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David Hathcox

SEE STORY BELOW

NIDA Director Nora Volkow, M.D., tells attendees at APA's 2017 Annual Meeting how psychiatry can help end the opioid crisis in this country. Additional coverage of the Annual Meeting appears throughout this issue.

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Social media offers another way for psychiatrists to collaborate.

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Suicide risk remains elevated long after psychiatric hospital discharge.

Tackling Opioid Overdose Epidemic Demands Multiple Approaches

Advances in policy, medical education, and research must be combined to slow the sharp rise in opioid addiction and overdose deaths plaguing the United States. ***BY AARON LEVIN***

The opioid crisis owes much of its origins to the health care system, and so the health care system must take up the cause to end it, said Nora Volkow, M.D., director of the National Institute on Drug Abuse (NIDA), at APA's 2017 Annual Meeting in San Diego.

Opioid abuse has a "devastating impact," Volkow told an overflow crowd. "There were 33,000 opioid overdose deaths in 2016, and the epidemic has touched everyone, which is what we have stressed—that addiction can happen to anyone."

How bad is the epidemic? Volkow recounted a meeting she attended at the Vatican, where an American surgeon remarked: "For the first time, we don't have a lack of organs for donation."

Psychiatry has a greater role to play in resolving the addiction crisis, Volkow said.

"Psychiatrists need to get more involved in the management of chronic pain conditions," she said. "Psychiatry's presence reinforces the point that addiction is a disease and thus a responsibility of the health care system."

NIDA is now working with APA to develop a curriculum for psychiatry residents built on the premise that patients with nonaddictive mental illnesses must get treatment for addictions, given that comorbidity of mental illness with substance abuse is extremely common.

The epidemic was shaped in part by good intentions gone wrong, fueled in the 1990s by a rising concern for pain treatment ("pain as the fifth vital sign")

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PERIODICALS: TIME SENSITIVE MATERIALS

Britain's Psychiatrists Offer Help in Coping With Terrorism

The president of the Royal College of Psychiatrists emphasizes that people are far more resilient after a traumatic event than often given credit for.
BY AARON LEVIN

It's been a tough year for the British.

A terrorist drove a car onto the sidewalk on London's Westminster Bridge on March 22, killing four pedestrians, and then stabbed a police officer before being shot to death. Then on May 22, 22 people were killed by a suicide bomber as they left a pop concert in Manchester. On June 3, a second ramming and stabbing attack occurred on London Bridge and at

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PSYCHIATRIC NEWS

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Negative Emotional States Help Drive Alcohol Use Disorder, Koob Says

The NIAAA director is credited with significantly broadening knowledge of the adaptations within reward and stress neurocircuits that lead to addiction. ***BY MARK MORAN***

Alcohol and drug addiction appears to impair not only brain areas critical to reward, but over time also sensitizes other brain areas involved in negative emotional states—dysphoria, anxiety, and irritability—when access to the drug or stimulus is prevented.

"We can all agree that addiction is a chronic, relapsing disorder characterized by a compulsion to use a substance or stimulus," said George F. Koob, Ph.D., director of the National Institute on Alcohol Abuse and Alcoholism (NIAAA), at APA's 2017 Annual Meeting in San Diego. "But we now believe that a critical component of addiction is the emergence of negative emotional states when access to the substance is prevented. This is what I have called the 'dark side of addiction.' "

David Hathcox

George Koob, Ph.D., says he doubts that medication can "cure" alcoholism, but it can be an important tool in the biopsychosocial treatment of alcohol use disorder.

Koob described recent research indicating that negative emotional states are activated in parts of the brain outside the reward circuit that become sensitized as an individual's addiction increases over time and appear to involve a number of stress-related neurotransmitters that cause anxiety and irritability when an addict's drug of choice is denied or not available.

These stress-related neurotransmitters include corticotropin-releasing factor (CRF), norepinephrine, dynorphin, vasopressin, glucocorticoids, or other neuroimmune factors.

"Compulsive drug taking produces a reduction in reward neurotransmission in the basal ganglia and a recruitment of brain stress neurotransmission in the extended amygdala that

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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.

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contribute to dysphoric-like responses and a negative emotional state," Koob said. "We believe that these brain systems mediating negative emotional states are activated by acute excessive drug intake, sensitized during repeated withdrawal, and persist into protracted withdrawal."

In combination with social and environmental cues that trigger the desire to use or drink, these negative emotional states drive drug seeking and relapse in addiction, Koob said. He described an individual who has faced workplace consequences due to alcoholism or addiction; driving home, he feels humiliated and agitated. "He sees his favorite bar, and the lights go off," Koob said.

Koob is an internationally recognized expert on alcohol and stress and the neurobiology of alcohol and drug addiction. As director of NIAAA, he oversees a broad portfolio of alcohol research ranging from basic science to epidemiology, diagnostics, prevention, and treatment.

He began his career investigating the neurobiology of emotion, particularly how the brain processes reward and stress. He subsequently applied basic research on emotions, including on the anatomical and neurochemical underpinnings of emotional function, to alcohol and drug addiction, significantly broadening knowledge of the adaptations within reward and stress neurocircuits that lead to addiction.

This work has advanced the understanding of the physiological effects of alcohol and other substance use and why some people transition from use to misuse to addiction while others do not.

At the lecture, Koob reminded psychiatrists that despite the existence of three FDA-approved drugs to treat alcohol use disorder—disulfiram, naltrexone, and acamprosate—less than 20 percent of addicted individuals get treatment, and less than 10 percent get pharmacotherapy. Moreover, he said data now indicate that as many as 15 percent of deaths from opioid overdose also involved alcohol use.

Koob's research suggests hope for the development of medications that can diminish negative emotional states associated with withdrawal from alcohol or drugs, and he noted that anti-stress neurotransmitters such as oxytocin have shown promise.

But he cautioned against hoping for a magic bullet. "I don't think medication can ever cure addiction," he said. "Rather, medication may be one piece in an armamentarium. Behavioral therapies, which many of you provide, will be needed to help patients achieve homeostasis in the rest of their lives." **PN**

Session on Goldwater Rule Elicits Diverse Reactions From Participants

More than 50 years after the 1964 election, the Goldwater Rule still raises questions within American psychiatry. **BY AARON LEVIN**

"The Goldwater Rule is a masterpiece of contradictions," said Jerrold Post, M.D., summing up the various—and occasionally contradictory—views held by psychiatrists about Section 7.3 of APA's ethics code in a session at APA's 2017 Annual Meeting in San Diego.

The fact that Section 7.3 of the *Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry* continues to be a source of often heated discussion among psychiatrists may be testimony both to the current state of American political affairs and to a sense by some that this particular principle overly restricts members of the profession from legitimately expressing their views.

The Goldwater Rule, the popular name for Section 7.3, was developed after a number of psychiatrists declared during the 1964 presidential election that Sen. Barry Goldwater, the Republican candidate, was "psychologically unfit" to be president. Goldwater sued and won damages from *Fact* magazine, which had solicited the comments. The episode called into question the scientific grounding and the trustworthiness of the psychiatric profession.

Promulgated in 1973, Section 7.3 states that psychiatrists should not offer a "professional opinion" about a public figure without a face-to-face examination and obtaining that person's consent. The annotation was intended to protect the subject of the statement from harm, to avoid discouraging potential patients from seeking treatment, and to prevent undermining the public's perception of the psychiatric profession.

"The Goldwater Rule is a valuable component of the ethics of psychiatry," said former APA President Paul Appelbaum, M.D., the Dollard Professor of Psychiatry, Medicine, and Law at Columbia University College of Physicians and Surgeons and a member of APA's Committee on Judicial Action.

Appelbaum noted three challenges to the rule: that it inhibits public education about mental illness, that nonpsychiatrists offer diagnoses anyway, and that psychiatrists sometimes assess historical figures whom they have not examined personally.

"We can educate the public in general terms without labeling people," said Appelbaum. "I'm less concerned about what a [nonpsychiatrist] journalist has to say. Mere observation through the media is inadequate and unreliable, because in making a diagnosis, we do more than check off symptoms."

Post said he practices what, in its most recent iteration, is now an accepted exception to Section 7.3—the extended analyses of world leaders under controlled conditions of scholarship. Such was his job at the Central Intelligence Agency for 20 years. Post was praised by policymakers and excoriated by at least one psychiatrist for his public assessment in Congressional testimony of Saddam Hussein's leadership abilities at the time of the Gulf War in 1991.

While Post said his experience could be valuable in the present political climate, he has declined media requests for comment in deference to APA's official position. Nevertheless, he believes that psychiatrists have an ethical obligation to contribute to the public discussion on matters related to candidates for office. He also said that he thinks it is unfortunate that APA members cannot comment on opinions offered by nonprofessionals, such as reporters.

"The Goldwater Rule is more a guideline for etiquette than an enforceable moral dictum," said Claire Pouncey, M.D., Ph.D., a private practitioner in Philadelphia. "When the Goldwater Rule functions as a gag rule, it is in itself unethical."

Codes of ethics are important because they help elevate an occupation to a profession, said Pouncey. "The Goldwater Rule makes a good rule of thumb to remind psychiatrists of our shared professional standards," she said. "But it denies a full moral role for psychiatrists by preventing the possibility of grappling with and justifying our own moral values and choices in a messy, imperfect world. It's time to eliminate if from Section 7, not reinforce it, but the principle and the history are still instructive and should be taught."

Section 7.3 was never intended to take away moral agency from psychiatrists, said Allen Dyer, M.D., Ph.D., a professor of psychiatry at George Washington University. He served on APA's Ethics Committee when it first developed the statement in 1973.

"It's not a rule; it's a caveat," he said. "We were formulating principles, not rules. We never intended to take away moral agency."

Stigma and the shaky scientific underpinnings of psychiatry in the 1960s also played a role, said session chair Nassir Ghaemi, M.D., offering another argument for change.

"The rationale for the Goldwater Rule says that we don't know what we're doing," said Ghaemi, a professor of psychiatry at Tufts University School of Medicine. "In 1964 and 1973, psychiatry was different; it was mostly psychoanalytic, and the need for an in-person evaluation was pushed by the psychotherapeutic approach, not by the diagnosis."

He continued, "Political candidates have medical evaluations but not psychiatric examinations because of the assumption that a psychiatric condition is bad." The implication of the Goldwater Rule is that even psychiatrists stigmatize psychiatric disorders. Some diagnoses might even be helpful. Depression may confer a sense of realism, and hypomania may spur creativity, for example. "The real question we should ask is, 'What psychological traits make for good leaders once they come into office?'"

Former APA President Paul Summergrad, M.D., the Dr. Frances S. Arkin Professor and chair of the Department of Psychiatry at Tufts University School of Medicine, served as the session discussant. He observed that while physicians have the same right to free speech as other citizens, they gain authority but are also constrained by the role of their profession.

"Decisions made in a democracy, whether we like them or not, must be dealt with great seriousness and a sense of gravity, including commentary about public figures," he said. "We must be circumspect. I come down on the side of restraint as part of our professional obligations. The Goldwater Rule is a good thing." **PN**

"The Goldwater Rule is a valuable component of the ethics of psychiatry."
—Paul Appelbaum, M.D.

Epidemic

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and a mistaken belief that opioids taken for pain would not induce addiction, said Volkow. Policies to reduce pain had unexpected consequences.

"Our prescription practices went completely awry," she said. "From 1991 to 2011, the number of prescriptions for oxycodone and hydrocodone rose from 76 million to 219 million. In 2013, doctors wrote about 260 million prescriptions for opioids, enough for one month's use for every adult in the U.S."

