in Alzheimer's and other neurodegenerative diseases.

The screen identified two candidates: trazodone and dibenzoylmethane, a natural product (related to curcumin) that is being tested for anti-cancer properties.

The researchers next treated mice modeled to have prion disease and tauopathy (which mimics frontotemporal dementia) with these two candidates. Treatment with trazodone and dibenzoylmethane improved memory deficits, reduced nerve degeneration and atrophy, and prolonged survival in both mouse models.

"Importantly, in both models, the drugs were first administered at a stage of early but established disease, equivalent to early symptomatic human disease," the authors wrote. "These drugs therefore represent an important step forward in the pursuit of disease-modifying treatments for Alzheimer's and related disorders."

As trazodone is already used in elderly patients with dementia as a sleep aid, the authors suggested that clinical studies of this drug would be worthwhile.

This research was published in April in the journal *Brain*.

Halliday M, Radford H, Zents K et al. Repurposed Drugs Targeting eIF2 α -P-mediated Translational Repression Prevent Neurodegeneration in Mice. *Brain.* April 19, 2017. [Epub ahead of Print] <https://academic.oup.com/brain/article/doi/10.1093>



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Molecular Link Identified Between Childhood, Adult Neurological Disorders

Children with neuronal ceroid lipofuscinosis (NCL)—the most common childhood neurodegenerative disorder—and adults with frontotemporal dementia (FTD)—the most common form of dementia in adults under 60—may have more in common than researchers once suspected.

While it was known that both disorders involve defects in a protein known as progranulin (a component of a cell's recycling machinery), patients with FTD and NCL typically present with different symptoms. A study in *Science Translational Medicine* has found evidence that patients with FTD accumulate excess cellular debris in the eyes and brain—a hallmark characteristic of NCL.

The researchers made this discovery when analyzing the postmortem neuron samples from 15 people who had FTD and progranulin mutations; this debris was not found in samples from 16 individuals without dementia, nor six individuals with Alzheimer's disease.

The researchers next scanned the retinas of 11 dementia-free people with a mutation in their progranulin gene (GRN) and 22 age-matched controls. Once again, they found excess cellular deposits in the eyes of the GRN carriers but not the controls.

According to the authors, the findings suggest autofluorescent retinal imaging, which is rapid and noninvasive, could be used to monitor people with GRN mutations and potentially identify early signs of FTD. **PN**

Ward M, Chen R, Huang H-Y, et al. Individuals With Progranulin Haploinsufficiency Exhibit Features of Neuronal Ceroid Lipofuscinosis. *Sci Transl Med.* April 12, 2017; 9 (385): eaah5642. <http://stm.sciencemag.org/content/9/385/eaah5642>

At Risk

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individuals deemed to be at risk of psychosis (see article on page 23).

Yang and Seidman said that issues of stigma and self-identify are vital clinical issues, and the totality of experience that young people bring to treatment in an early intervention clinic is likely to affect their attitude toward recovery and their trajectory and outcome.

"These individuals may have been bullied in school or ridiculed, or they may have had good or bad experiences with mental health clinicians," Seidman said. "At least 80 percent of individuals in clinical high-risk clinics have already had some experience with mental health treatment. If clinicians face these labels and descriptions about being at risk for psychosis or schizophrenia with empathy, and teach people about what they mean and don't mean, it's possible to have a much better outcome than if clinicians simply ignore it and pretend the problem is not there." **PN**

Shooting

continued from page 1
uates the event.”

Anniversaries of the tragedy may remind the Virginia Tech community of the students and faculty members whose lives were cut short, but the university’s response in the intervening years has been positive, said Frieбен, who still works at the Cook Center.

“There’s less stigma,” he said. “Faculty and staff are more ready to refer a student with whom they are concerned to the Dean of Students Office or to the counseling center. The usage of services has grown—as it has at college counseling centers generally—and there appears to be more willingness to seek help. The university has been supportive, expanding the center’s staff, although community resources still remain limited.”

College counseling services are busier than ever these days.

