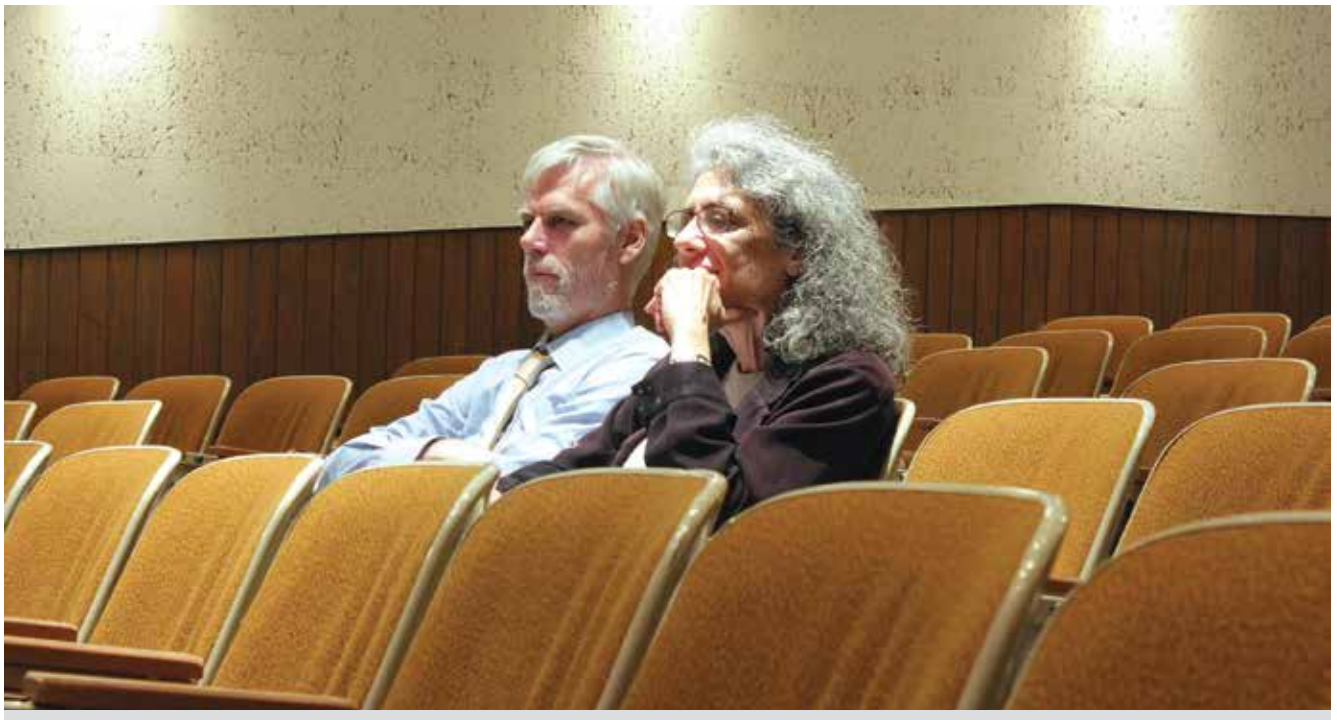
WWW.PSYCHNEWS.ORG | THE FIRST AND LAST WORD IN PSYCHIATRY | VOLUME 52, NUMBER 8, APRIL 21, 2017

PSYCHIATRIC NEWS

AMERICAN PSYCHIATRIC ASSOCIATION

ISSN 0033-2704



Joseph Mango

Psychiatrist Kenneth Wells, M.D., and Elyn Saks, J.D., Ph.D., watch rehearsals of "The Center Cannot Hold," an opera on which they collaborated about Saks' hospitalization for schizophrenia and her later recovery. Wells wrote the music and the original draft of the libretto, with input and advice from Saks. "The Center Cannot Hold" was first performed last summer at UCLA. See story on page 8.

No. of Seniors Matching Into Psychiatry Takes Large Leap

The trend toward integrated care and recent advances in neuroscience have raised the profile of psychiatry as the profession that treats the "whole person," APA leaders say.

BY MARK MORAN

A total of 923 U.S. senior medical school students matched with a psychiatry residency in this year's National Resident Matching Program (NRMP), up from 850 in 2016.

This year's figure continues a steady increase in the number of seniors entering psychiatry in recent history. The number of medical school seniors choosing psychiatry grew from 483 in 2000 to 640 in 2010.

The match, in which the choices of graduating medical students are "matched" with those of residency programs, is typically watched as an indicator of workforce size and makeup in the various medical specialties for the coming year.

"This year's match is good news for our profession and for our patients," said APA President Maria A. Oquendo, M.D., Ph.D. "There is a shortage of psychiatrists—a drastic shortage in some areas—so of course it is good to see our numbers increasing. Our profession is becoming increasingly attractive to young physicians, promising exciting advances in brain science along with our traditional focus on the person behind the disease."

APA CEO and Medical Director Saul Levin, M.D., M.P.A., said he believes

see **Match** on page 20

Collaborative Care Leaders Seek To Bring Model to Residency Training

While many residency programs offer electives in integrated care, only a few have rotations in which trainees work in consultation to primary care as a regular part of their training.

BY MARK MORAN

The Collaborative Care Model (CoCM) may be an opportunity for psychiatry training programs to leverage stressed manpower resources to support primary care clinics served by the department, while teaching young psychiatrists the skills necessary for the health system of the future.

At last month's meeting of the American Association of Directors of Psychiatric Residency Training (AADPRT) in San Francisco, Anna Ratzliff, M.D., director of the University of Washington Integrated Care Training Program, and Hsiang Huang, M.D., M.P.H, program director of the Psychosomatic Medicine Fellowship at Cambridge Health Alliance, introduced residency directors to the tools necessary for training young psychiatrists in the CoCM.

Tristan Gorrindo, M.D., director of APA's Division of Education, also spoke at the workshop. "While we have over a decade of evidence testifying to the efficacy of the collaborative care model, most psychiatrists, including training directors, are just learning the nuts and bolts of the model," Gorrindo told *Psychiatric News*. "We used this workshop as an opportunity to empower training directors with knowledge they could then use to fold into their training programs and support residents who are looking to work in this model after graduation."

In an interview with *Psychiatric News*, Ratzliff said the model can be a way for psychiatry departments to begin to fundamentally rethink how they use stressed resources to meet the demand for patient care.

"There is an opportunity for psychiatric academic programs to be on the leading edge in developing collaborative care rotations to help their departments leverage available psychiatric resources

see **Training** on page 20

PERIODICALS: TIME SENSITIVE MATERIALS

INSIDE

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

SUBSCRIPTIONS
U.S.: individual, $139. International: APA member, $189; nonmember, $209. Single issues: U.S., $24; international, $41. Institutional subscriptions are tier priced. For site licensing and pricing information, call (800) 368-5777 or email institutions@psych.org.

EDITORIAL OFFICES
Telephone: (703) 907-7860
Email: cbrown@psych.org
Web site: psychnews.org

ADVERTISING SALES
Frank Cox, Kathleen Harrison, Tim Wolfinger, Eamon Wood, Pharmaceutical Media Inc., 30 East 33rd Street, New York, N.Y. 10016; (212) 904-0379; fax: (212) 685-6126; twolfinger@pminy.com. Nonpharmaceutical and Classified advertising: ewood@pminy.com; (212) 904-0363.