Opioids work well for acute pain, but the body develops tolerance within days, requiring higher and higher levels of the drug to achieve the same levels of analgesia, she said. However, the tolerance in the brain's pain network rises faster than tolerance in the brainstem's breathing centers, ultimately slowing or stopping breathing and leading to death by overdose.

Development of different interventions are already under way, said Volkow. Last year the Centers for Disease Control and Prevention issued prescribing guidelines for acute pain, urging providers to prescribe no more than a three-day supply of opioids, use nonopioid therapies, choose immediate-release formulations, and follow up to reevaluate risk of harm. Volkow noted that sometimes emergency department physicians and dentists send patients home with prescriptions for a 30-day supply of painkillers, most of which can be diverted or misused.

"We all face the challenge of seeing that patients with pain—particularly chronic pain—are properly treated," she said. "Throughout education and training, med students, doctors, nurses, pharmacists, and dentists must learn when to use opioids and then use them carefully with close monitoring."

The Drug Enforcement Administration pushed manufacturers to reduce production by 15 percent in 2016. Data from 2015 show that the number of prescriptions for opioids decreased, but opioid overdoses still rose. As prescription opioids become harder to obtain, users shift to illegal and often more lethal variants. They transition first to relatively cheap heroin but eventually move on to synthetic opioids like fentanyl.

"Fentanyl is a good anesthetic in the operating room because it's rapid acting and can be stopped rapidly," said Volkow. "But it is 50 times more potent than heroin, so only a tiny dose is needed for effect, and addicts often overdose before they finish injecting."

Worse yet is carfentanyl, which packs 5,000 times the punch of heroin.

Science has more work to do, as well, starting with increasing knowledge about brain pathways and the role of genetics in addiction.

"We also need to develop more treatments for managing chronic pain that are less addictive and not based on opioid receptors," she said. For instance, inflammatory mediators prevent the production of pain, and cannabinoids regulate stress reactions to it. Targeted opioid analgesics with less addiction and overdose potential were explored in the past without success, but more is known today, and those alternatives may be worth another look.

More treatment options are needed, too. Naloxone has proven its value in reversing overdoses, and reductions in costs make it more widely available. Fentanyl requires multiple doses of naloxone, so there is a need to find other drugs to prevent respiratory depression, said Volkow. "I would like to see a longer-acting version to protect users from overdosing again while offering a chance for longer-term postoverdose interventions."

Medication-assisted treatment is a promising approach to treating opioid addiction, but 60 percent of addicts are not receiving such care, largely because of the stigma attached to the treatment, she said. Methadone, buprenorphine, naloxone, and naltrexone are currently available.

"This is not 'exchanging one drug for another,' " she said. "That argument betrays a lack of understanding of how these drugs work."

A more significant problem is that there are not enough trained providers and treatment sites to meet the demand. Other barriers exist as well. Making a daily trip to a methadone clinic requires making a decision about treatment once a day, and addiction erodes free will and self-control, so NIDA is working with pharmaceutical companies to develop extended-release versions that would likely increase compliance. In rural areas with few doctors, such treatment could be monitored by nurses or other providers.

An even higher-risk avenue of research lies in the development of vaccines that would make antibodies to capture drugs. So far vaccines have not produced enough antibodies to capture enough drug, but research continues.

Nonetheless, research and policy solutions can go only so far, added Volkow in an interview with *Psychiatric News* following her talk.

"The epidemic is most acute in parts of our country where people have experienced a loss of hope and opportunity and culturally meaningful beliefs," she said. "We have to tackle this as a social problem along with the biological issues." **PN**

The CDC's Guideline for Prescribing Opioids for Chronic Pain is posted at https://www.cdc.gov/drugoverdose/pdf/guidelines_factsheet-a.pdf. The NIDA research report titled "Medications to Treat Opioid Addiction" is posted at https://www.drugabuse.gov/publications/research-reports/medications-to-treat-opioid-addiction/overview.

NIH Partners With Industry to Stem Opioid Crisis

Data from the Centers for Disease Control and Prevention suggest that more than 90 Americans die every day from opioid overdoses, an epidemic that seems to be becoming only more entrenched. To get in front of this public health crisis, the National Institutes of Health (NIH) is teaming up with the pharmaceutical industry in a three-pronged research initiative.

"Recent NIH-industry partnerships, such as the Accelerating Medicines Partnership, demonstrate the power of public–private collaboration in speeding the development of new medications," wrote NIH Director Francis Collins, M.D., Ph.D., and National Institute on Drug Abuse Director Nora Volkow, M.D., in a special report published May 31 in the *New England Journal of Medicine*. "Ending the opioid crisis will require this kind of collaboration."

This new public-private partnership will include short- , intermediate- , and long-term research strategies aimed at developing better opioid overdose-reversal interventions, finding new medications and technologies to treat opioid addiction, and developing nonaddictive therapies for chronic pain. In addition, a goal that cuts across all three focus areas is to reduce the time typically required to develop new safe and effective therapeutics by half.

In the article, Collins and Volkow highlighted existing drugs developed through such partnerships, including Probuphine, a long-lasting buprenorphine implant recently approved by the FDA, and Narcan nasal spray.

But while pharmacology will be front and center, Collins and Volkow stated that other clinical avenues will be pursued as well. These include brain-stimulation technologies such as repetitive transcranial magnetic stimulation, gene therapies that deliver anti-inflammatory proteins directly to sites of pain, and even opioid-targeted vaccines to keep these drugs out of the brain.

"The Role of Science in Addressing the Opioid Crisis" is posted at http://www.nejm.org/doi/full/10.1056/NEJMsr1706626.

Volkow Honored by Psychiatry Department Chairs

Nora Volkow, M.D., director of the National Institute on Drug Abuse, was presented the Presidential Award for 2017 by the American Association of Chairs of Departments of Psychiatry in May. The organization presents the award each year to a psychiatrist for distinguished scientific achievement and leadership in the field of psychiatry. Volkow was honored for her groundbreaking psychiatric research on drug addiction. She is flanked by Ondria Gleason, M.D. (left), chair of the Department of Psychiatry at the University of Oklahoma School of Community Medicine, and Britta Ostermeyer, M.D., chair of the Department of Psychiatry and Behavioral Sciences at the University of Oklahoma Health Sciences Center.

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David Hathcox

At APA's 2017 Annual Meeting in San Diego, NIMH Director Joshua Gordon, M.D., Ph.D., talked about the NIMH budget, the promise of the 21st Century Cures Act, and use of data-driven models to understand mental illness.

NIMH Director Describes What's Next for Institute

NIMH Director Joshua Gordon, M.D., Ph.D., comments on how clinical trials and the Research Domain Criteria initiative need to evolve. **BY NICK ZAGORSKI**

The National Institute of Mental Health (NIMH) has experienced some big changes since Joshua Gordon, M.D., Ph.D., became the director last fall. In December 2016, then President Barack Obama signed the $6 billion 21st Century Cures Act into law, which among other things expanded funding for mental health research and strengthened enforcement of parity legislation. In January, the institute experienced its first administration transition under Gordon's leadership, as President Donald Trump took office.

Addressing attendees at APA's Annual Meeting in May, Gordon discussed the institute's funding outlook and priorities for the future.

For 2017, NIMH received an $80 million boost in funding, $38 million of which is designated to the BRAIN (Brain Research through Advancing Innovative Neurotechnologies) Initiative. The passage of the 21st Century Cures Act secured additional funding through 2026 for the BRAIN Initiative and the Precision Medicine Initiative (PMI)—a program that aims to understand the role that an individual's genetics, environment, and lifestyle can play in the prevention or treatment of disease.

"The budget picture is looking brighter," Gordon said, noting that there are several points researchers should consider to best position themselves to receive support for their projects.

"The most important criteria for us is excellent science," Gordon said. Just because a study is high risk, refutes existing dogma, or is expensive does not mean it will be rejected, if the underlying science is good, he added. "I would rather spend $1 million on a clinical trial whose results I can trust versus $500K only to find out that the ambiguous results mean starting all over."

On the topic of trials, Gordon reminded the audience that NIMH has shifted toward an "experimental therapeutic" paradigm for intervention trials. As Gordon explained, the institute will no longer fund a study that solely looks to demonstrate different clinical effects. "We don't want a situation where an intervention shows no effect, and the investigators say, 'Well, we used the wrong dose or we didn't pick the right population, but if we try again, it might work.' Ideally, a negative finding should offer as much value as a positive result."

Therefore, interventions need to first demonstrate some measurable effect on a biological target in humans; an experimental drug, for example, needs to show how it alters receptor activity. Then, the clinical trial assesses if the drug successfully engages the target receptor and how that relates to changes in symptoms.

The goal is that no matter the trial outcome, the findings add to existing knowledge by providing clues on how the intervention can be refined or modified moving forward.

Gordon then touched on another NIMH initiative of interest to APA, one that is tied to the question of how diagnoses are formulated—the Research Domain Criteria (RDoC).

While Gordon said he believes a rethinking of the mental health diagnostic system is warranted, he acknowledged that the RDoC implementation had several problems. The RDoC initiative was carried out in a top-down manner, with experts deciding what constitutes a "domain of mental behavior."

Gordon said he wants to shift RDoC to be a bottom-up, data-driven project. "A *DSM* symptom or RDoC domain both likely reflect a dysfunction in a latent construct such as executive function or working memory," he said. "These dysfunctions, in turn, reflect changes in brain physiological states, and those altered states have a root cause. We need to gain more information on those underlying causes."

Switching to a data-driven model would require a tremendous number of biological and genetic samples, which could potentially be an expensive endeavor.

However, Gordon noted that some existing programs might be able to provide the data needed. Part of PMI, for example, is a program called All of Us. This program aims to recruit 1 million diverse Americans to provide biological samples and health information to create a national research resource. Researchers in any field could use this resource to study how individual differences in genetics, lifestyle, and environment influence health and disease.

"One of my goals is to ensure that All of Us is representative not only in traits like ethnicity, geography, and socioeconomics, but also in the volunteers' mental health," Gordon said.

He added that the Veterans Administration (VA) has a similar program under way called the Million Veteran Program. In the past, it has been difficult for outside groups to access VA data, but Gordon noted that in speaking with new VA Secretary David Shulkin, he is hopeful that collaboration and data sharing between the VA and NIMH will increase. **PN**

DHA Director Describes Integration of Military Health Care Services

Vice Adm. Raquel Bono directs an agency mandated to standardize best health care practices across military service lines and create a more globally integrated health care system. **BY MARK MORAN**

"We are strongest when we work together across service lines," said Navy Vice Adm. Raquel Bono, director of the Defense Health Agency (DHA). "As a surgeon, I am not going to ask for a scalpel in a different way because the patient is in the Army or the Navy. Our common mission is the patient we serve, regardless of what kind of boots he or she wears."

Bono made her remarks at APA's 2017 Annual Meeting in San Diego, where her theme was partnerships—across military service lines and, importantly, with physicians in the civilian sector.

"As director of the DHA, I have the opportunity to oversee where our best practices are occurring and work to expand, integrate, and standardize those practices across the military," Bono said. "If we do this the right way, we have a real opportunity to create a robust system serving all of our military service men and women and their families."

Bono said that the integration of health care across service lines is codified now in the most recent National Defense Authorization Act. Under the law, the mission of the DHA is to do the following:

- Create a more globally integrated health system, accountable as a combat support agency.