“At colleges and universities in general, there is now a stronger spotlight on mental health,” said Ludmila De Faria, M.D., a clinical assistant professor of psychiatry and a staff psychiatrist at the Florida State University Student Health Center in Tallahassee and chair of APA’s Caucus on College Mental Health. “Today, there is more awareness that things can go wrong.”

In the three or four years after the shooting at Virginia Tech, there was a dramatically increased demand for services there, particularly for anxiety, but that spike in need eventually died down as a generation of students moved on, said Frieбен.

One troubling aspect of the shooting was that late in 2005, more than a year earlier, Cho was reported to campus police for stalking a women student and briefly committed involuntarily to a psychiatric hospital in Radford, Va. He was released and kept two initial appointments at the university’s counseling center. However, no outpatient commitment order was ever received by the center, and a state report on the event is not clear about whether he received further care.

To avoid losing track of students referred out, the 42-person Cook Center now employs a case manager and coordinator of emergency services, Robert Ritchey, M.S. He maintains communication with community clinicians and oversees emergency services and crisis management of students, attends all hearings at the hospital, and follows up after involuntary hospitalizations. In addition, a second psychiatrist was hired in 2007, a post now filled by James Reinhard, M.D., a former commissioner of mental health for Virginia.


“In the past, college counseling centers would refer out their more severely ill patients to the community, but you can lose track of them sometimes,” said Frieбен. “Today, there is a reversal, with more emphasis on keeping the most unwell students in house.”

De Faria and Frieбен both noted the increasing role of care teams on college and university campuses. Care teams comprise representatives from the dean of students,

health and counseling centers, faculty, enrollment offices, and campus security. Anyone with a concern about a student can notify the care team, which then can break down jurisdictional silos and exchange information to be sure the student receives needed care and doesn’t fall through the cracks.

April 16, 2007, left its mark on everyone in the Virginia Tech community, said Frieбен. For a while, there was no respite.

“For three years after 4/16, summer didn’t feel like summer,” said Frieбен. “It took four years before summer felt like summer again, with some down time.” **PN**

 “Va. Psychiatrists Respond to Tragedy at Tech” is posted at <http://psychnews.psychiatryonline.org/doi/full/10.1176/pn.42.10.0001>. “Mass Shootings at Virginia Tech,” the report of the Virginia governor’s review panel, is posted at <https://governor.virginia.gov/media/3772/fullreport.pdf>.

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Cancer Survivors

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experience mental health issues discuss them with their doctor, and many do not take advantage of professional counseling or support groups.

“Healing starts after treatment,” says Jill Kaplan, M.S.W., L.C.S.W., program director of the Cancer Support Community of Central New Jersey, who works closely with members of the psychiatric community. “That’s

when emotional side effects creep up.”

One common side effect Kaplan sees among survivors is a feeling of isolation. “Often priorities have changed for the survivor, but not necessarily for their family and friends, who are expecting the same person to emerge from this life-changing experience,” said Kaplan. “The adjustment can be challenging.” In contrast, Kaplan continued, some survivors struggle with the notion that they haven’t changed enough from their experience.

For those who didn’t have a healthy lifestyle before having cancer, there may be a sense of guilt, as well as a newfound dedication to caring for oneself. For those who did everything “right,” there is often a sense of betrayal. “I hear survivors say, ‘I took care of myself, and I still got cancer.’ They don’t know what to trust anymore.”

Working with those who have experienced cancer often calls for a collaborative approach across the various mental health disciplines, said Kaplan,

but she observes that survivorship is not a linear process. “Where we meet a survivor isn’t necessarily where you might meet them.”

No matter where along the survivorship continuum a patient is, Kaplan suggests anyone working with a cancer survivor ask specific questions, such as: What was your life like before cancer? What is it like since cancer? How have you changed—physically, emotionally, spiritually, even financially?

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“We need to understand the whole person and how cancer has altered his life,” said Kaplan, adding that she gives cancer patients, survivors, and all those working with them the same advice: “Roll your sleeves up, and strap yourself in. It’s going to be a roller coaster ride.”