CHANGES OF ADDRESS
Call the APA Answer Center at (888) 35-PSYCH in the U.S. and Canada; in other countries, call (703) 907-7300.

AMERICAN PSYCHIATRIC ASSOCIATION

FROM THE PRESIDENT

APA Reaches Out to Capitol Hill on Opioid Epidemic

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

The day was dreary enough. As if thunderstorm warnings were not enough, there were tornado threats in Washington, D.C. APA was scheduled to host a congressional hearing on an equally dreary, if important topic: the opioid epidemic. We rushed from APA headquarters to the Cannon House Office Building, tumbling out of the taxi, umbrellas helplessly flapping in the wind. We passed through security, the metal detectors quiet as we made our way in. The white marble halls were full of people bustling around. The House had just finished its morning session minutes before we arrived.

We entered our assigned room, and it was packed. There, we would meet with House staffers and members of the public to give them information about the epidemic and persuade them to stay focused on this deadly problem.

The speakers in the line-up were simply spectacular. Dr. Nora Volkow, director of the National Institute on Drug Abuse, talked about the biological basis of addiction and what was needed to stem the increasing toll of prescription opioid misuse. In her inimitable, compelling style and completely off the top of her head, she described the challenges of treating pain and the limitations of our toolbox to appropriately address it without exposing patients to the risk of addiction. She spoke passionately about the importance of research to find new methods for identifying vulnerable individuals and to delineate the neurobiological changes that lead to the inexorable addiction that haunts some of those exposed to prescription opioids.

Dr. Kyle Kampman discussed the medication treatments currently available for opioid addiction. He detailed, in an accessible way, the pharmacology of the various medications that can avert withdrawal, craving, and the experience of euphoria to varying degrees. His description of why medications with a short half-life have limited utility was vividly persuasive. As well, he underscored the importance of psychotherapeutic interventions, so critical to a holistic approach to psychiatric conditions.

Dr. Nasir Naqvi presented a case that poignantly illustrated the challenges of health insurance denials for those with opioid dependence. He explained how stigma is codified in the way that some insurance companies go about approving detox or inpatient treatment, increasing the risk of relapse and even death. A key aspect of the case he presented was that it challenged many preconceptions about opioid addiction. He exposed how this is not an illness of the disenfranchised or marginalized; it touches every corner of our society, regardless of income or education.

Early in the session, we were delighted to have Rep. Paul Tonko from New York tell the audience about his inspired work to quell this national disaster. He urged those present to stay in the fight and keep this issue front and center. His speech was nothing short of rousing.

People directly impacted by this hideous epidemic gave presentations that moved the discussion from scientific facts to real life. Ginny Atwood Lovitt is the executive director of the Chris Atwood Foundation, which was started in memory of her little brother who died from a heroin overdose at age 21. She eloquently described her brother's opioid addiction, which ultimately caused the spiral that led to his death. Galvanized by this tragedy, she described how she became a state-certified master opioid overdose reversal trainer and led a successful effort to pass a Virginia law to allow instructors like herself to dispense naloxone.

Joseph Zabel, president of Great Falls Pools in Great Falls, Va., described his trajectory in recovering from substance use disorder. Poised and thoughtful, Joseph explained how his work with

see ***From the President*** *on page 12*


13


14


16

IN THIS ISSUE

Register Now for San Diego!

APA's 2017 Annual Meeting is just weeks away, but it's not late too register. Learn the latest about the meeting's special sessions and events and register today at www.psychiatry.org/annualmeeting. For more information on the meeting, see page 11.

Departments

LEGAL NEWS

Intellectual Disability Still a Bar To Death Penalty, Says Court

The Supreme Court rejects state death-penalty standards that are unsupported by the latest "medical or judicial authority."

BY AARON LEVIN

iStock/lillisphotography

The U.S. Supreme Court on March 28 reaffirmed that intellectual disability was a constitutional barrier to the death penalty.

The ruling in the case of *Moore vs. Texas* upheld two previous decisions (*Psychiatric News,* June 20, 2014) and said that current mental health standards had to be applied in such cases.

"The Court, consistent with APA's position, sent the case of Bobby Moore back to a lower court after finding that Texas failed to apply contemporary medical standards for making the diagnosis of intellectual disability," Marvin Swartz, M.D., told *Psychiatric News.* Swartz is chair of APA's Committee on Judicial Action and a professor of psychiatry and behavioral sciences at Duke University School of Medicine.

APA signed onto an amicus brief last year in support of Moore together with the American Academy of Psychiatry and the Law, American Psychological Association, National Association of Social Workers, and National Association of Social Workers Texas Chapter.

Moore killed a store clerk in Houston during a robbery in 1980 and was convicted and sentenced to death. He later challenged the sentence on grounds of intellectual disability. A lower court agreed, based on Supreme Court decisions in the *Atkins v. Virginia* (2002) and *Hall v. Florida* (2014) cases.

In *Atkins*, the court said that the Eighth Amendment "restrict[s] … the State's power to take the life of any intellectually disabled individual." In *Hall,* it held that a state "cannot refuse to entertain other evidence of intellectual disability when a defendant has an IQ score above 70."

Moore scored an average of 70.66 on six IQ tests, marginally above a cutoff of 70, which is adjusted by a five-point standard error of measurement. He also had adaptive deficits in conceptual, social, and practical skillsets, any one of which would have confirmed intellectual disability, said the opinion.

"In [*Hall*], the Court clarified that the definition should comport with contemporary medical standards, avoid a rigid IQ cutoff score, and take into account the overall functioning of the individual," said Swartz.

However, the Texas Court of Criminal Appeals (CCA) rejected those precedents and said that the death sentence should be carried out, based on guidelines it had adopted in another case. That case, known as *Ex parte Briseno,* used standards based on the ninth edition (1992) of a manual by the American Association on Mental Retardation, not more recent revisions.

The current legal benchmarks for determining intellectual disability are the 11th edition of the American Association on Intellectual and Developmental Disabilities' clinical manual (AAIDD–11) and the fifth edition of APA's *Diagnostic and Statistical Manual of Mental Disorders,* said Justice Ruth Bader Ginsburg, writing for the 5-3 majority.

The present definition of disability includes "intellectual-functioning deficits, adaptive deficits, and the onset of these deficits while still a minor," she noted, but the Texas CCA relied, "without citation to any medical or judicial authority," on seven factors it claimed applied to determination of intellectual disability.

The Court pointed to a certain arbitrariness in the Texas CCA's use of the *Briseno* standard. The state applies it only in death penalty cases, not in evaluating students, and it uses the "latest edition of the *DSM*" to assess juveniles in the criminal justice system.

The Court's conservative wing disagreed with the majority.

"The Court … crafts a constitutional holding based solely on what it deems to be medical consensus about intellectual disability," wrote Chief Justice John Roberts in his dissent, backed by Justices Clarence Thomas and Samuel Alito. "But clinicians, not judges, should determine clinical standards; and judges, not clinicians, should determine the content of the Eighth Amendment. Today's opinion confuses those roles, and I respectfully dissent."

The majority did not see that bright line between the two professions. *Hall* permitted some leeway in interpretation but only so much, said Ginsburg.

"*Hall* indicated that being informed by the medical community does not demand adherence to everything stated in the latest medical guide," she said. "But neither does precedent license disregard of current medical standards." PN

The U.S. Supreme Court's opinion in the case *Moore vs. Texas* is posted at https://www.supremecourt.gov/opinions/16pdf/15-797_n7io.pdf.