- Direct enterprise-wide shared services, standardizing clinical and business practices that produce better health and better care.

- Manage TRICARE for 9.4 million beneficiaries around the world. TRICARE is the health care program for uniformed service members and their families around the world.

- Deliver coordinated health care and support high-quality coordinated care in all multiservice markets.

Regarding the visible wounds of battle, Bono said that the integration of the services is producing results. In the years since the wars in Afghanistan and Iraq started, the case fatality rate per battle injury has dropped.

The invisible wounds have been more challenging. Bono solicited the help of psychiatrists in the civilian community to treat returning soldiers with traumatic brain injury and posttraumatic stress disorder.

"We are very concerned about the suicide rate," she said. "We are not dealing with a single, unitary phenomenon, but one that is very complex depending on the individual. We recognize that we don't have all the answers, and we can't do it alone. Partnering with others is going to be invaluable."

Vice Adm. Bono brings to her role a distinguished career in medicine and the military. She obtained her baccalaureate degree from the University of Texas at Austin and attended medical school at Texas Tech University. She completed a surgical internship and a general surgery residency at Naval Medical Center Portsmouth and a trauma and critical care fellowship at the Eastern Virginia Graduate School of Medicine in Norfolk.

David Hathcox

Raquel Bono, M.D., said the military seeks the expertise of psychiatrists in the civilian sector in treating the "invisible wounds of war."

Shortly after training, Bono saw duty in Operations Desert Shield and Desert Storm as head of Casualty Receiving at Fleet Hospital 5 in Saudi Arabia from August 1990 to March 1991. Upon returning, she was stationed at Naval Medical Center Portsmouth as a surgeon in the General Surgery Department and attending surgeon at the Burn Trauma Unit at Sentara Norfolk General Hospital.

Before becoming the director of the DHA, Bono served as director of the National Capital Region Medical Directorate of the DHA and as the 11th Chief of the Navy Medical Corps from September 2013 to October 2015.

Bono said military and civilian health care providers share a common overarching mission and have much to offer each other. The military is prepared to reach out to the civilian sector, she said, such as when Patrick Downes and Jessica Kensky—victims of the 2013 Boston Marathon bombing—were invited to Walter Reed National Military Army Hospital in Washington, D.C., and partnered with "battle buddies" who had lost limbs in battle.

Bono showed a video clip of a moving interview with Downes, who said, "We feel like we were embraced by the military family in a home that was meant for them."

Said Bono: "We have a sacred mission to care for our military service men and women and their families, but we also have a mission to share our experience and expertise with others. We hope you will share your experience and expertise with us." **PN**

RESIDENTS' FORUM

It's Never Too Early to Start Being an Advocate

BY LUMING LI, M.D.

Being an advocate in Washington, D.C., can be daunting, especially for a physician in training. While one never knows whether or to what extent advocates can influence politics, I know that individuals can make a difference. With health care legislation now making its way through Congress that proposes to cut coverage for millions of Americans and reduce access to mental health care, it has never been more important to act in solidarity with our colleagues and build a voice in Washington.

Recently I had the opportunity to do just that—I was fortunate to be part of a delegation to Capitol Hill with the Yale Department of Psychiatry. My chair, John Krystal, M.D., eagerly supported an "Advocacy Day" for residents and invested much time in preparing two other residents and me for the event. Also, we scheduled meetings with a number of congressional staffers, including those working for members of Congress from Connecticut and our home states, and with both Democrats and Republicans.

Particularly memorable were our meetings with the Connecticut senators' staffers, including Joe Dunn (Sen. Chris Murphy's staffer, who admirably wrote the bulk of the mental health reforms for the 21st Century Cures Act), and Brian Steele (an eager health staffer for Sen. Richard Blumenthal). The staffers emphasized that physicians are able to help lawmakers by sharing stories about our patients. We talked about our Medicaid patients who need access to suboxone and discussed the need for auxiliary services including transitional living programs. The Connecticut staffers were very sympathetic and told us to send them more stories about our work.

Luming Li, M.D., is a PGY-3 resident in the Yale Adult Psychiatry Residency Program.

After the meetings, we went to Rockville, Md., to meet with staff at the National Institute on Drug Abuse, National Institute of Mental Health, and National Institute on Alcohol Abuse and Alcoholism. They

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David Hathcox

From left: Science writer Apoorva Mandavilli (moderator) and panelists Karen Cropsey, Psy.D., Erika Saunders, M.D., Jennifer Wagman, Ph.D., and Gail Robinson, M.D., described lessons learned from their professional experiences to help women in academic psychiatry advance in their careers.

Panel Discusses the Obstacles Facing Women in Medicine

On average the annual income difference between men and women psychiatrists of comparable age, rank, and productivity is $15,000, according to a study in JAMA Internal Medicine*.* ***BY NICK ZAGORSKI***

Cheryl McCullumsmith, M.D., Ph.D., an associate professor of psychiatry at the University of Cincinnati, was helping to plan a session for the annual meeting of the National Network of Depression Centers (NNDC) when the group she was working with realized that all the scheduled panelists were men.

After a short pause, one of the other planning committee members said to McCullumsmith, "Cheryl, you're a female. You should speak at the meeting."

While the scenario may sound like that of a bygone era, this was prior to NNDC's 2016 annual meeting.

McCullumsmith's experience is far from rare in medicine, where women still lag behind men in representation at major meetings or in high-ranking academic or clinical positions. Studies, including a 2016 report in *JAMA Internal Medicine*, found that even women who achieve great academic success tend to encounter biases such as lower pay.

What does this mean for the field of psychiatry? At APA's 2017 Annual Meeting, McCullumsmith joined with other women colleagues to share their experiences and strategies for overcoming gender disparities in medicine in the session "Sticky Floor or Glass Ceiling? An Open Panel Discussion About Keeping and Advancing Women in Academic Psychiatry."

Jennifer Wagman, Ph.D., an assistant professor of global public health at the University of California, San Diego, described data from a 2012 survey of women in academic medicine that compared their advancement relative to men.

The data indicated that as early as at the assistant professor level, women in medicine are outnumbered by men; and these numbers only worsen as they move up the academic ranks—from associate professors to full professors to department chairs. Women also report lower income and less career satisfaction.

Interestingly, the same surveys found that women researchers had similar numbers of funded grants as men, yet reported fewer publications on average.

"More research is needed to understand why equal grant productivity does not translate to equivalent publications," Wagman said. "However, the observed differences look to be attributed to a loss of female faculty over time due in part to inequitable salaries and inadequate support for family leave. It shows that policies of protection and correction are needed."

What policies might be helpful? Erika Saunders, M.D., chair of psychiatry at Penn State University, suggested that part-time medical training might be one way to make work-life balance for new mothers more manageable.

"Part-time training does bring both advantages and disadvantages," Saunders said. She described feedback from psychiatry residents who had done part-time training at the University of Michigan. Some residents liked that they were not being left behind; others expressed feeling less connected to their fellow residents. "But the majority said it was positive for their success and their professional development."

Other policies that promote career flexibility, including family-friendly leave of absence policies or paid paternal leave may also help to promote the advancement of women clinicians.

Even women who move up the academic ladder can face significant obstacles, noted Karen Cropsey, Psy.D., an associate professor at the University of Alabama School of Public Health. For example, women are more likely than men to be put in perilous leadership positions. She cautioned that while research has shown that the "glass cliff" exists, it remains unclear why. It could be a case of setting up women for failure or it might be a positive bias that women can handle stress better and manage successfully in times of crisis, she said.

Gail Robinson, M.D., a professor of psychiatry and obstetrics/gynecology at the University of Toronto, rounded out the panel session with some helpful advice to help crack that academic glass ceiling, or as she phrased it, "that dense layer of men."

"Women tend to be more reserved, but success requires self-promotion, and that involves communication and visibility," she said.

While Robinson noted that it is important to be respectful, it is important to do so in a way that is not perceived as subordinate. Avoid framing responses with phrases like "I hope" or "I feel" or overapologizing for perceived slights, she suggested.

"Your main goal is promoting yourself," she concluded. "Yes, you have to make contributions. But don't assume they will become known and you will be rewarded. Take credit for your accomplishments." **PN**

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enthusiastically told us about their work. It was terrific to hear about their interaction with members of Congress and their staffers and learn how we can help them by sharing information with members of Congress and consumers. It was awe-inspiring to meet the woman who was largely responsible for putting together the Surgeon General's report—"Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health."

Our day finished with an illuminative meeting with Anita Everett, M.D., the chief medical officer of the Substance Abuse and Mental Health Services Administration (SAMHSA) and now APA's president. She told us about SAMHSA's priorities, including implementation of evidence-based substance use treatment programs and first-episode psychosis programs. We discussed the development of robust behavioral health integration programs and the challenges of charting innovation in mental health.

In summary, I am appreciative that my residency program provides an opportunity to advocate on mental health issues on behalf of our patients and future patients. In addition, I was impressed by the diplomacy and generosity exhibited by everyone with whom we met as they shared their perspectives and experiences. We started relationships with new people and deepened conversations with old friends. Our presence was warmly welcomed, even by people with opinions different from our own.

A quote by Margaret Mead inspires me to continue this advocacy work: "Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it's the only thing that ever has." Physician advocacy is a professional duty, and individual voices can be heard. There truly cannot be health without mental health. **PN**

David Hathcox

Paul Appelbaum, M.D., says that major companies are developing digital applications that can track patient data in real time.

To Google or Not to Google: Patient Online 'Footprint' Is Easily Accessible

If psychiatrists Google patient information on a routine basis, it could be regarded as a standard of care. And that means the practice could become a legal duty to monitor patients' online information. **BY MARK MORAN**

Are you Googling your patients' names? You may not be alone.

A pilot survey of 48 attending and 34 resident physicians at a large academic medical center found that 43 attendings said they had considered Googling a patient's name and 40 had actually done so, while 33 residents said they had considered Googling a patient, and 32 said they had done so.

The survey was reported by Liliya Gershengoren, M.D., M.P.H., at APA's 2017 Annual Meeting in San Diego in the session "Patient Targeted Googling: Oh! What a Tangled Web We Weave, When First We Practice to Deceive."

The practice of Googling a patient's name may be too easy to resist and may seem innocuous. Among both attendings and residents, "curiosity" was prominently cited as the reason for Googling a patient, and among attendings, it was the most cited reason in outpatient and private practice settings. "Patient care" was most often cited as the reason among attendings in emergency department settings.

The same pattern was true for residents. "Patient requested" was the least often cited reason for Googling a patient among both attendings and residents and across all practice settings. These are among other reasons cited:

- "To learn if an outpatient who stopped coming had died."
- "Patient reported being on TV, but I was suspicious that this might not be true."
- "To get a sense of the plausibility or implausibility of what the patient reports."
- "This is a basic form of collateral."
- "Validate public information."
- "In all cases it can actually provide important information about the patient's interaction with the world and their projection onto the world."
- "Famous problem in the news."
- "Criminal background."

Moreover, when asked if they had informed patients either before or after Googling their names, a majority of both attendings and residents responded "never."

'Everybody Does It'

"Curiosity is a double-edged sword," Gershengoren told *Psychiatric News* after the symposium. "I think it requires further research. Curiosity can be a good thing if the physician is truly concerned about the patient and wants to find out information that can help patient care. On the other hand, curiosity can be a more serious concern if a clinician is seeking online information solely for personal reasons that aren't related to advancing patient care.