“Every cancer survivor is going to experience some cancer-related distress,” agreed Allison Applebaum, Ph.D., director of the Caregivers Clinic at Memorial Sloan Kettering, which has

developed a survivorship program that includes psychosocial services. For survivors whose post-cancer distress is not disabling, a cognitive and behavioral approach is often sufficient to help them adapt to their “new normal.” For survivors who may be experiencing post-cancer trauma—even if it doesn’t meet the *DSM* requirements for PTSD—psychiatrist-prescribed medication along with counseling may be in order.

The end of treatment, while a cause for celebration, is often a trigger for

anxiety and depression, according to psychiatrist Lorenzo Norris, M.D., assistant dean of student affairs at George Washington University School of Medicine and Health Sciences and former director of GWU’s Survivorship Center Psychiatric Services. “They reach a transition point when active treatment is completed, and they feel that they’re on their own,” he said. “That can be a huge hurdle, especially for those who may not have a robust social network.”

Norris said it’s important for psychiatrists and other mental health professionals to provide survivors an opportunity to talk about their experience and understand how it fits into their own life narrative.

“You don’t have to be a psycho-oncologist,” says Norris, “but you should be comfortable working with those in the field of oncology and with those who are experiencing the stresses that survivorship brings, including family members who are also significantly

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affected by the illness.”

Norris remarked that for himself, his work with cancer patients and survivors is among his most authentic and rewarding experiences.

For Allen Dyer, M.D., Ph.D., a professor of psychiatry and behavioral sciences at George Washington University and current director of its National Cancer Survivorship Resource Center, his professional role is also very personal. Dyer himself is a cancer survivor and knows firsthand

that “it’s not over when it’s over.”

“Experiencing cancer is like living through a tsunami,” he says. “It comes over you unexpectedly, and, if you survive, you must live with a new reality.”

The feelings that accompany that new reality change over time, according to Dyer, but they can arise at any time, even years later. “You may have been so busy just trying to stay alive that you didn’t ever have a chance to talk about your feelings,” he said.

Dyer’s own survivorship has

included the common “stages of grief,” though with some modifications. Instead of denial, for example, it was more “disbelief,” he recalled. And rather than acceptance, it was more like “coming to terms.”

“As a cancer survivor, you have to come up with your own expressions of your unique experience,” he said.

Even now, 19 years after a bone marrow transplant to treat his multiple myeloma, Dyer said that he and his wife sometimes look at each other and

think, “How did we get through that?” To answer that question for himself and for others, Dyer wrote a book, *One More Mountain to Climb*, that talks about his personal relationship with illness, health, trauma, and resilience.

While additional training in psycho-oncology is useful when working with cancer patients and survivors, it is not necessary, Dyer tells other psychiatrists. “The skills you already have are translatable. Just be empathic and help your patients tell their story.” **PN**

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From the President

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(FDA) for a “listening session” to the panel discussion about the Patient-Centered Oriented Research Institute hosted by Sens. Bill Cassidy and Chris Murphy and the briefings on suicide and the opioid epidemic, there were ample opportunities to converse with key federal leaders about essential issues that confront our patients and our members.

Importantly, it was a tremendous opportunity for APA (and me) to learn from leaders such as Dr. Nora Volkow about her views on how best to address the opioid epidemic and what APA can do to help and from Dr. Robert Cardiff about how APA can best support the FDA's work by publishing practice guidelines to set standards in the space where FDA-approved treatments are limited. These are being translated into APA actions as we speak.

Third, there were the legislative issues. I don't think I will forget the signing of the 21st Century Cures Act any time soon. There to represent APA, and flanked by my close buddies from the American Foundation for Suicide Prevention and my long-time colleague, Dr. Josh Gordon, who is now director of the National Institute of Mental Health, I watched with deep emotion as the legislation was signed into law by President Obama. At that same

ceremony, I was also privileged to witness President Obama presenting Vice President Joe Biden with the country's highest civilian award, the Medal of Freedom.
But yes, I was going somewhere with this. As I mentioned, there was more (unexpected) work to be done during the two-week hiatus between the RANZCP and APA meetings. On Thursday, May 11, I joined with several leaders of medical associations (ACP, AOA, AAFP, ACOG, and AAP)

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to meet with key Republican senators to express APA's opposition to the American Health Care Act (AHCA).