ETHICS CORNER

Teach, Advocate, and Return Phone Calls: A Path to Personal Development

BY CLAIRE ZILBER, M.D.

Do you consider professional ethics as nothing but a set of rules involving our conduct with patients? Follow the rules and you'll stay out of trouble? In truth, the philosophers who evolved concepts of personal and professional ethics were less concerned with rules than they were with social justice, personal well-being, and refining the life of the mind. If we contemplate what it means to be ethical psychiatrists, we may consider not only our behavior with patients and colleagues, but also our demeanor in all aspects of our lives. We may advance our experience of professional ethics in myriad ways, including teaching, affecting public policy, or even extending polite courtesy to strangers.

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

In the fourth century BCE, Hippocrates instructed physicians to practice professional ethics and gave this reason: "To preserve the purity of my life and my art." In addition to prescribing regimens "for the good of my patients according to my ability and my judgment," he also vowed to teach students the art of medicine "without fee or written promise."

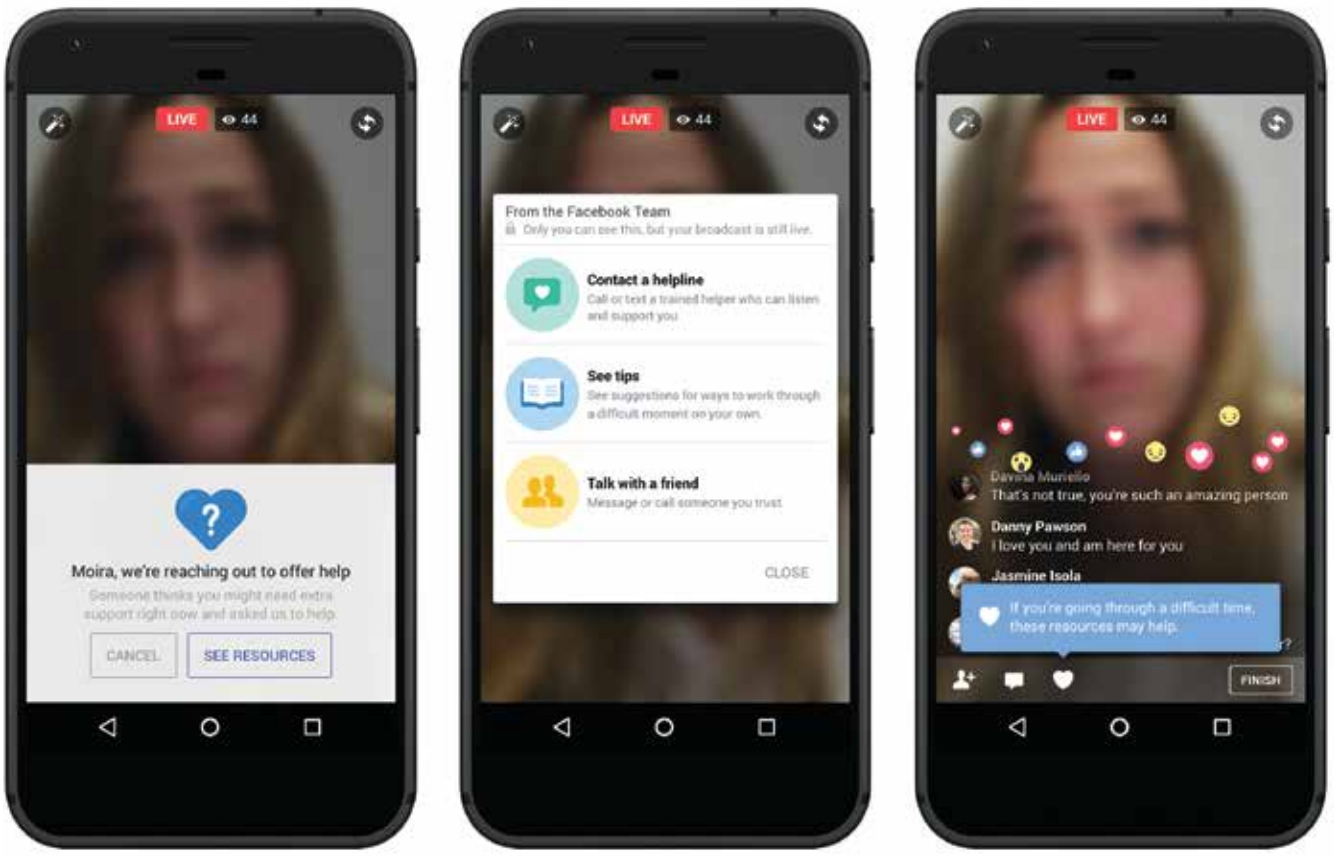
In Hippocrates' time, physicians taught only the sons of physicians for free. In contemporary society, there are many more ways to discharge our duty to educate. Teaching medical students, residents, fellows, colleagues, and health care providers from other disciplines through lectures or supervision remains a valuable and honorable activity. Educating our patients, their families, and the public is a newer way to pass on the gift of medical knowledge.

Freely transmitting our knowledge is not the only avenue to enhance our experience as ethical individuals. The 17th-century German philosopher Gottfried Liebniz envisioned a "society united to serve goals of justice and charity that transcend self-interest." He would have approved of California's Proposition 63, which in 2004 established a 1 percent tax on all personal incomes over $1 million to fund new mental health programs. Unfortunately, although this program has generated millions of dollars and funded an array of prevention programs, it has not necessarily benefitted those with chronic mental illness. While the program achieves the goal of charity, it may be falling short of justice by allocating resources to the worried well rather than the seriously ill. This failure should not cause us to give up, but should inspire mental health activists and advocates to further efforts to affect public policy toward a more effective mental health care system.

A Dutch contemporary of Liebniz, Baruch de Spinoza, established three

see ***Ethics Corner*** *on page 12*

PROFESSIONAL NEWS



Facebook

Experts React to Facebook's Updated Suicide Prevention Tools

Psychiatrists spoke favorably about Facebook's latest efforts to educate users about resources and build communities of support around people who may be at risk of suicide, but also cautioned that much remains unknown about how safe and effective such technology might be.

TECH TIME

BY JENNIFER CARR

Facebook made headlines last month after the company announced it was updating tools to make it easier for users to connect friends they suspect may be experiencing thoughts of suicide with resources in real time.

For years, the social media giant has encouraged users to report suicidal content to the company's Help Center and offered tips on how to offer support to a friend in need. The tools unveiled in March expand upon this effort by creating a mechanism for the social networking site's more than 1.8 billion users to flag concerning videos as they are broadcast over Facebook Live and live chat with professionals at crisis centers such as the National Suicide Prevention Line through Facebook Messenger.

"When someone is thinking of suicide or hurting themselves, we've built infrastructure to give their friends and community tools that could save their life," Facebook co-founder and CEO Mark Zuckerberg wrote in a post to the Facebook community in February.

Still, he acknowledged, there is room for improvement. "There are billions of posts, comments, and messages across our services each day, and since it's impossible to review all of them, we review content once it is reported to us. There have been terribly tragic events—like suicides, some live streamed—that perhaps could have been prevented if someone had realized what was happening and reported them sooner." He added, "Artificial intelligence can help provide a better approach."

> "[W]e still do not have data about how reliable or valid these technology-based suicide assessments really are for social media, as actual research has been limited."—John Torous, M.D.