"After I saw these data, I realized we need to have a more detailed research survey just looking at that question alone—what does 'curiosity' mean—and how it may be employed in different treatment settings," she said. "I also want to look at how other specialties may or may not be using online information about patients."

When asked if the results from the survey surprised her, Gershengoren responded, "Not much. I did this survey as a fourth-year resident, and I already knew anecdotally that Googling information about patients was common."

Quoting an iconic line from the 1999 movie "Cruel Intentions," Gershengoren said, "Everybody does it; it's just that nobody talks about it."

She added, "Hopefully, the symposium has given us a way to talk about it."

Digital Phenotype Is Permanent Record

At the symposium, four other experts explored how Googling, and other forms of collecting collateral information, may raise a host of questions—ethical and clinical—about how that information can affect the physician-patient relationship and clinical care.

Psychotherapy expert Glen O. Gabbard, M.D., discussed the impact of the Internet on the doctor-patient relationship and potential boundary violations. Robert Boland, M.D., past president of the American Association of Directors of Psychiatric Residency Training (AADPRT), presented a model curriculum for teaching residents about professionalism and the Internet as well as recommendations from the AADPRT Task Force on Professionalism and the Internet. (For further coverage, see an upcoming edition of *Psychiatric News*.) John Luo, M.D., an expert on psychiatry and informatics, concluded the session by Googling the name of a volunteer from the audience to show how revealing the Internet may be, for better or worse.

Surfacing information about a patient through a simple Google search is only the beginning of how accessibility of patients' online information may affect the relationship between psychiatrist and patient and patient care, whether in a positive or negative way—or in no way at all.

Past APA President Paul Appelbaum, M.D., explored the ethical and legal implications of using a patient's "digital phenotype"—which refers to the entirety of an individual's online presence—as well as emerging technologies that may be used to track patients online in real time. He outlined five areas of concern that individual psychiatrists, and the profession generally, must think about with regard to use of a patient's digital phenotype: accuracy of online information, clinical effectiveness and impact on patient care, efficiency in terms of the time and effort required to collect and assimilate online information, privacy concerns, and boundary considerations.

(Appelbaum and Carl Fisher, M.D., explored these topics in an article in *Harvard Psychiatry Review* titled "Beyond Googling: The Ethics of Using Patients' Electronic Footprints in Psychiatric Practice.")

A digital phenotype can include Facebook and other social media postings, emails, and comments on blogs and other websites. Appelbaum said the potential effect of all this new information on patient care is far reaching. "We are creating a new kind of medical record with all this information," he said. "It creates a permanent record that once would not have been accessible, but now can be accessed by insurers or in legal procedures."

Some patients may actually ask their psychiatrist to monitor their Facebook posts. "It is not at all inconceivable that a patient could tell his or her psychiatrist, 'I get into these online arguments, and I get very, very angry. I want you to see what happens,' " Appelbaum said.

But doing so could open a door that psychiatrists had never anticipated, he suggested. "People are wondering if we might see a legal duty to monitor patients' online presence," Appelbaum said. "Legal duty depends on a standard of care. The standard of care is in the hands of our profession. To the extent that we begin routinely Googling or otherwise collecting collateral online information, we may be establishing a standard of care that will be enforced against us." **PN**

An abstract of "Beyond Googling: The Ethics of Using Patients' Electronic Footprints in Psychiatric Practice" is posted at https://www.ncbi.nlm.nih.gov/pubmed/28504978.

Assembly Backs Blocking MOC as a Condition of Licensure

Six states have passed laws prohibiting physician licensure from being contingent on the completion of Maintenance of Certification, and two other states have similar laws pending. **BY MARK MORAN**

Maintenance of Certification, physician wellness and burnout, and solitary confinement of juvenile detainees were among the issues considered by APA's Assembly at its meeting held in conjunction with APA's 2017 Annual Meeting in San Diego.

Assembly members voted in favor of APA adopting the position that decisions regarding licensure, hospital privileges and credentialing, and/or participation on insurance panels should not in any way be conditioned upon a physician's completion of or participation in Maintenance of Certification (MOC) or Osteopathic Continuous Certification. This position will be brought before the Board of Trustees at the Board's meeting in Washington, D.C., this month.

MOC, especially the Part IV Performance in Practice component, has been the source of enormous consternation among physicians across medical disciplines who have found the Part IV requirements cumbersome and not clinically meaningful. In an address two years ago to the APA Assembly, American Board of Medical Specialties (ABMS) President and Chief Executive Lois Margaret Nora, M.D., J.D., acknowledged that the MOC process, and in particular the Part IV performance-in-practice component, needs to be improved and refined. She said that the ABMS was responding to physician concerns by a "relaxation" of requirements and an expansion of activities that count toward fulfillment of Part IV.

But she also said she believed that Part IV should be retained and in time would be "embraced" by physicians. "I have heard from physicians who say, 'Part 4 has changed my practice for the better. We are doing things now that have improved the quality of care our patients receive.'"

("Performance in practice" refers to a requirement that physicians build into their routine practice the capacity to assess their performance continually against guidelines for best practices and make improvements to meet those guidelines.)

At press time, six states—Georgia, Kentucky, Maryland, Missouri, Oklahoma, and Tennessee—had enacted legislation stating that physician licensure cannot be contingent on completion of MOC requirements. Two other states—Michigan and Texas—have similar legislation pending.

"The Assembly and the membership have voiced their grave concerns on the issue of MOC," APA CEO and Medical Director Saul Levin, M.D., M.P.A., told *Psychiatric News* after the meeting. "Members see the closed-book MOC exam as being behind the times, and they express concern that the exam content is not relevant to their individual practice. Similarly, members have expressed concern that there is a large opportunity cost associated with these exams, which require them to take time away from their practice and families to study and travel to exam centers."

Physician Wellness a Priority

In other business, the Assembly approved an action paper to continue the mission of the Ad Hoc Work Group on Physician Well-Being and urged APA to develop resources for increasing awareness about physician burnout, depression, and suicide, as well as interventions for promoting physician wellness, including recommendations for institutional response to physician suicide.

The action paper also calls on APA to do the following:

- Revise its 2011 Position Statement on Physician Wellness to affirm APA's commitment to ensuring the well-being of its members and to encourage members to serve as leaders in promoting well-being initiatives within their institutions, training programs, and systems of care.

- Promote further investigation of the underlying causes of increased rates of burnout, depression, and suicide among physicians and to expand the evidence base for innovative wellness interventions.

- Work with stakeholder organizations, including the Federation of State Medical Boards, to remove questions about treatment for psychiatric disorders, including substance use, from licensing applications (initial or renewal) and employment applications and instead focus on relevant, current functional impairment due to either physical or mental illness.

- Collaborate with the AMA to develop joint initiatives to prioritize these issues.

- Work with the Accreditation Council for Graduate Medical Education to encourage residency programs to improve access to mental health treatment for residents and fellows, recognizing that such facilitation will likely take different forms and may vary based on a variety of program and institutional factors.

Other Actions

Assembly members also voted for APA to support the AMA policy statement opposing the use of solitary confinement in juveniles and to draft its own position statement on this issue by May 2018.

The Assembly also voted for APA to adopt and promote the international Neuroscience-based Nomenclature (NbN) standard terminology in its publications, policies, and communications and seek opportunities to promote adoption of NbN terminology by payers and policymakers. The NbN is a project of five international psychopharmacological research organizations to rename psychopharmacological medications to more accurately reflect their neurobiological action in the brain.

The five international organizations spearheading the project are the European College of Neuropsychopharmacology, the American College of Neuropsychopharmacology, the Collegium Internationale de Neuropsychopharmacologie, the International Union of Basic and Clinical Pharmacology, and the Asian College of Neuropsychopharmacology.

In a paper published in July 2014 in *European Neuropsychopharmacology*, members of a task force representing the five groups (including David Kupfer, M.D., chair of the *DSM-5* Task Force) proposed a new template comprising a multi-domain pharmacologically driven nomenclature. The domains are class of drug, referring to primary pharmacological target and relevant mechanism; family, reflecting the relevant neurotransmitter and mechanism; neurobiological activities; efficacy and major side effects; and approved indications.

In an interview with *Psychiatric News* last year, Kupfer said the five domains represent varying levels of complexity—depending on the needs of patients, clinicians, pharmacologic researchers, and basic scientists—but the essential feature of the template is that it would replace indication-based titles with a nomenclature based on pharmacology and neurobiological action. An example of this would be the reclassification of the drug clomipramine—casually referred to as an "antidepressant." According to the NbN proposal, it would be reclassified as a "serotonin reuptake inhibitor." Also under the proposal, perphenazine, referred to as an "antipsychotic," would be called a D2 receptor antagonist. **PN**

Actions approved by the Assembly must be approved by the Board of Trustees before they are considered official APA policy. APA members may access the archive of Assembly actions, including approved position statements, at https://www.psychiatry.org/about-apa/meet-our-organization/governance-meetings/governance-meeting-archives.

Winners of Assembly Election Announced

At its meeting held in conjunction with APA's 2017 Annual Meeting in San Diego, members of the APA Assembly chose James R. Batterson, M.D., of Kansas City, Mo. (right), as the group's next speaker-elect. He had been serving as the Assembly's recorder. Steven Daviss, M.D., a representative from the Maryland Psychiatric Society, was elected recorder. The new officers began their terms at the close of the Annual Meeting, at which time Theresa Miskimen, M.D., of Piscataway, N.J., became the speaker of the Assembly.

David Hathcox

Winners of Resident/Medical Student Poster Competition Announced

David Hathcox

From left: Tristan Gorrindo, M.D., director of APA's Division of Education; Martha Levine, M.D., who represented Michael Nakhla, M.D.; Saul Levin, M.D., M.P.A., APA CEO and medical director; Sebastian Cisneros, M.D.; Anita Everett, M.D., then APA president-elect; Zelde Espinel, M.D.; Linda Worley, M.D., vice chair of APA's Scientific Progam Committee; Amber Mansoor, M.D.; Philip Muskin, M.D., M.A., chair of the Scientific Program Committee; and Matthew LaCasse, D.O.

The Resident/Medical Student Poster Competition is an APA Annual Meeting tradition that allows residents and medical students to attend the meeting, present their research, and be recognized for quality work. Eligible participants can submit abstracts for posters in five categories: Clinical Case Studies, Psychosocial and Biomedical Research Projects, Patient-Oriented Care and Epidemiology, Community Development and Service Projects, and Curriculum Development and Educational Projects. Submitted abstracts are evaluated by a panel of judges. All submitted posters are presented at the Annual Meeting, and winners receive a medal and bragging rights for themselves and their institutions.

This year's winners were Michael Nakhla, M.D., for "What I Think I Look Like: A Photographic Study of Perceived Body Image in Patients With Eating Disorders"; Zelde Espinel, M.D., for "Global Mental Health Outreach, Screening, and Intervention for Highly Traumatized Colombian Women Victims of the Armed Conflict"; Sebastian Cisneros, M.D., for "Cortisol Response to the Trier Social Stress Test and Variability in Suicidal Ideation"; Amber Mansoor, M.D., for "Mental Health and HIPAA in Today's World of Social Media and Smart Phones"; and Matthew LaCasse, D.O., for "Heavy Metal Psychosis: Not the Music." **PN**

Columbia Residents Win MindGames Competition for Second Straight Year

This disorder, first described by Karl Ludwig Kahlbaum, can occur in the context of several disorders and medical conditions and is frequently used as a DSM *specifier.*

Don't know the answer? See the end of this article. That's one of the questions (technically, answers) posed to residents from the New York State Psychiatric Institute-Columbia University, University of Texas Health Science Center at San Antonio (UTHSCSA), and Washington University, St. Louis, at the 11th annual MindGames competition held during APA's 2017 Annual Meeting in San Diego.