So, I bet you get the picture: serving as APA president has been a lot of work. I have done it with gusto. I have learned a tremendous amount. I am grateful to have been entrusted by you, the APA membership, to work on your behalf. APA is as strong as ever, and it's a good thing given all the challenges we face. **PN**

Dementia

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part of the AMA's Physician Consortium for Performance Improvement (PCPI). Some of those original measures were incorporated into the Physician Quality Reporting System, previously the main quality reporting program for Medicare. The program has been replaced by the Merit-Based Incentive Payment System (MIPS). In 2015, the AAN and the APA

formed the multidisciplinary work group to improve the original measures and to identify areas calling for new ones. The work group consisted of 26 members from 21 organizations including physician, patient, caregiver, advanced practice provider, psychologist, payer, and nursing representatives. "APA worked closely with the AAN to come up with a set of measures that would reflect the state of the art in dementia care," Roca said. "We are

hoping that members who take care of persons with dementia will look at these measures as useful guides to what constitutes quality of care." **PN**

A description of the new quality measures and the process by which they were developed is posted at <http://ajp.psychiatryonline.org/doi/full/10.1176/appi.ajp.2017.17401>. A summary of the measures is posted at www.psychiatry.org/psychiatrists/practice/quality-improvement/quality-measures-for-mips-quality-category/dementia-updates.

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Cannabis

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conditions, which include nausea and vomiting from chemotherapy, spasticity from multiple sclerosis, and pain.” Volkow, who was not part of the NASEM committee, continued, “NIDA strongly agrees with the report’s finding that there are impediments to performing quality research on cannabis and cannabinoids and that there is a need to address these

impediments so that researchers can draw more confident conclusions.” The report found that the strongest evidence for the therapeutic value of cannabis or cannabinoids continues to be limited to certain types of chronic pain and nausea/appetite stimulation. Even in these instances, the report noted that the evidence of therapeutic value comes from studies that used isolated cannabinoid formulations and not the cannabis plant, which contains hundreds of varied chemicals.

Other purported health benefits such as controlling tics in Tourette’s syndrome, improving motor problems in neurodegenerative diseases, and reducing anxiety disorders remain unproven. In addition, “there are currently no consistent quality controls, no assurances that patients are informed about side effects, and unclear recommendations about dosing and route of administration,” Volkow wrote. “It is important for people to understand


the range of effects produced by cannabis as they weigh the risks and benefits for treating their health conditions with products from state dispensaries,” she continued. Sachin Patel, M.D., Ph.D., the James G. Blakemore Chair and Associate Professor of Psychiatry and Behavioral Sciences at Vanderbilt University Medical Center, who was one of the members of the NASEM committee tasked with creating the report, acknowledged that while gaps still remain as to whether cannabis and related compounds are medically useful, there have been notable scientific advances in this area of research.

“There has been a dramatic change in our understanding of how cannabis acts on the brain, and the role that specific cannabinoid molecules and their receptors play,” he told *Psychiatric News*.

In March, Patel and his lab reported findings that suggested augmenting or depleting 2-arachidonoylglycerol (2-AG)—a naturally occurring cannabinoid in the brain—altered how mice respond to stress. Administering 2-AG to the animals appeared to make them better able to cope to stressful stimuli, for example. When the researchers gave the animals THC, they found they displayed similar stress resilience, suggesting that THC operates on a similar mechanism as 2-AG.

Patel cautioned against extrapolating the findings in mice to support the use of cannabis for the prevention or treatment of posttraumatic stress disorder (PTSD). As the NASEM report noted, the overall evidence base to support marijuana use for this disorder remains limited, and there are known risks in smoking marijuana. However, he noted that his findings demonstrate how molecules and receptors are important in the stress response, giving other researchers and pharmaceutical companies distinct targets to pursue.