John Torous, M.D., chair of APA's Smartphone App Evaluation Work Group, applauded Facebook's efforts. "Any time you are able to identify and connect a person experiencing mental health issues with resources and help is definitely a good thing," he told *Psychiatric News*. "But we still do not have data about how reliable or valid these technology-based suicide assessments really are for social media, as actual research has been limited."

Torous is the co-director of the digital psychiatry program at Beth Israel Deaconess Medical Center.

Facebook Looking Ahead to AI

In the announcement outlining the updates to the Facebook's suicide prevention tools, the company said it is testing pattern recognition to identify and streamline the reporting of suicidal posts. Currently, users must see a post by a friend suggesting thoughts of suicide or self-injury and report the content to Facebook. Artificial intelligence (AI) and pattern recognition based on posts previously reported for suicide could one day make the option to report a post about "suicide or self-injury" more prominent on concerning posts or even flag such posts to automatically be called to the attention of Facebook representatives.

"We are starting this limited test in the United States and will continue working closely with suicide prevention experts to understand other ways we can use technology to help provide support," the announcement stated.

Psychiatric News made multiple attempts to reach Facebook for more information on how tests of AI are being introduced on the site and how psychiatrists might obtain more information about the effort. At press time, the company had not responded.

Service Raises Privacy Issue

"It's great to hear Facebook is doing something, … but we need to tread carefully," John Luo, M.D., health science clinical professor in psychiatry and director of the psychiatry residency program at the UC Riverside School of Medicine, told *Psychiatric News*.

"As a clinician, I know that predicting a patient who is suicidal is murky enough. … No matter how good [Facebook's] algorithm is, there will be false positives," he continued. "There is also the challenge of balancing privacy versus safety."

Torous agreed, pointing to the public outcry in 2014 over Samaritans Radar, an app that tracked words and key phrases on Twitter and alerted users when someone they followed was using language suggesting distress. Within days of the app's launch, people took to social media to voice concerns that the information could be used to target vulnerable people on Twitter. In less than two weeks, the app was suspended. This episode illustrated the challenges that experts face as they try to develop online tools that offer appropriate support to people with mental health problems without compromising the user's safety and privacy.

"Psychiatrists should certainly be excited by efforts to use technology to support people with mental illness," Torous said. "But, as a field, we have high standards and expect a certain level of evidence. We expect to know how things work. We only know of the Samaritan app issues because it gained public attention."

The mental health community could benefit greatly from knowing more about Facebook's latest efforts, he added.

Social Media Could Fill a Gap

Previous studies suggest that some people disclose more personal information on a computer than to a person,

see ***Facebook*** *on page 12*

PROFESSIONAL NEWS

Report Details National Shortage Of Psychiatrists and Possible Solutions

APA joins medical directors in looking at causes of and remedies for the shortage of psychiatrists in the United States.

BY AARON LEVIN

An increasing shortage of psychiatrists, especially those working in public sector and Medicaid-funded programs, is occurring even as demand for services increases, according to a report from the National Council for Behavioral Health.

The report cited a study commissioned by the U.S. Department of Health and Human Services indicating that the current workforce of approximately 45,580 psychiatrists would need to increase by 2,800 to meet current demands for psychiatric care. In other words, there is currently a 6.4 percent shortage in the psychiatry workforce. Based on estimates of retirement and new entries into the workforce, the projected unmet need in 2025 will be 6,090 psychiatrists, or a deficit of 12 percent of the workforce.

Psychiatrists are essential to the larger mental health care system because of their medical training and their ability to prescribe and manage medications for patients, but they face a number of constraints.

"Aging of the current workforce, low rates of reimbursement, burnout, burdensome documentation requirements, and restrictive regulations around sharing clinical information necessary to coordinate care are some of the reasons for the shrinkage," said the report, which was produced by representatives from professional societies (including APA), insurers, patient groups, government agencies, and service providers.

Like other medical professionals, psychiatrists are concentrated in metropolitan areas, leaving 77 percent of U.S. counties ranked as "underserved."

In addition, psychiatry largely uses an "old-fashioned" delivery system, said Joseph Parks, M.D., chair of the National Council for Behavioral Health, whose National Council Medical Director Institute issued the report.

"We need to make greater use of data analytics, work more in teams with other providers like psychiatric nurses and physician assistants, and expand systems to pay for telepsychiatry and collaborative care," said Parks in a teleconference at the report's release.

Telepsychiatry is helpful not only for patients in remote locations but also for those who have trouble getting to a clinic because of physical disabilities. Patients have largely accepted the modality, and electronic communications systems have become standard elements in the lives of younger people.

National politics could play a role, as well. About 50 percent of new psychiatry trainees are international medical graduates, and possible changes in the H1B visa program could interfere with that flow, said Parks, who is also director of the Missouri Department of Mental Health.

*see **Shortage** on page 13*

Recommendations to Increase Access to Psychiatric Care

The National Council for Behavioral Health's report recommends that APA and the council work together with their members to increase the engagement of psychiatrists with outpatient and inpatient programs that accept commercial, Medicare, and Medicaid coverage. Here are some steps that can be taken to accomplish that goal:

- Expand opportunities for psychiatric providers to practice in alternative clinical settings, such as peer-run services and family support services.
- Negotiate with payers to establish models of reimbursement that recognize the true cost of psychiatric providers.
- Provide more support in clinical settings that allow providers to work up to their level of licensure.
- Build competence in the workforce to address the impact of psychiatric providers on reducing the total cost of care for high-need, high-risk, high-cost populations that have mental health and substance user disorders co-occurring with chronic medical conditions.
- Address billing and reimbursement inequities and limits to help to level the playing field as innovative models of care become established.
- Establish payment rate and methodology parity with medical-surgical reimbursement in Federally Qualified Health Centers and other primary care settings that will provide incentives for psychiatric providers to participate in these programs and remove the business incentive to minimize psychiatric services in order to avoid financial losses.

Moreover, steps can be taken to improve efficiency of the delivery of psychiatric services. Among them:

- Reduce no-shows in outpatient psychiatric programs by setting up open-access models of scheduling.
- Expand telepsychiatry by reducing regulatory barriers and reimbursing adequately.
- Add adequate support for prescribers.
- Reduce the administrative burdens around information sharing and documentation requirements.

RESIDENTS' FORUM

Let's Talk About Tobacco Use

BY CORNEL N. STANCIU, M.D., AND SAMANTHA A. GNANASEGARAM, M.D.

Throughout residency we are trained to manage patients with unipolar depression on antidepressants, titrate mood stabilizers for those with bipolar disorders, and choose the right antipsychotic for schizophrenia-spectrum conditions. We refer patients with opioid or alcohol use to substance use treatment and prescribe sleeping aids to manage insomnia. What about patients with nicotine use disorder? As residents, we learn to engage patients in a motivational discussion about weighing harms and benefits of smoking; however, when it comes to offering FDA-approved pharmaceuticals to aid in their quit attempts, we sometimes fall short.

Almost half of our patients with mental illness smoke. According to the Centers for Disease Control and Prevention, these patients die five years sooner from heart and lung diseases and cancers related to smoking. Unfortunately, without adequate treatment, patients who smoke cigarettes have difficulty quitting and often turn to alternatives such as electronic cigarettes and vaping devices despite a paucity of evidence regarding their long-term consequences and efficacy for smoking cessation. It is well established that despite similar motivation, patients with mental illness are less likely to quit and more likely to relapse compared with the general population. It is apparent that these individuals warrant more than just counseling.