For the second year in a row, it was the team from Columbia that emerged victorious in a competition that pits residents from psychiatry programs across the country against each other with questions about medicine in general and psychiatry in particular. The event has become a popular attraction at the Annual Meeting. Pictured with the trophy after the competition are (from left) Columbia residents Anthony Zoghbi, M.D., Joel Bernanke, M.D., and Wei-Li Chang, M.D.

David Hathcox

Judges for the competition were past APA President Michelle Riba, M.D.; Richard Balon, M.D., director of psychiatry residency training at Wayne State University; and Marcy Verduin, M.D., assistant dean for students at the University of Central Florida College of Medicine. The moderator and host was Art Walaszek, M.D., director of psychiatry training at the University of Wisconsin.

MindGames is open to all psychiatry residency programs in the United States and Canada. The preliminary competition for this year's game began in February, when teams of three residents took a 60-minute online test consisting of 150 multiple-choice questions. The questions follow the ABPN Part I content outline, covering both psychiatry and neurology, with a few difficult history-of-psychiatry questions. The winners were the three top-scoring teams with the fastest posted times.

Playing for UTHSCSA were Tyler Kimm, M.D., J. Travis Hendryx, M.D., and Manu Sharma, M.D. For Washington University, the contestants were Shan Siddiqi, M.D., Ludwig Trillo, M.D., and Nicholas Trapp, M.D.

The correct answer is "What is catatonia?"

David Hathcox

The winners of this year's Awards for Advancing Minority Mental Health were honored at the American Psychiatric Association Foundation's benefit in San Diego. From left are Eli Perez of Otsuka; award winner Farha Abbasi, M.D.; Daniel H. Gillison Jr., executive director of the APA Foundation; award winners David Bond (representing the Trevor Project), Susan Peterson, and Lianne Smith, M.D.; and Mary Chi Michael of Otsuka. Otsuka supported the awards.

Advancing Minority Mental Health Awards Presented by APA Foundation

The 2017 APA Foundation Awards for Advancing Minority Mental Health were announced at the annual benefit of the American Psychiatric Association Foundation held in conjunction with APA's 2017 Annual Meeting in San Diego.

The awards, created in 2003, recognize psychiatrists, other health professionals, and organizations that have undertaken innovative efforts to raise awareness of mental illness in underserved minority communities, increase access to care, overcome cultural barriers to care, and improve the quality of care for underserved minorities, particularly those in the public health system or with severe mental illness.

Here are brief descriptions of this year's winners:

• **Farha Abbasi, M.D.,** has publicly addressed the barriers that stigmatize and silence discussion of mental health issues within the Islamic community. She is a clinical assistant professor in the Department of Psychiatry at Michigan State University, a staff psychiatrist at the University's Olin Student Health Center, and a former APA/APAF SAMHSA Minority Fellow. She established the Muslim Mental Health Conference, now in its ninth year, which brings together faith leaders, health care providers, and researchers to examine topics related to mental health across the American Muslim community. She is the managing editor of the *Journal of Muslim Mental Health* and works directly with the Muslim-American community to encourage integration into, rather than isolation from, mainstream society. She has trained more than 50 Imans from southeast Michigan, who are now partners in these initiatives.

• **Lianne Smith, M.D.,** has been involved in advancing mental health of minorities in multiple arenas both locally in the Harlem and Brownsville communities in New York City, where she was engaged in research on the social determinants of health, and internationally, where she was instrumental in establishing an international rotation for New York University (NYU) psychiatry residents in a hospital in Ghana. Smith, a former APA Diversity Fellow, is a clinical assistant professor of psychiatry at NYU and attending psychiatrist at the Manhattan Psychiatric Center Outpatient Clinic.

• **Susan Peterson** is a nationally certified school psychologist in Las Vegas, a former board-certified teacher, and an award-winning parenting author. She has spent the majority of her career working to promote and advance the early childhood education of young minority students and to educate parents about the early childhood assessment process for special education services.

• **The Trevor Project** in West Hollywood, Calif., is the leading national organization providing crisis intervention and suicide prevention services to lesbian, gay, bisexual, transgender, and questioning youth (LGBTQ). The goal of the Trevor Project is to save lives by providing support through free and confidential crisis programs, targeting LGBTQ youth aged 13 to 24. **PN**

FRESH TALK

'Connecting' With Social Media

BY LILA ABOUEID, M.D.

The future of our field lies not only in its science and practice, which of course count, but in the newest members to join our profession as residents and fellows in psychiatry and its subspecialties. Thanks to Dr. Jeffrey Borenstein, the editor-in-chief of Psychiatric News*, residents and fellows on the APA Council on Communication now have a place to share what they are learning as communicators. It was Dr. Seuss who said, "Why fit in when you were born to stand out?" You will be hearing from residents and fellows who stand out in all the best ways as contributors to this column.*

—Lloyd I. Sederer, M.D.
Vice Chair, Council on Communications

Social media has become one of the cornerstones of modern communication, making it easier to instantaneously connect with people all around the world. There are various outlets, particularly in the field of psychiatry, that have allowed users to connect and expand communication platforms. The Psychiatry Network and Women's Psychiatry Group on Facebook, originally started by Dr. Christina Girgis, are examples that have gained a large social following. The Facebook pages provide a private, secure forum for psychiatrists to learn about job opportunities and referral sources and to receive feedback and suggestions on difficult clinical cases; in short, to share, learn, and grow.

In this article, I highlight an example of how social media can be used to enhance clinical and advocacy work in psychiatry and provide support networks for psychiatrists. The following answers are provided by Dr. Girgis, consultation-liaison service medical director at Edward Hines Jr. VA Hospital and associate program director for the Loyola University Medical Center General Psychiatry Residency Program.

Lila Aboueid, M.D., is PGY4 at SUNY Downstate Medical Center and a member of APA's Council on Communications.

Social media has great potential for education and communication across the world. By using its features to our advantage, it is possible to encourage professional networking, clinical discussion, and advocacy for both patients and ourselves.

Q: Please describe how you came up with the idea of starting the Psychiatry Network and Women's Psychiatry Group.

A: Over the last couple of years, there has been a proliferation of physician groups on Facebook. One of the largest—with more than 66,000 members—is the Physician Moms Group (PMG), founded by Dr. Hala Sabry. I was added to this group and saw that it's a great resource for women physicians to connect with each other. I

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Terrorism

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nearby Borough Market. Eight members of the public died and 48 were injured before the three attackers were killed by police. On June 14, London's Grenfell Tower went up in flames, with 79 dead at press time. Then, on June 19, a man drove a van into a group of pedestrians near a mosque in North London, an apparent act of revenge against Muslims.

The events may have been horrifying but, on some level, they were not surprising to those who live in the United Kingdom.

"Yes, we notice sirens more than before, and we see more armed police, but it's not as if this is actually new," said Sir Simon Wessely, a professor of psychological medicine at the Institute of Psychiatry at King's College London and president of the Royal College of Psychiatrists (RCP), in an email interview. Britain dealt with Irish Republican Army violence from the 1970s to the 1990s and bombings in 2005 in the London Underground that killed 52 and injured 784 people. Older residents recall the Blitz, the German aerial bombardment of London during World War II.

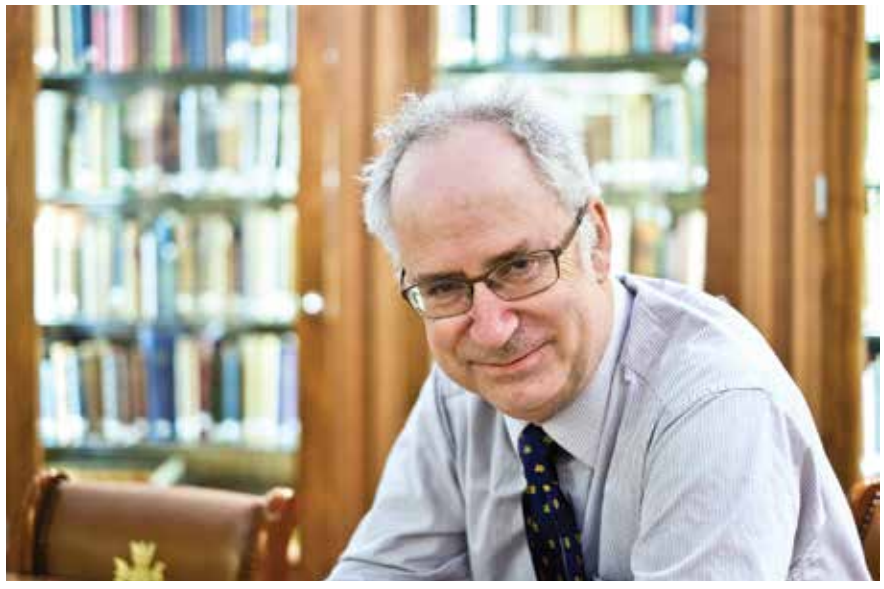
Wessely has observed a pragmatic approach by his fellow citizens in coping with these events, at least so far.

"We are in the transition period in which each individual act of violence causes a ripple of fear across the city, at least until we have all established that our loved ones are safe," he said. "And indeed, as our mobile networks become more robust and more people check into Facebook, this has become easier. And after that we talk to each other."

The British stiff upper lip may be a cliché, but Wessely and his RCP colleagues do their best to discourage catastrophizing about psychological reactions in the wake of the multiple recent disasters.

"People are far more resilient in the face of traumatic events than they are sometimes given credit for," wrote Wessely in a letter to the *Times of London* just after the Manchester bombing. Following recommendations in a 2016 RCP position statement, the letter cautioned against an immediate search for psychopathology. "Screening should not be done until at least three months after the event, so that those affected have a chance to deal with their emotions by talking to friends and family first."

The presence of Britain's National Health Service (NHS) may ease some of the access issues confronting people seeking psychiatric care, although the 2016 RCP position statement did call for "better provisioned," evidence-based trauma services in all areas of the country.



"We will do what we always do—queue for buses at Waterloo station whilst looking at our phones," observes Sir Simon Wessely.

The British government, through the Home Office, set up a website headed "Terror attacks: support for people affected." It contains links for "victims, witnesses, and those affected" by each specific attack and again notes that most people will recover naturally but that some may need professional help if "symptoms are severe or continue beyond four weeks." Those individuals are urged to visit their general practitioner and can use a sample letter posted on the site to give to the doctor, which says in part: "It is often difficult to talk about mental ill-health, and the purpose of this letter is to support those who are experiencing symptoms to start a conversation with their GP or health care practitioner about their options for treatment."

Links are also provided to find local psychological therapy services within the NHS, and there is a 24/7 victim support telephone line that offers "emotional and practical support to anyone affected by the terrorist attack[s]."

The chair-elect of the child and adolescent psychiatry faculty at the RCP, Bernadka Dubicka, M.D., a child and adolescent psychiatrist at the Care Foundation Trust in Lancaster, in May urged a thoughtful approach for parents to address the concerns of children.

"We would not advise hiding your child from what may be on the news or social media," said Dubicka through the RCP. "Respond to their questions or concerns and help them to understand that although what has happened is awful, these events are extremely rare."

The RCP position statement also advises against psychological debriefing shortly after traumatic events, since that practice has been shown to cause more harm than good.