“Although a single report could not hope to address all the complexities of cannabis, cannabinoids, and their health effects, NASEM is to be commended for tackling a massive and often contradictory literature and for making a strong case for the need for further research,” Volkow wrote. **PN**

 “The Health Effects of Cannabis and Cannabinoids: The Current State of Evidence and Recommendations for Research” is posted at <https://www.nap.edu/catalog/24625/the-health-effects-of-cannabis-and-cannabinoids-the-current-state>. Volkow’s blog is posted at <https://www.drugabuse.gov/about-nida/noras-blog/2017/02/nasem-report-recommends-removing-barriers-to-cannabis-research>. Patel’s research paper, “Endocannabinoid Signalling Modulates Susceptibility to Traumatic Stress Exposure” is posted at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5379055/>.

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Uncertainty

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that trainees who return to their country of origin may be delayed when trying to reenter the United States. He said on at least three occasions—prior to the Trump administration—he has had to write to congressional representatives from New York to help expedite the return of trainees who have been held up on reentry to the United States.

APA has joined other medical groups in expressing concern about the situation. A February 8 position statement by the Council on Medical Specialty Societies (CMSS), issued after the first presidential order, was signed by APA and more than 30 other organizations. “Progress against disease will falter if the global community engaging together in medical care is divided by policies that bar members of certain nationalities from entering the United States,” according to the statement. “We call on national leaders to eliminate barriers to scientific exchange and medical education.”

APA Director of Education Tristan Gorrindo, M.D., who participated in the AADPRT session, said psychiatry has historically relied on large numbers of IMG trainees to fill positions, often in underserved areas. In this year’s National Resident Match, 568 of the 1,495 psychiatry slots were filled by graduates of international medical schools.

AADPRT President Sandra DeJong, M.D., said the special session at the AADPRT meeting was instigated by Immediate Past President Art Walaszek, M.D., in response to mounting concerns in the educational community.

“We felt that the executive orders on immigration had put international medical graduates in psychiatry in a uniquely difficult position,” DeJong said. “This was an effort to hear from people in the field in the face of many questions, especially uncertainty among trainees that if they traveled out of the country, they would not be allowed back in.”

DeJong echoed others interviewed by *Psychiatric News* saying that the executive orders likely had no effect on this year’s match. “There are contractual agreements in place now [between training programs and IMGs who will come to the U.S. for training], so we are hopeful that the trainees who have matched for this year will be allowed to respect those contracts.”

She added, “Institutions will need to rally around and support their IMG trainees and faculty. IMGs tend to be recruited to programs that are underserved and fill a particular niche, often working in underserved areas. It’s a workforce issue, but it is also an issue of well-being for our residents

Processing of J-1 Visas Appears to Be on Time



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Most foreign national residents training at U.S. teaching hospitals are carrying a J-1 visa, a temporary, educational and cultural exchange nonimmigrant visa that allows trainees to stay in the country for the duration of their training; candidates for the visa must demonstrate an intent to return to the country of origin.

IMGs applying for J-1 sponsorship must receive certification from the Educational Commission on Foreign Medical Graduates (ECFMG). ECFMG provides J-1 visa sponsorship but does not issue visas or make decisions about who should receive one; that decision is made by agencies of the U.S. government.

Upon completion of training, J-1 physicians are obligated to return to and reside in their home country for at least two years before being eligible to return to the U.S. Importantly, legal options exist for J-1 physicians to remain in the U.S. after training, the most common of which is employment in a medically underserved area.

Currently, ECFMG sponsors over 10,000 J-1 physicians in U.S. graduate medical education. This number includes physicians entering their first year of training, as well as physicians who renew their visa sponsorship to continue in subsequent years in their training programs.

Some residents may have an H-1B visa. The latter is for temporary workers in a specialty occupation and

does not require a proof of intent to return to the country of origin; holders of an H-1B visa are eligible to apply for permanent resident status. The ECFMG does not sponsor candidates for the H-1B visa.