Having a passion to study addictive disorders, we asked our clinic patients about their tobacco use and how their tobacco use impacts their lives. We also saw how patients' psychiatric conditions are impacted by their tobacco use. Nicotine use can worsen psychiatric conditions such as anxiety and insomnia, and for those who stopped using other substances, it can contribute to relapse.

During our residency, we have observed that medications for smoking cessation are underprescribed. At the beginning of residency, we learned about the black-box label for neuropsychiatric side effects (such as increased aggression and suicidality) associated with varenicline and bupropion. We would also hear about how, in clinical practice, some experienced senior physicians have seen individuals whose depression, irritability, or aggression has worsened upon having been placed on these medications by their primary care physician. All this translated into hesitancy in even considering discussing such medication options with patients.

In light of recent trials that resulted in the FDA removal of the black-box label, over the past year we started several of our stable psychiatric patients on varenicline or bupropion along with

*see **Residents' Forum** on page 18*

Cornel N. Stanciu, M.D., and Samantha A. Gnanasegaram, M.D., are PGY-4 residents in the Department of Psychiatry and Behavioral Medicine at East Carolina University. In July, Stanciu will be entering an addiction psychiatry fellowship at Dartmouth-Hitchcock Medical Center.

COMMUNITY NEWS

Joseph Mango

Elyn Saks, J.D., Ph.D. (seated with composer Kenneth Wells, M.D.), says that "The Center Cannot Hold" accurately and vividly captures the trauma of involuntary hospitalization and the use of restraints. "Ken did a remarkable job. The opera accurately portrays the experience of having an acute psychosis and being treated in an involuntary setting."

Psychiatrist Teams With Elyn Saks On Opera Depicting Psychosis

Wells was concerned to show the anguish of clinicians confronted with psychosis, the dilemma of keeping patients safe, and the limitations of treatment.

BY MARK MORAN

"...Lost in a sea of madness! Lost in madness!
Elyn Saks, Yale law student, 27. Mad as a hatter! Why?
...How many times must I see it? See all the lives that are ruined?
...I had a dream long ago to cure schizophrenia! To save the lives that it ruined!
There's nothing I can do. There is no cure.
...When control is lost, she needs restraints!
It seems barbaric. She won't accept it. Yet it's her only hope!
I must keep her safe! Safe from herself! Safe from madness!"

—Aria sung by "Dr. Kerrigan" in "The Center Cannot Hold"
by Kenneth Wells, M.D., and Elyn Saks, J.D., Ph.D.

If opera is a musical form that condenses a narrative into intensely emotional turning points, then the story of a brilliant and creative woman with psychosis—one who once shouted Beethoven's Fifth Symphony all night long to ward off hallucinations while she was in restraints—might seem a natural for operatic dramatization.

So, when Elyn Saks, J.D., Ph.D., lawyer, human rights activist, and recovering schizophrenia patient got together with psychiatrist Kenneth Wells, M.D.—an opera librettist and composer by avocation—a creative joint venture was born. Saks had served as a guest speaker for a performance of Wells's first opera about Eleanor Roosevelt, "The First Lady," in winter 2010. Afterward she said, "Let's collaborate!"

Wells, who is the David Weil Professor of Psychiatry and Biobehavioral Sciences at the UCLA David Geffen School of Medicine, responded, "OK. A research grant or an opera?" "Both" Saks replied. The research grant about state variations in the use of physical restraints in psychiatric hospitals was never funded, but the opera would come to fruition when "The Center Cannot Hold," a chamber opera in two acts, was staged for the first time at UCLA last summer. (Wells is also director of the Center for Health Services and Society at the UCLA Semel Institute and affiliated adjunct staff at RAND.)

Wells wrote the music and the original drafts of the libretto, with consultation from Saks. "The Center Cannot Hold" is based on the memoir by Saks of the same title and focuses on a period of hospitalization in New Haven when she was in law school at Yale in the 1980s.

In an interview with *Psychiatric News*, Wells said that as a psychiatrist—and as an artist—he is interested in the "turning points" in human lives, when individuals make a dramatic break from the past or move in a new direction.

"For Elyn, a turning point was when she got out of the hospital during her first year of law school and fought to get back into law school," he said. "I saw that as tremendously courageous."

Well's Work Explores Clinician's Anguish

The hospitalizations were harrowing, and Saks was in restraints for significant periods of time—an experience that would serve as a catalyst for her later work advocating for the human rights of patients with schizophrenia (see box). For Wells, who was a resident in psychiatry just before the period of Saks's hospitalization when use of restraints and seclusion was very common, it was crucial in telling her story to include the perspective of the clinicians.

The aria reproduced above for "Dr. Kerrigan" (a fictional name for the attending inpatient psychiatrist) reflects the dilemma of the clinician ordering that a patient be restrained.

"In constructing the libretto, I put a lot of myself into it," he said. "Dr. Kerrigan's aria is a monologue justifying the use of restraints as the only recourse to keep her safe, but also expresses his own doubts and the hopes for a cure that he once had.

"I was a resident during the era when Elyn was hospitalized. A substantial part of the opera is telling the story of what it is like to be learning about mental illness and the experience of training. You sometimes have to do things to patients you are not sure are right. You are part of an infrastructure in the hospital where there are sometimes conflicts among staff, and people may feel threatened by patients if they are potentially violent. It's an intense setting, but one also full of hope for recovery."

continued on next page

'Restraints Are Not a Benign Intervention'

Severe mental illness can be deeply foreign to people who have never experienced it. Psychiatrist Kenneth Wells, M.D., co-author of the two-act opera based on the memoir *The Center Cannot Hold* by Elyn Saks, J.D., Ph.D., said he worried that some of the most intense scenes—as when Saks shouts the words to Beethoven's Fifth Symphony to ward off the demons in her mind—might evoke laughter. But the audience at last summer's performance at UCLA was composed of many patients, family members, and clinicians who knew better.

"It turns out some in the audience were terrified," he said. "Many told me that it felt very real and very frightening as the performance allowed them to get into Elyn's mind. I hadn't anticipated that."

Saks herself had the same reaction. "I have to say that watching it brought back painful memories—seeing how I was treated and how scared I was being restrained," she told *Psychiatric News*. "Ken did a remarkable job. The opera accurately portrays the experience of having an acute psychosis and being treated in an involuntary setting."

Today Saks is the Orrin B. Evans Professor of Law, Psychology, and Psychiatry and the Behavioral Sciences at the USC Gould School of Law. "Restraints today are seen as a treatment failure, and some jurisdictions have taken strenuous steps to minimize their use," she said. "It is said that restraints keep people safe, but in fact people have been injured or died while in restraints. It's not a benign intervention."

ASSOCIATION NEWS

What Happens in Congress Today Affects Your Patients Tomorrow

Lama Bazzi, M.D., first became attracted to the work of APAPAC during residency. She believes her fellow early career psychiatrists have a special stake in advocating for the profession and its patients.

BY MARK MORAN

For early career psychiatrists, the future is now, says Lama Bazzi, M.D., the early career psychiatrist (ECP) trustee on APA's Board and a member of the Board of Directors of the APA political action committee (APAPAC).

"Although as early career psychiatrists, we may be at the busiest phase of our professional lives—building our careers while also starting or raising families—we are the ones who are going to be impacted in the future by decisions that are made by policymakers today," Bazzi said.