"The provision of counseling in the short term simply doesn't work as it does not afford people the time or space to deal with traumatic events in their own way," agreed forensic psychiatrist Neil Greenberg, M.D., a professor of military mental health at King's College London, in a statement issued by the RCP. "Most people who experience distress after a traumatic event will recover without the need for any professional intervention."

However, Wessely acknowledged, those who are injured or who never make contact with their loved ones again may have difficulty recovering. And he also cautioned that things could get worse.

"If this becomes the new norm as happened in Belfast or Tel Aviv, then we will habituate to different ways of living and accept increasingly onerous restrictions on our lives, but we are not at that stage yet," he said. **PN**

The Royal College of Psychiatrists' position statement "Responding to Large-Scale Traumatic Events and Terrorism" is posted at http://www.rcpsych.ac.uk/pdf/PS03_2016.pdf. The Home Office's website "Terror attacks: support for people affected" can be accessed at https://www.gov.uk/government/collections/terror-attacks-support-for-people-affected. There is specific information related to each of the recent attacks.

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looked for a similar group for psychiatrists and could not find one, so in 2015 I decided to start the Women's Psychiatry Group. Initially I added around 50 psychiatrists or so, thinking the group would remain fairly small, but it grew quickly and now has almost 3,000 members.

In the meantime, however, I had a number of requests from residents who wanted to join the group, and I also realized it would be valuable to have a group that was open to both men and women psychiatrists. In January 2016, I formed the Psychiatry Network (nicknamed PsychNet) and opened it to all psychiatry residents, fellows, and attendings. An international group, it has members in the United States, Canada, South and Central America, the Middle East, Europe, Australia, and Asia. It's been amazing to have psychiatrists from all over the world connected with each other in this way.

Q: How have people benefited from participation in your groups?

A: I think the major benefit is being able to learn from others' knowledge and experience. The most common type of posts is clinical, with someone either asking a general question (for example, "What's everyone's experience with using vitamins and supplements to augment treatment for depression?") or presenting de-identified cases and asking for feedback. One of the great features of the group is the range of expertise among members—we have psychiatrists in all subspecialties, working in all types of settings. There are generally multiple responses in real time, and it's interesting to see the way that the original poster incorporates the feedback into his or her practice. I love hearing updates on cases that benefited from feedback from the group.

Members also get ideas and recommendations from each other for patient and educational resources, such as pharmacology conferences, books for patients on specific topics, and suggestions for free and useful CME.

Another benefit of the group is providing a platform for networking for jobs. Recently, for example, members have inquired about jobs in certain regions and asked for feedback

see **Fresh Talk** *on page 21*

Share Your News!

Psychiatric News has launched a new online feature that reports on APA members' promotions, honors, and other achievements. A link to the new feature will be included in the weekly *Psychiatric News Update* and in each print issue of *Psychiatric News.* Members are invited to send brief announcements to Executive Editor Cathy Brown at cbrown@psych.org. If you do not receive the *Update*, subscribe at https://paracom.paramountcommunication.com/form/65107/1202.

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The 'Big Easy' Decision: Join Us in New Orleans!

This APA meeting focuses not only on clinical issues but also social and political issues that impact psychiatry. It is held in a small setting that encourages networking with experts. ***BY GLENDA WRENN, M.D.***

The APA community is facing challenging uncertainty about the future of health care in the rapidly changing practice environment. Community psychiatry serves a central function to provide services in settings that enable individuals to live productive lives and is the structural support that can prevent unnecessary and costly health care services.

At a time when there are more questions than answers regarding health care reform, the call for collective impact and engagement has never been louder. Many of you have felt a strong desire to connect with colleagues and take advantage of opportunities to discuss substantive issues that impact our communities. As vice chair of the Scientific Program Committee for IPS: The Mental Health Services Conference, I can assure you that this year's conference (October 19 to 22) will educate, equip, and inspire you to action. The conference, whose theme is "Enhancing Access and Effective Care," promises to deliver an enriched experience that will rejuvenate as well as educate you. If you have never attended the IPS or have been away for a few years, I want to highlight a few aspects of our program that I am particularly excited about.

- **Stepping Outside the Clinic.** What happens when you take community psychiatry to the actual community? When community traumatic events emerge from a setting of chronic adversity and disadvantage, psychiatrists can lead within the community with impactful contributions as partners with other stakeholders.

The presentation by Deborah Blalock, M.D., "Tragedy in the Sanctuary: The Charleston Community's Response to the Emanuel A.M.E. Massacre," addresses the unfortunate reality of racism and violence in many communities. As many of them suffer from woefully inadequate and underfunded psychiatric services, psychiatrists are again summoned to act outside the clinic walls as advocates for mental health equity. Joe Parks, M.D., will lead the workshop "Addressing the Problem of Access to Psychiatric Services," which will stimulate your thinking about ways to address access to care. These sessions speak to the role of psychiatrists in community settings as advocates, change agents, and leaders.

- **Tackling Hot Topics.** We won't be debating climate change at the IPS, but two sessions involve this important issue from the perspective

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FROM THE EXPERTS

Psychodynamic Psychotherapy Today

BY GLEN O. GABBARD, M.D.

Psychodynamic psychotherapy today involves a spectrum of treatments. Some are specifically tailored to disorders—for example, transference-focused psychotherapy and mentalization-based therapy for borderline personality disorder. Others are more general and deliberately *not* focused on symptom removal.

All psychodynamic therapies are based on a thoroughgoing understanding of human subjectivity and how it interacts with the individual's relationship with both the external and internal environment. It occurs on a continuum from expressive or interpretive interventions, on the one hand, to supportive and empathic interventions, on the other, and incorporates unconscious conflict, internal representations of relationships, and idiosyncratic and complicated meanings that are attached to experience. Central to dynamic psychotherapy is a search for the truth about the self that leads to a greater sense of authenticity.

While controlled studies of dynamic psychotherapy were once scarce, that situation has changed. Two highly influential randomized, controlled trials have been published in the last few years that compared the outpatient treatment of major depression with psychodynamic therapy and with cognitive-behavioral therapy. Both studies reported that no statistically significant treatment differences were found for any of the outcome measures between cognitive-behavioral therapy and psychodynamic therapy. These two studies together have done much to influence the acceptance of psychodynamic therapy as an empirically validated treatment.

In the July 2015 *Lancet Psychiatry,* Falk Leichsenring, D.Sc., and his team discussed 64 randomized, controlled trials that demonstrated convincing evidence of the efficacy of psychodynamic therapy in common mental health disorders. They concluded that there is substantial evidence for the efficacy of psychodynamic therapy in depression, anxiety disorders, somatoform disorders, eating disorders, substance-related disorders, and personality disorders. The effects of the psychodynamic therapy were found to be stable or increased in follow-up assessments.

Some forms of psychodynamic psychotherapy eschew a symptom focus. A fundamental principle of psychodynamic thinking is that we are consciously confused and unconsciously controlled. We don't really know ourselves. Because of a variety of conflicts, prohibitions, anxieties, and defenses, we tend to hide out from

Glen O. Gabbard, M.D., is a clinical professor of psychiatry at Baylor College of Medicine. He is the author of *Long-Term Psychodynamic Psychotherapy: A Basic Text, Third Edition,* from APA Publishing. APA members may purchase the book at a discount at https://www.appi.org/Long-Term_Psychodynamic_Psychotherapy_Third_Edition.

ourselves, and the task of the psychodynamic therapist is to join the patient in a search for the patient's true self.

One of the most distinctive features of psychodynamic psychotherapy is that the therapist addresses the *person* with the illness, not simply the problematic symptoms. Patients who come to psychotherapy, like everyone else, have built up a lifetime of defenses so that self-deception is a ubiquitous factor in psychodynamic psychotherapy. We would like to be known and validated and recognized, but we are riddled with shameful fantasies, fears, and wishes, and we worry that others will think badly of us if we reveal the hidden aspects of ourselves. Hence psychodynamic psychotherapists are determined to help patients get in touch with who they are and what they want to do with their lives.

One of the most distinctive features of psychodynamic psychotherapy is that the patient comes for help but unconsciously resists the insights provided by the therapist. The defenses in the patient's inner world become resistances when the patient enters into the interpersonal relationship that psychotherapy provides. Hence the patient may dismiss what the therapist says, come late for sessions, "forget" the day and time of the session, and draw a blank when asked to speak about what is distressing. The dynamic therapist helps the patient look at the defenses marshalled against the therapist and the underlying fears of being shamed, exposed, misunderstood, controlled, and coerced.

In an era of "quick fixes" and instant gratification on the Internet, psychodynamic psychotherapy fills a need for connection, understanding, empathy, and authenticity. The psychotherapist listens, acknowledges the presence of ambivalence, and helps the patient sort out the sources of distress. The days of strict abstinence and neutrality are long gone. The dynamic therapist knows that psychotherapy is a two-person field and studies the interaction between the two parties with the idea that he or she may influence what is happening in the patient. Above all, the therapy is a collaboration between patient and therapist for answers that seem elusive. **PN**

References for this article are posted at http://psychnews.psychiatryonline.org/doi/full/10.1176/appi.pn.2017.7a14.

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of mental and population health. These sessions are not to be missed: the symposium led by David Pollack, M.D., "Climate Change: The Ultimate Social Determinant of Health and Mental Health" and the workshop led by Elizabeth Haase, M.D., "Sickly Hot: Clinical Consequences of Climate and How to Protect Your Patient."

- **Networking for Introverts.** If you have never attended IPS or have not attended in a few years, you should know that one of the best aspects of this conference is the opportunity to meet with other psychiatrists in an intimate setting conducive to networking. You'll have plenty of opportunities to speak with presenters and participate in small group discussions. Medical students and residents have many opportunities to meet prominent thought leaders in community psychiatry, both after presentations and at other events. Finding like-minded psychiatrists who are concerned about the social determinants of health and advocate to change the systems and structures undermining access to care is a unique opportunity that IPS provides. If you are a bit intimidated at the thought of networking at large meetings, IPS is the ideal conference to meet people who could become part of a lasting network of colleagues, mentors, and fellow change agents.

Finally, there's no doubt that the Big Easy has much to offer with its historic charm, exciting culture, and culinary delights. I hope you are as excited as I am to attend these and other sessions while making new connections and have decided to join us in New Orleans! **PN**

Register now at advance registration rates at https://www.psychiatry.org/ips and take advantage of APA's preferred hotel rates. Residents may attend for only $95.

New Research Shows Multiple Genes May Be Associated With PTSD

Case-control genetic studies are beginning to reveal the roles of specific genes in determining risk for posttraumatic stress disorder. **BY AARON LEVIN**

The search for the origins of posttraumatic stress disorder now extends beyond a triggering event into the affected individual's genotype, which may eventually hold clues for more successful treatment, according to speakers at the 12th Annual Amygdala, Stress, and PTSD Conference. The conference was held at the Uniformed Services University of the Health Sciences in Bethesda, Md.

"It is clear that PTSD has a significant heritable component," said Douglas Williamson, Ph.D., a professor of psychiatry and behavioral sciences at Duke University. "Estimates range from 26 percent to 38 percent of the risk."

The Psychiatric Genetics Consortium has pooled data from hundreds of thousands of cases and controls in genomewide association studies to increase the ability to detect new loci of interest in PTSD. "What is needed now is evidence of the functional relevance of these newly identified loci," he said.

Williamson is a principal investigator on the STRONG STAR Research Consortium, a pre- and post-deployment study that recruited 4,112 U.S.