The most recent annual report on Graduate Medical Education by the American Medical Association, appearing in *JAMA* (December 6, 2016), indicates that as of December 31, 2015, there were 2,889 residents with H-1B temporary worker visas.

In a March 9 message to IMG trainees (after the revised executive order was issued but before it was blocked in state courts), William Pinsky, M.D., president and CEO of the ECFMG, said, “J-1 physicians and dependents who are nationals of the six countries [specified in the EO] and have an expired passport visa are strongly discouraged from international travel while the visa suspension remains in effect.”

In an interview with *Psychiatric News*, he remained cautious. “I would still counsel IMG trainees [from the six countries] not to travel if they can avoid it,” he said. “The risk is that if they are out of the country, and for some reason the executive order goes into effect, they could be detained from returning to their training program.”

However, he emphasized a long working relationship with the U.S. State Department in processing visas and expediting them when necessary. “That good relationship continues,” he said. “My big concern [after the executive orders] was whether those who matched this year and needed J-1 visas would be processed in time. It appears to us that the processing of visas is proceeding without delay. That’s good news and should be a relief to program directors.”

But Pinsky also agreed that the executive orders have created a new perception of the United States as unwelcoming to immigrants. “My concern for the future is whether parents will decide they don’t want to send their kids to the United States, if they see us as an unfriendly country, and will look for other options for training,” he said.

during a stressful period and in the context of concern about physician and trainee wellness generally.”

Shalini Bhutani, Ph.D., assistant vice provost and executive director of the Bechtel International Center at Stanford University, also spoke at the AADPRT meeting about the effect of the executive orders on the wider academic community. The Bechtel Center sponsors foreign nationals seeking to work at Stanford on specialized visas.

In an interview with *Psychiatric News*, she said processing of some specialized visas has already been affected. For instance, in the past candidates for H1 visas could apply for


“premium processing” (at a cost of \$1,225) that would ensure faster processing. (Normal processing time for H1 visas is six to nine months; premium processing shortened the period to two to three weeks.)

“Universities could bring people in throughout the year on a timely basis,” she said. “But now premium processing has been suspended for six months. We don’t know how long that will be in effect, but it’s another area where there could be a huge impact.”

Bhutani said that in the atmosphere of heightened suspicion of immigrants, border officials may feel they have license to act with impunity in

all sorts of unpredictable ways—for instance, by confiscating laptops or other electronic devices on which travelling physicians may be storing data relevant to research or education.

“It’s the kind of issue that is on the periphery of the large one, which is that the current atmosphere has made racism and discrimination possible,” Bhutani said. “The genie is out of the bottle—I don’t know that we can put it back.” **PN**

 The CMSS position statement on “International Collaboration in Medicine” is online at <https://cmss.org/new/cmss-position-on-international-collaboration-in-medicine/>.

Experts

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its continuing life. The therapist may offer “helpful comments” or allow the patient to “vent” or serve as a “sounding board” or provide a sympathetic ear or give short-term advice, but none of these tactics is likely to result in significant improvement or to resolve the problems for which the patient sought treatment. The therapy becomes an end in itself rather than a means to some ultimate benefit.

Effective therapy usually requires both a positive relationship, the

therapeutic alliance, and an operational plan, the methodology selected to best meet the patient’s needs. When the therapist gives up the plan and begins to provide only support, the relationship becomes the sole reason to continue. The therapeutic alliance can, of course, promote a positive therapeutic outcome—indeed, therapy will not succeed without it—but it will not be sufficient in itself nor can it be relied on when other, more targeted efforts fail.

Rather than settle for a “supportive” strategy when treatment is unproductive and stalled, the trainee, with

the supervisor’s help (or the experienced clinician who runs into the same problem) should look for the reason the therapy falters. The possible causes are many and varied. To name a few: Does the treatment plan need to be revised? Are there problems not apparent at the initial evaluation that should be addressed? Is there an unrecognized problem within the therapy, such as a transference issue? Whatever the identified reason for the stalemate may be, when it is recognized and addressed, therapeutic progress can usually resume and lead to a better outcome. **PN**