She urged all psychiatrists, at whatever stage they are in their career, to become involved with and support APAPAC. But as an early career psychiatrist and representative to the board for that cohort of APA's membership, Bazzi believes the call to participate in advocacy is especially urgent.

"We don't practice psychiatry in a vacuum; our professional lives and the lives of our patients are shaped by what happens at the executive level of government, in Congress, and in state legislatures," Bazzi said.

She urged members to attend the APA Annual Meeting in San Diego and visit the APA Advocacy booths located in the Exhibit Hall and outside of the registration area in the convention center and learn how to become involved in APA's advocacy activities.

> "I didn't at the time appreciate what APA does for us and what APAPAC advocacy does to help us and our patients."
>
> —Lama Bazzi, M.D.

APAPAC is the political arm of APA, the voice for APA and its members on Capitol Hill and APA's best instrument for getting more friends of psychiatry elected to Congress. APAPAC plays a vital role in APA's advocacy efforts, giving psychiatry a seat at the table in the health care policy arena. The APAPAC Board of Directors is composed of 13 psychiatrists from around the country, as well as ex-officio members including APA CEO and Medical Director Saul Levin, M.D., M.P.A.

Importantly, APAPAC supports candidates on both sides of the aisle who have demonstrated an understanding of and support for the profession and people with mental illness. "Whatever your political opinions and whichever party you support, as psychiatrists we all want the same things," Bazzi said. "We want access to care for our patients, we want to be able to provide our patients the very highest quality treatment, and we want to be fairly reimbursed for our work. Supporting the PAC is not so much about politics as it is about supporting what is best for our patients. That's why I feel so passionate about APAPAC."

Bazzi graduated from medical school in Lebanon and did her psychiatry residency at the State University of New York (SUNY) Downstate Medical Center, in Brooklyn. She then completed a forensic fellowship at Case Western Reserve University in Cleveland.

Today, she is director of the inpatient unit at Maimonides Mental Health Center, also in Brooklyn, where she and colleagues work with a diverse community of patients—"many of whom are underserved and really need a lot of intensive care," she said.

It was during her residency that she began her involvement with APA. At the 2009 Annual Meeting in San Francisco, where she had a poster on display, Bazzi encountered staff representatives from APAPAC in the Exhibit Hall.

"They were talking about what APA does for its members and how federal and state policy affects us as physicians and affects our patients," she said. "This was really impressive to me. I didn't at

see **APAPAC** on page 19

APAPAC to Hold Reception in San Diego

Now is an opportune time to join APAPAC and support the effort to educate congressional candidates about mental health issues. APAPAC contributors who have donated at least $250 ($125 for resident-fellow members) are invited to the APAPAC reception on Monday, May 22, from 8 p.m. to 11 p.m. at the Ultimate Skybox at Diamond View Tower. All others are invited to purchase tickets: $100 for general members, $50 for early career psychiatrists, and $25 for resident-fellow members. More information is posted at www.psychiatry.org/psychiatrists/advocacy/apapac.

Joseph Mango

continued from previous page

To convey this, Wells created The Resident ("a fictional character who is sort of the Ken Wells of the story," he said), someone both eager and to some degree overwhelmed by what he is learning about psychosis and the limitations of treatment. The character of Elyn Saks is portrayed in the opera by three singers: the narrator of the opera (mature Prof. Saks), the younger Elyn as law student, and the psychotic representation of Elyn, called "The Lady of the Charts."

It goes without saying that Wells is a lover of opera, and he comes from a family of professionals in medicine, engineering, and other fields also possessed of diverse artistic talents. "I like to think that there are similarities between the creation of an opera score and the work of a psychiatrist," he said. "A psychiatrist listens and enters into the life of another, gaining insight and coming out with an interpretation. Something like that was involved in translating Elyn Saks's words into music."

At the end of the first act of "The Center Cannot Hold," the mature Prof. Saks, reflecting on her younger self portrayed in restraints, sings:

"It's hard to speak up for yourself
when you're psychotic.
Tied down and drugged and separated
from all things familiar,
...I had to fight back. Some labels you
must not accept!
We all have the right to dream!
I declare the right to dream!"

To which the hospitalized younger Elyn responds: "Can I still dream?" and the chorus of doctors, nurses, and patients on the ward reply, "We have a dream of hope and cure."

Wells told *Psychiatric News* that as important as depicting the reality of psychosis in an involuntary treatment setting is the message of hope, the dream of a cure, and the promise of recovery. After all, Saks would graduate from law school—as "The Center Cannot Hold" depicts—and would go on to be a sought-after legal scholar and advocate for people with mental illness.

Wells said he hopes other physicians—especially young medical students and trainees—as well as patients, families, and the general public will see it, and he would like to see the video shown at APA meetings next year. "I want people who see the opera to know that it is possible to have a meaningful life and have a psychotic illness," he said. PN

A video of the opera performed at UCLA is posted online at http://www.mentalhealthamerica.net/opera. More info about the opera may be accessed at "The Center Cannot Hold Opera" website at http://hss.semel.ucla.edu/team/tcch/. Quotations from the copyrighted libretto are used with the permission of Wells and Saks.

Annual Meeting Highlights Strategies To Acheive Equity in MH Care

A number of sessions at the Annual Meeting will emphasize the importance of cultural competency skills in treating patients and interacting with colleagues.

BY VABREN WATTS

iStock/Yuri_Arcurs

From the mental health of college students of color to the advancement of women in the mental health profession, several aspects of diversity and health equity in psychiatric practice will be discussed at this year's Annual Meeting.

"Conversations around diversity allow for awareness of biases that may be presented toward a particular group of people during an interaction between clinician and patient or between a clinician and colleague," Ranna Parekh, M.D., director of APA's Division of Diversity and Health Equity, told *Psychiatric News*.

Previous research suggests that such biases can negatively impact patient outcomes, further increasing health disparities.

Parekh said as the population of the United States continues to become more diverse, improving quality and access to health care among all cultural and racial backgrounds is critical. This year's sessions on diversity and health equity, she said, will highlight strategies that can be used to reduce disparities in mental health care.

One featured session is "Focusing on the Mental Health and Emotional Well-Being of College Students of Color," sponsored by the Steve Fund. The fund is in memory of a young African-American graduate of Harvard University who died by suicide in 2014 (*Psychiatric News*, November 3, 2014).

"Research shows that young people of color are not getting their mental health needs met," said Annelle Primm, M.D., M.P.A., the session chair and senior medical advisor to the Steve Fund. "This can be attributed to many factors including stigma and lack of access to culturally sensitive mental health care on college campuses. … The barriers that block mental health treatment among these college students warrant our attention."

Panelists will discuss their experiences of providing mental health care to students of diverse backgrounds in a racially charged, homophobic, and transphobic society. They will also discuss the importance of avenues to increase students' access to mental health services such as crisis hotlines, peer counseling programs, and campus medical professionals.

The conversation on meeting the mental health needs of minority populations will continue in a session with clinicians from the Department of Psychiatry and Behavioral Sciences at Stanford University School of Medicine. In "Theatrical Vignettes as an Educational Tool to Improve Communication in Asian-American Families," they will describe how they are using theatrical vignettes to improve communication between Asian-American parents and teenagers.

"Family expectations to achieve academically is a leading stressor among Asian-American teens, putting them at risk for depression and suicidal behaviors," said Rona Hu, M.D., medical director of the Acute Psychiatric Inpatient Unit at Stanford. "The culture and self-expectation that the parents experienced as adolescents in their country can be very different from those of their Americanized teens," Hu added. "We saw an opportunity to help these families with a therapeutic method that has no side effects."