Army soldiers, collecting blood samples to look for genes that were up- or down-regulated following deployment. They identified 403 PTSD cases and 934 controls who had experienced or witnessed a traumatic event and endorsed having "intense fear, helplessness, or horror" as a result but had not reached case level.

Comparing the two groups, the researchers identified two novel genes: GRM7, associated with probable current PTSD symptoms, and OXSR1, associated with lifetime PTSD.

GRM7 serves as a presynaptic regulator of neurotransmission in the mammalian central nervous system and has been associated with major depression. GRM7 was downregulated in PTSD cases. Separate studies by Williamson's Duke colleague Ahmad Hariri, Ph.D., based on more than 1,000 fMRI face-matching scans, found that coupling early traumatic stress exposure with the risk allele of GRM7 produced overactive responses to fearful faces and revealed higher levels of activity in both the left and right amygdalae following increased stress. Less is known about OXSR1, but it appears to regulate downstream kinases in response to environmental stress.

Other genes play a role as well. Postmortem human brain studies have found significant differences in gene expression in the subgenual prefrontal cortex (PFC) among patients with PTSD versus those with major depression or control subjects, reported Ronald Duman, Ph.D., a professor of psychiatry and neuroscience at Yale University School of Medicine. Output to the amygdala from the subgenual PFC is required to extinguish fear.

A study of 31 brains found that 169 genes were down-regulated and 107 upregulated in people diagnosed with PTSD, said Duman.

Most of these genes influenced cytokine and chemokine pathways, he said. "That suggests that psychological distress induces dysregulation of the immune system and that novel treatments or combinations of treatments should consider use of anti-inflammatories to keep that in check."

Two genes in particular were tied to behaviors related to PTSD. SGK1 (serum glucocorticoid regulating kinase-1) was reduced in the subgenual PFC in brains from people with PTSD but not in those with major depressive disorder. Clinical research has shown a loss of glucocorticoids in PTSD patients, and studies of learned helplessness models in rats have noted a decreased expression of SGK1.

Decreased spine synapses are also reported in animals expressing the dominant negative allele, supporting the hypothesis that this leads to atrophy of those neurons, said Duman. Neuronal atrophy in the PFC, as seen in the retraction of dendrites and loss of spine synapses between neurons, is also caused by stress and may be involved in the inability to extinguish and possibly the inability to control functions of these glucocortical neurons, in the amygdala, nucleus accumbens, and many other brain regions that receive downstream projections, he said.

Blood levels of a second gene, the FK506 binding protein (FKBP5), are decreased in PTSD patients. Again, expression is greater in the subgenual PFC in PTSD patients, although not in patients with depression.

"Upregulation of SGK1 and FKBP5 may reduce fear and enhance extinction, so they also may serve as blood biomarkers for PTSD as well as for treatment response," said Duman.

NPAS4, a brain-specific, activity-dependent transcription factor, is also upregulated in the subgenual PFC and may be a key hub gene for regulating other genes and transcription factors, he said. "NPAS4 inhibits excitatory synapses and excites inhibitory synapses to bring the circuit back into balance."

As for treatment, ketamine has been observed to rapidly reduce symptoms in PTSD patients, said Duman. A single dose of ketamine significantly reverses the deficit in spine synapses in stressed animals and

see **Genes** *on page 18*

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All Patients at Risk for Suicide After Psychiatric Facility Discharge, Study Finds

Home visits, social support, and care coordinators accompanying discharged patients to appointments can lower suicide risk. **BY HARRIET EDLESON**

All patients are at risk for suicide after they are discharged from psychiatric facilities, not just patients who were admitted for suicidal thoughts or behaviors.

That is the finding from 50 years of data synthesized in an international meta-analysis published online in *JAMA Psychiatry* on May 31.

The authors reported that the suicide rate of patients in the first three months after discharge was approximately 100 times the global suicide rate of 11.4 per 100,000 patients per year in 2012. Patients admitted with suicidal thoughts and behaviors had rates nearly 200 times the global rate. Even many years after they were discharged, previous psychiatric inpatients had suicide rates that were approximately 30 times higher than typical global rates, according to the authors.

"Our findings better support the views of authors who believe in a more universal approach to suicide prevention that might focus on periods of high risk but that extends for periods of years," wrote Daniel Thomas Chung of the University of New South Wales in Australia and colleagues.

The meta-analysis looked at 100 English-language, peer-reviewed studies published from January 1, 1946, to May 1, 2016. They included 183 patient samples and more than 17,000 deaths by suicide.

The authors reported that the suicide rate was highest within three months after discharge and among patients admitted with suicidal ideas or behaviors. Pooled suicide rates per 100,000 patient-years were 654 for studies with follow-up periods of three months to one year, 494 for studies with follow-up periods of one to five years, 366 for studies with follow-up periods of five to 10 years, and 277 for studies with follow-up periods longer than 10 years. (A pooled estimate postdischarge suicide rate is the rate that summarizes the earlier studies; it is similar to an average. Each study is weighted depending on the sample size.)

The high suicide rate of discharged patients might be attributable to multiple factors, according to the authors. Among them are changing legal and other criteria for admission. Co-author Matthew Michael Large, M.B.B.S., D.Med.Sci., told *Psychiatric News* that since the mid-1970s, danger to self or others is cause for an involuntary admission to a psychiatric facility in many jurisdictions. He noted that in an "era of declining bed numbers over the last 30 years, the threshold for admission has gone up."

Other factors included shorter lengths of inpatient treatment, increased prevalence of substance use, publication bias in favor of recent studies from regions with a higher suicide rate, and greater acuity of illness among those admitted in the deinstitutionalization era. Large said that deinstitutionalization has occurred in almost all of the high-income countries in the meta-analysis including the United States, Canada, Australia, and the United Kingdom.

Early intervention is crucial to preventing suicide among discharged psychiatric patients. "Efforts aimed at suicide prevention should start while patients are in the hospital, and the period shortly after discharge should be a time of increased clinical focus," the authors wrote. However, since the study also suggested that previously admitted patients, particularly those with prior suicidality, remain at a markedly elevated risk of suicide for years, they should be a focus of efforts to decrease suicide in the community, they added.

The suicide rate in the United States has continually increased in the past decade. In contrast, the rates of eight of the other 10 leading causes of death in the United States have declined in recent years, wrote Mark Olfson, M.D., M.P.H., a professor of psychiatry at Columbia University School of Medicine, in an accompanying editorial. He was not involved in the meta-analysis.

"The national increase in suicide rate brings renewed urgency to suicide research and implementation of effective suicide prevention programs," he wrote.

Olfson noted that in the United States, transitions from inpatient to outpatient care are often "poorly managed" and suggested that the connection between inpatient and outpatient psychiatric services be strengthened to help lower suicide risk during the first months when the risk is highest.

"Only about half of psychiatric inpatients receive any outpatient care during the first week after hospital discharge, and only about two-thirds receive any outpatient mental health care during the first month," he wrote.

An observational study in the United Kingdom found that implementing a policy of following up with patients within seven days of discharge was associated with a "significant decrease in suicide during the three months after hospital discharge," Olfson wrote.

He suggested that to make meaningful progress in reducing the rate of suicide, "system-wide reforms in monitoring patients after hospital discharge will likely need to be complemented with traditional suicide-specific patient interventions." Among the traditional suicide-specific interventions are crisis-intervention lines, crisis-counseling services, and on-call mental health services.

Related literature shows that "time-limited interventions" including home visits, social support, and having care coordinators accompany recently discharged psychiatric patients to outpatient appointments "improves continuity of care and reduces the risk of early hospital readmission," Olfson told *Psychiatric News*.

"The new findings will hopefully build support among public and private payers for reimbursement of transitional care services during the high-risk period following psychiatric hospital discharge," he said. **PN**

"Suicide Rates After Discharge From Psychiatric Facilities: A Systematic Review and Meta-analysis," is posted at http://jamanetwork.com/journals/jamapsychiatry/fullarticle/2629522. The accompanying editorial, "Suicide Risk After Psychiatric Hospital Discharge," is posted at http://jamanetwork.com/journals/jamapsychiatry/fullarticle/2629518.

Genes

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increases synaptic connections and the function of those neurons in the PFC.

"Ketamine may cause a big boost in synaptic connections that may improve the response to cognitive-behavioral therapy," he said.

However, ketamine is also a drug of abuse and has serious side effects, so interest is switching to developing a ketamine-like drug that produces the same kind of rapid synaptic response but without unwanted side effects.

Duman would like to increase the number of his subjects to 110 and expand analysis to other parts of the PFC, the amygdala, and hippocampal subregions. One daunting factor that has already emerged is managing the vast quantity of information produced in these analyses, he said. More than 60 million pieces of data emerge from each sample, so bioinformatics is as important as biochemistry.

Williamson also noted the need to genotype larger populations of treated individuals to learn what genomes indicate which people respond best to which treatments over time. **PN**

FDA Database Supports Antidepressant Actions of Four Drugs

Patients taking ketamine were 67 percent less likely to report depression than those taking other pain medications, according to an analysis of the FDA Adverse Event Reporting System. **BY NICK ZAGORSKI**

Could an FDA database that compiles reports of negative side effects of approved medications point researchers to medications that could be used off-label to treat symptoms of depression? Researchers at the University of California, San Diego (UCSD), believe the answer may be yes, according to an article appearing May 3 in *Scientific Reports*.

"Although FAERS [the FDA Adverse Event Reporting System] was originally intended to track frequent adverse events, with sufficient ... data, it can also be used to track the beneficial outcomes indirectly through monitoring reductions of related complaint frequencies," wrote Ruben Abagyan, Ph.D., a professor in UCSD's Skaggs School of Pharmacy and Pharmaceutical Sciences, and colleagues. The team reported that data contained in this tracking system provided additional evidence of the antidepressant effects of the anesthetic ketamine.

While several trials have demonstrated the acute efficacy of ketamine in treating treatment-resistant depression, bipolar depression, and more, most of these trials have had a low number of participants. For a larger sample of patients, Abagyan's team scoured over 8 million patient reports entered in FAERS between 2004 and 2016 and identified 41,337 patients taking ketamine (either alone or in combination with other agents) for pain and 238,516 patients taking other combinations of medications for pain.

They found that the incidence of reported depression was about 67 percent less among the ketamine group compared with people taking other pain relievers. Pain reports were also significantly lower in patients taking ketamine.

"This study extends small-scale clinical evidence that ketamine can be used to alleviate depression and provides needed solid statistical support for wider clinical applications," Abagyan said in a press release.

Ketamine was not the only drug to show some antidepressant action in the FAERS analysis; people getting facial Botox injections, the non-steroidal anti-inflammatory agent (NSAID) diclofenac, and minocycline also had reduced depression symptoms. Botox's effects may be tied to the fact that facial nerves are connected to brain regions regulating mood and emotion. Diclofenac and minocycline, meanwhile, both display anti-inflammatory properties, and research suggests that inflammation contributes to depression.

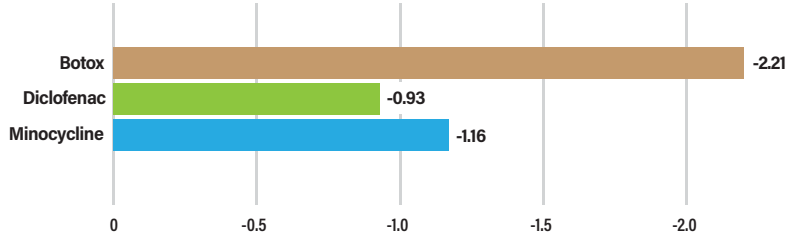
To determine whether the potential antidepressant effects of NSAIDs were influencing the differences between patients taking ketamine and other pain medications, Abagyan and his team reanalyzed the groups, excluding people in either group who took NSAIDs. Patients taking ketamine reported depression 64 percent less often than those on other pain relievers.

"This study outlines a methodology for discovering off-label pharmacology of existing approved drugs. This method can be applied to other indications and may reveal new important uses of already approved drugs, providing reliable justification for new indications without large investments in additional clinical trials," Abagyan and colleagues concluded in their report.

The Skaggs School of Pharmacy and Pharmaceutical Sciences funded this research. **PN**

Potential Antidepressants Uncovered in FDA Database

Analysis of side-effect reports from the FDA Adverse Event Reporting System found protective effects of Botox, diclofenac, and minocycline against depressed mood. Numbers reflect the negative log odds ratio, with more negative value representing greater protective effect.



Source: Isaac Cohen, et al., *Scientific Reports*, May 3, 2017

"Population Scale Data Reveals the Antidepressant Effects of Ketamine and Other Therapeutics Approved for Non-Psychiatric Indications" is posted at https://www.nature.com/articles/s41598-017-01590-x.

JOURNAL DIGEST

BY NICK ZAGORSKI

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Pupil Dilation May Help Determine Depression Risk

Pupil dilation in response to emotional stimuli may help identify individuals who are at greatest risk for depression following a natural disaster, according to a report in *Clinical Psychological Science*.

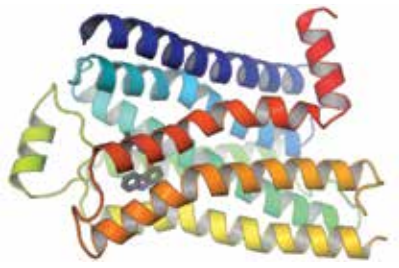
"After major stressful events like natural disasters, research suggests only about 20 to 25 percent will go on to develop a depressive disorder," said lead study author Mary Woody, a Ph.D. student at Binghamton University in New York, in a press release. These findings suggest "that pupil dilation could be used to identify those who are at greatest risk for depression."

Woody and her colleagues at Binghamton University evaluated 51 women who were living in Binghamton in 2011, when catastrophic floods swept through the region. As part of a separate study, these women had their pupillary responses to emotional images assessed prior to the floods.

The researchers found that decreased pupil dilation to emotional expressions predicted a significant increase in depressive symptoms following the flood, but only in women who experienced higher levels of flood-related stress.

Some previous research has found that pupillometry can predict who responds best to psychotherapies such as cognitive-behavioral therapy. The current study builds on that research and suggests that pupillometry could identify good candidates for psychotherapy in the immediate aftermath of a natural disaster.

Woody M, Burkhouse K, Siegle G, et al. Pupillary Response to Emotional Stimuli as a Risk Factor for Depressive Symptoms Following a Natural Disaster: The 2011 Binghamton Flood. *Clin Psych Sci*. May 23, 2017. [Epub ahead of print] http://journals.sagepub.com/doi/full/10.1177/2167702617699932



Opabinia regalis

Researchers Discover Potential Pathway Toward Sustained Pain Relief

G-protein coupled receptors (GPCRs) are known to regulate pain transmission, but most GPCR-targeted painkillers have failed in clinical studies. A study published in *Science Translational Medicine* has demonstrated that one GPCR known as neurokinin 1 receptor (NK1R) can migrate inside the cell in response to pain—and out of reach of most traditional analgesics.

Using rodent models, researchers from Monash University in Australia and colleagues observed that when stimulated by pain, NK1R moved from the surface of nerve cells to intracellular compartments known as endosomes. When the researchers used chemical and genetic techniques to block the ability of NK1R to internalize, they found that the animals showed less pain sensation in their paws after injections of capsaicin.

The researchers then joined an NK1R inhibitor (spantide I) with a cholesterol-like molecule, thus allowing the drug to directly pass through the fatty cell membrane and into the cells. This method provided sustained pain relief that lasted several times longer than spantide I without this conjugate.

"Our study suggests that therapeutic targeting of endosomal GPCRs is a paradigm of drug delivery that offers more effective and selective treatment for pathophysiological conditions,

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including chronic pain," the investigators concluded.

Jensen D, Lieu T, Halls M, et al. Neurokinin 1 Receptor Signaling in Endosomes Mediates Sustained Nociception and Is a Viable Therapeutic Target for Prolonged Pain Relief. *Sci Transl Med*. May 31, 2017; 9(392): eaal3447. http://stm.sciencemag.org/content/9/392/eaal3447.short

iStock/Obencem

Biomarker for Alzheimer's May Be Modifiable by Stress Reduction

The repressor element 1-silencing transcription (REST) factor—a protein that regulates stress responses in the brain—may be a viable blood-based biomarker of Alzheimer's disease (AD), reports a study appearing in *Translational Psychiatry* by researchers at University College London.

Previous studies suggest that reduced levels of REST in the brain are associated with increased cognitive impairment, but it was unknown if REST measured in plasma would differ between people with AD, mild cognitive impairment (MCI), and healthy controls.

When the researchers compared plasma REST levels in people with stable MCI, people with worsening MCI, Alzheimer's patients, and healthy controls, they found that plasma REST levels declined with increasing severity of impairment.

Next, the investigators explored whether interventions that target stress might lead to changes in REST levels. The researchers measured REST in 81 older adults with symptoms of depression or anxiety but not dementia before and after the adults participated in a mindfulness-based stress reduction program or health-education program as a control.

Mindfulness-based training was associated with an increase in REST levels compared with the control intervention, and increased REST was associated with a reduction in depression and anxiety symptoms.

"These findings presented here are of great significance for the diagnosis and clinical management of AD, as determining REST in blood provides a prognostic marker that can help stratify patients for inclusion in trials, identify those at high risk of 'stress-induced' cognitive decline, and determine the efficacy of therapeutic interventions," the study authors wrote. "Importantly, we demonstrated that REST levels can be modulated through a relatively brief behavioral stress-reduction intervention and that changes in REST are associated with clinical improvements."

Ashton N, Hye A, Leckey C et al. Plasma REST: A Novel Candidate Biomarker of Alzheimer's Disease Is Modified by Psychological Intervention in an At-Risk Population. *Transl Psychiatry*. June 6, 2017; 7(6): e1148.

iStock/CTRPhotos

Risk Factors Identified For Autism-Related Hospitalization

Researchers at Brown University have identified five factors that may increase the risk of psychiatric hospitalization in children and adolescents with autism spectrum disorder (ASD).

Notably, only two of the five risk factors identified in the study were related to ASD symptomology: lower adaptive functioning and higher severity of social-affective ASD symptomology. The other three risk factors related to psychiatric hospitalization were the presence of sleep problems, the presence of a mood disorder, and living with a single caregiver. Of these, the presence of a mood disorder was the strongest risk by far, with roughly a seven-fold increased risk of hospitalization.

The analysis came from two large datasets of ASD patients. The Autism Inpatient Collection (AIC), which incorporates data from six children's psychiatric hospitals specializing in developmental disorders, and the Rhode Island Consortium for Autism Research and Treatment (RI-CART), which includes ASD patients and families from the general community.

By comparing 218 patients between the ages of 4 and 20 from AIC with 255 age- and gender-matched RI-CART youth who were not hospitalized, the researchers were able to identify traits that were independently associated with hospitalization risk.

"[T]he present findings reveal indicators that may be useful for identifying children and adolescents at greater risk of psychiatric hospitalization as well as offer potential targets for individual and family intervention aimed at reducing the likelihood of requiring acute psychiatric services," the authors noted.

The analysis was published in *Journal of Autism and Developmental Disorders*.

Righi G, Benevides J, Mazefsky C, et al. Predictors of Inpatient Psychiatric Hospitalization for Children and Adolescents With Autism Spectrum Disorder. *J Autism Dev Disord*. May 23, 2017. [Epub ahead of print] https://link.springer.com/article/10.1007%2Fs10803-017-3154-9

iStock/Peopleimages

CBT Found to Have Long-Term Benefits for Body Dysmorphic Disorder

Cognitive-behavioral therapy (CBT) has been shown to be effective at treating adolescent body dysmorphic disorder (BDD) in the short term, but few studies have examined long-term effects of this intervention.

A follow-up study of adolescents with BDD who received CBT now provides evidence that improvements can last for up to 12 months. The study, led by researchers at Kings College London, was published in *Behavior Therapy*.

As part of the original study, 26 adolescents aged 12 to 18 received 14 sessions of CBT for BDD over a four-month period. Two months after the last CBT session, the researchers assessed BDD symptoms, as measured by the Yale-Brown Obsessive-Compulsive Scale Modified for BDD, as well as other outcomes including depression, disease insight, and quality of life. They found that BDD symptom scores dropped by around 11.5 points, and several secondary measures also improved.

Study participants were evaluated for an additional 10 months, during which they received three CBT booster sessions.

During the follow-up period, the researchers found that the adolescents maintained their BDD symptom improvements and that the number of participants who could be classified as responders (>30 percent reduction in symptom scores) increased from 35 percent to 50 percent. Secondary outcomes remained stable as well.

Despite these improvements, the authors noted that by 12-month follow-up, only about half of the sample could be classified as "treatment responders." Additionally, two participants attempted suicide during the follow-up period, and five sought consultations for cosmetic procedures.

"Our findings suggest that a significant proportion of adolescents who receive CBT for BDD continue to experience clinically significant symptoms in the longer term and remain vulnerable to a range of potential risks and negative outcomes. ... For this reason, we recommend long-term monitoring of these patients." **PN**

Krebs G, de la Cruz L, Monzani B, et al. Long-Term Outcomes of Cognitive-Behavioral Therapy for Adolescent Body Dysmorphic Disorder. *Behav Ther*. July 2017; 48(4): 462-473. http://www.sciencedirect.com/science/article/pii/S0005789417300023

Fresh Talk

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about contract negotiations and salary expectations. Members are also able to compare how their jobs are structured with others' and get ideas about ways to run their own clinics and practices.

Finally, one of the more intangible but extremely valuable benefits of the group is having so many members who can identify with each other, whether it is dealing with a patient suicide or difficult patient interactions or spending hours on the phone on prior authorizations. It can be tremendously helpful and supportive to not feel alone when we are going through our day-to-day struggles as psychiatrists.

Q: How would you like to see the group develop in the future?

A: One thing I would like to see is the formal organization of the group in which we come together and start advocating on issues important to us, such as fair reimbursement for mental health care, health insurance reform, and simplification of the board recertification process. Members have also requested CME to be available through the group, which is currently cost-prohibitive, but this would be a wonderful way to formalize the education that members receive from the group.

Q: Do you have any advice for colleagues who are thinking about ways to incorporate social media into psychiatric practice/outreach?

A: Just do it—reach out to colleagues! I have made a number of colleagues/friends over the past two years through the groups, both locally and otherwise, and have met some fantastic people in person at conferences and events as a result of networking through the groups. I have also had the opportunity to collaborate on various academic endeavors and am working on several projects that were initiated through these groups.

I would also encourage colleagues to take advantage of the various social media educational forums. Some members of the groups read the daily posts but tend to refrain from participating in the discussions. While it may seem intimidating or daunting to engage in the vast world of the Internet—and certainly some precautions should always be taken when online—these forums offer privacy and a range of personal and professional benefits. **PN**