The theatrical vignettes are written and acted out by faculty, residents, and medical students of Asian descent. Each vignette presents a problematic situation concerning the teen such as bad grades or issues regarding social life. The presenters offer two responses that are typical of parents: one that may increase the teen's likelihood to become emotionally distressed or rebellious, and another that may open the line of communication between parent and teen. Hu told *Psychiatric News* that the vignettes have received positive feedback as it relates to improving relations between parent and teens. She hopes that the session will inspire other academic institutions to create their own vignettes that are specific to the cultural demographics of their community.

Residents and faculty from the Department of Psychiatry at Yale School of Medicine will sponsor "The New Face of Diversity: Yale's Social Justice and Mental Health Equity Residency Curriculum." This session will describe how the department is educating residents on connections between social justice and mental health care.

Presenters will describe the curriculum that is required throughout each year of residency and its four courses. They include "Cultural Psychiatry," which focuses on the disparities in mental health care; "Exploring Bias," which covers the social determinants of health associated with bias, racism, and privilege; "Structural Competency," which provides an understanding of the challenges faced by populations in the five surrounding neighborhoods of New Haven, Conn.; and "BioPsychoSocial," which addresses arriving at a correct diagnosis and devising culturally sensitive treatment plans.

"From our session, we hope attendees realize that learning about cultural competency is just as important as learning about neuroscience. Knowledge of both is necessary to improve patient outcomes in mental health care," said session chair Kali Cyrus, M.D., M.P.H., a fourth-year resident at Yale and second-year APA/SAMSHA fellow.

Discussions of cultural competency at academic institutions will continue with the session "Beyond Cultural Competency: How to Introduce a Discussion About Health Disparities Into One's Department/Organization," chaired by Kari Wolf, M.D., chair of psychiatry at Southern Illinois University School of Medicine.

A panel discussion about retaining and advancing women in academic psychiatry will feature Gail Robinson, M.D., a professor of psychiatry and obstetrics/gyncecology at the University of Toronto, and guest speaker Apoorva Mandavilla, the founder and editor-in-chief of *Spectrum*, a source of news for scientists interested in autism spectrum disorder. Robinson is APA's minority/underrepresented group trustee.

Additional sessions on diversity and health equity can be found in the APA Meetings App and the program guide available on site. PN

To register for APA's 2017 Annual Meeting, go to www.psychiatry.org/annualmeeting.

Sessions on Cultural Competency, Diversity Issues

SATURDAY, MAY 20
10 a.m.-11:30 a.m.
The Steve Fund: Focusing on the Mental Health and Emotional Well-Being of College Students of Color

2 p.m.-5 p.m.
Theatrical Vignettes as an Educational Tool to Improve Communication in Asian-American Families

SUNDAY, MAY 21
1:30 p.m.-3 p.m.
The New Face of Diversity Education: Yale's Social Justice and Mental Health Equity Residency Curriculum

TUESDAY, MAY 23
8:45 a.m.-9 a.m.
Beyond Cultural Competency: How to Introduce a Discussion About Health Disparities Into One's Department/Organization

WEDNESDAY, MAY 24
2 p.m.-5 p.m.
Sticky Floor or Glass Ceiling? An Open Panel Discussion About Keeping and Advancing Women in Academic Psychiatry

VIEWPOINTS

The Future of GME: Where Are We Headed?

BY RICHARD SUMMERS, M.D.

Trainees and educators are wondering about the impact of the Trump presidency on psychiatry training. Neils Bohr said, "Prediction is very difficult, especially if it's about the future." That is especially true now, but we can sketch out some of the issues.

The battle about the replacement of the Affordable Care Act (ACA) is just beginning, and veteran observers think there will be many iterations. But we know that parity, the required inclusion of mental health coverage in the benefit structure, Medicaid expansion, and maintenance of insurance by those recently enrolled are all under threat.

Health care legislation will affect training in at least three ways. First, the revenue stream of academic medical centers, community hospitals, and psychiatry departments will decrease, and we depend on those funds to run our educational programs.

Second, the movement toward integrated care was turbo-charged by the ACA. The free market may be less motivating. Since good clinical education is always built on good clinical services, it is unclear whether we will truly be able to flex our wings and train residents effectively in integrated care without sufficient clinical settings available.

Third, the current generation of psychiatry residents is very committed to public psychiatry, and we are in a political environment where the emphasis is on cutting social service expenditures to fund infrastructure and defense.

The next major issue is graduate medical education funding. By the end of the Obama presidency, we were anticipating cuts and the replacement of a portion of current entitlements with incentive payments. It's unclear whether the new administration will move in this direction. I expect that GME funding will be an issue in the coming years, and how a physician and orthopedist as secretary of Health and Human Services will relate to this concern is unclear.

Next, this administration's commitment to free market health care will likely result in continued fracturing of the care system in psychiatry with ever larger percentages of psychiatrists opting out of insurance and Medicare. This is confusing to trainees, while an understandable decision for individual practitioners, it undermines the commitment to a system into which we are trying to integrate our trainees.

The travel ban may be having a great impact on trainees and psychiatrists already. Depending on the next steps, this policy, and the associated elimination of "premium processing" for H1-B visas, could adversely affect many residency programs with international medical graduates and create greater stress and uncertainty in many training settings.

Finally, the heating up of the culture wars, and the more divisive social discourse, evokes new anxieties and uncertainties in many of our patients as well as our trainees and faculty. Although not exclusively, psychiatrists tend to be socially liberal, and many surely struggle with the greater tone of exclusion and intolerance. We will need to continue to learn from one another how to address this problem.

In conclusion, despite Neils Bohr's caution about predicting the future, I am pretty sure that the next few years will bring many challenges. It's a good thing that our commitment to training is strong and we have so many educators, chairs, and trainees involved in finding creative solutions. PN

Richard Summers, MD, is a clinical professor of psychiatry at the Perelman School of Medicine of the University of Pennsylvania and APA's Trustee-at-Large.

Facebook

continued from page 5

which could create new opportunities for social media to connect people with mental illness with care that might otherwise be missed, APA President Maria A. Oquendo, M.D., Ph.D., told *Psychiatric News.* Social media tools could also potentially decrease stigma, she added.

> "We're all looking for human touch and support—that's the social aspect of human beings. Psychiatry offers a patient the sense of connection and not being alone."—John Luo, M.D.

Efforts to expand use of social media to reach people with mental illness "should raise awareness among psychiatrists that many of their patients are likely using social networks," Torous added. "If a patient is expressing suicidal thoughts on a platform such as Facebook, this would be important information for the treating psychiatrist to know."

Torous encouraged psychiatrists to have a conversation with patients about their experiences on social media. "There is likely a value in asking patients about their experiences using social networks: Do they find them helpful? Are they promoting fear? Anxiety? Are they experiencing cyberbullying? The only way to obtain this information directly is by having an open dialogue with the patient."

Luo added that while he supports using social media tools to connect patients with mental illness to care, he cautions against becoming overly reliant on them.

"Unless society changes to point that we prefer engagement that is not personal, … I don't think psychiatrists are going to be replaced by robots or bot engines," he said. "We're all looking for human touch and support—that's the social aspect of human beings. Psychiatry offers a patient the sense of connection and not being alone." PN

Facebook's March announcement on suicide prevention tools is posted at https://newsroom.fb.com/news/2017/03/building-a-safer-community-with-new-suicide-prevention-tools/. Zuckerberg's letter to users is posted at https://www.facebook.com/notes/mark-zuckerberg/building-global-community/10154544292806634. More on reporting suicidal content to the Facebook Help Center can be found at https://www.facebook.com/help/contact/305410456169423.

Ethics Corner

continued from page 4

"rules of living" to assist individuals in their pursuit of mindful happiness. The first rule is to get along with the rest of humanity, that is, to follow accepted social customs and behave amicably with all other people. By following simple courtesies, such as returning phone calls from prospective patients even when our practices are full and helpfully offering a few referral suggestions, we promote the well-being of the public. Spinoza would add that by spending a few minutes in this courtesy, especially because there is no financial profit, we advance our personal development. Indeed, in addition to advancing personal development, this simple courtesy advances our profession's image. How confusing and hurtful must it be to an individual seeking psychiatric care to leave messages for psychiatrists and receive no returned calls. This silence may communicate more than lack of courtesy; it may suggest indifference or disrespect, tainting our profession's public image. In contrast, taking five minutes to return the call, even if we don't accept the patient into our practice, presents the profession as humane and committed to trying to help.

The truly ethical psychiatrist, the ethical human being, looks beyond mere rules and examines his or her own values to further individual development and refine the life of the mind. We need not all teach. Nor need we all become involved in public policy. I do believe we should be polite to everyone we encounter, although we may differ in our ideas about courtesy's extent. As each of us strives to reach our intellectual, humanistic, and spiritual ideals, our contemplation of ethics helps inform our growth. Out of such contemplation, a personal plan to advance ethics will emerge. PN

From the President

continued from page 3

Arise & Flourish to promote addiction prevention to teenagers and parents dovetailed with his passion for working with people with alcoholism and other addictions to help them recover and to bring a message of hope to parents and children who struggle with addiction.

I rejoined at the end, to talk about a well-kept secret: hidden behind the terrible epidemic of opioid overdose deaths looms the fact that many of these deaths are far from accidental. They are suicides.

I cannot say it was a fun afternoon. Many in the audience, myself included, nodded in recognition as we listened. There was many a moist eye among the listeners. And yet is was a powerful and moving afternoon. We had an unparalleled opportunity to reach those in government who may be able to effect change. All in all, it was an excellent day on the Hill, and perhaps, as it turned out, the harsh weather had set the right tone for this important discussion. PN

Psychotherapy Found Generally Effective For Borderline Personality Disorder

What may matter more than the type of specialized therapy are the elements of coherence, consistency, and continuity.

BY MARK MORAN

iStock/KatarzynaBialasiewicz

Specialized psychotherapies—especially psychodynamic psychotherapy and dialectical behavior therapy (DBT)—appear to be effective for alleviating some of the most debilitating symptoms of borderline personality disorder (BPD), but effects are small and studies are plagued by methodological problems, according to a meta-analysis published in *JAMA Psychiatry*.

Psychodynamic psychotherapy and DBT demonstrated efficacy for treating self-harm, suicidal behavior, and general psychopathology as well as reducing health service use in patients with BPD. However, the treatment effects were only modestly superior to usual care, suggesting that the type of psychotherapy used to treat BPD, per se, may not be as important as certain underlying shared mechanisms of therapy that are conducive to improvement.

In an editorial accompanying the study, Peter Fonagy, Ph.D., Patrick Luyten, Ph.D., and Anthony Bateman, M.A., suggest that those important mechanisms include coherence, consistence, and continuity. As these elements have steadily been incorporated into psychotherapeutic approaches to treating patients with BPD, the gap in effectiveness between specialized therapies and "treatment as usual" has likely diminished, they suggested.

The treatment characteristics of coherence, consistency, and continuity "are critical because they provide cognitive structure for a patient group that lacks in metacognitive organization," they wrote. "The importance of structuring of subjective experience as part of treatment has influenced how therapists—including the therapists in the treatment-as-usual (TAU) arm of trials—work with patients with BPD, so outcomes may have improved in TAU because iatrogenesis is likely to have decreased with the waning of unfocused exploratory and supportive interventions."

In the study, Ioana Cristea, Ph.D., of the Babes-Bolyai University in Romania and colleagues from several international institutions searched PubMed, PsycINFO, EMBASE, and the Cochrane Central Register of Controlled Trials using the terms "borderline personality" and "randomized trial." Thirty-three trials with 2,256 participants were included.

Standardized mean differences in efficacy were calculated using all outcomes reported in the trials for borderline symptoms including self-harm, suicide, health service use, and general psychopathology.

The results showed significant but small posttest between-group effect sizes in all outcome categories. For borderline-relevant outcomes and psychopathology, effects were small to medium. Most trials focused on DBT and psychodynamic approaches, and both types generated significant but still small effects compared with comparison interventions.

Statistical analysis suggested that the results may be inflated by risk of bias (greater attention paid to patients in experimental arms) and publication bias (the likelihood that trials would be published when results were favorable to the experimental arm).

The researchers noted that further study is needed and that prospective registration in clinical trial registries is necessary to address methodological problems in research on psychotherapy for BPD.

John Oldham, M.D., an expert on BPD and a former APA president, reviewed the report for *Psychiatric News*. He said that aside from the shortcomings and methodological problems in existing research, the news is generally good for the psychotherapeutic treatment of BPD.

Oldham agreed with Fonagy and colleagues that the type or "brand" of specialized therapy is not as important in psychotherapeutic treatment of BPD as are certain crucial elements that are shared by all effective therapies.

"An unfortunate byproduct of recent progress in the field has been the 'horserace' attitude sometimes heard from advocates of a particular treatment approach—that studies will one day 'prove' their favored approach to be the winner," Oldham said. "I don't think so, and I believe the Cristea report supports this broader view. Some therapies work well for some patients with BPD, and others may work well for others."

Oldham added, "I have argued that there are four essential ingredients for effective psychotherapy for BPD: a strong therapeutic alliance; availability of capable, well-trained therapists of many stripes; enough time to do the job right; and money—that is, somebody's got to pay for it. These are tough conditions to meet, especially in many parts of the country."

Oldham concluded that the Cristea report is good news. "A number of types of psychotherapy for BPD, examined carefully, can be effective, just as treatment as usual can be—especially, as emphasized by Fonagy and colleagues in the accompanying editorial, when it is carried out in a structured way by well-informed clinicians who understand deeply the nature of the illness," he said. PN

"Efficacy of Psychotherapies for Borderline Personality Disorder: A Systematic Review and Meta-analysis" is posted at http://jamanetwork.com/journals/jamapsychiatry/fullarticle/2605200. "Treating Borderline Personality Disorder With Psychotherapy: Where Do We Go From Here?" is posted at http://jamanetwork.com/journals/jamapsychiatry/fullarticle/2605196.

Shortage

continued from page 6

APA is advocating for additional funding and slots for graduate psychiatric training and for loan-forgiveness programs that encourage psychiatrists and other clinicians to practice in underserved areas, said APA CEO and Medical Director Saul Levin, M.D., M.P.A. New billing codes are needed to pay for collaborative care as well. Last year the Centers for Medicare and Medicaid Services created a CPT code and a fee for Psychiatric Collaborative Care Management Services that are now part of the 2017 Medicare fee schedule.

However, better reimbursement and a commitment to mental health parity are meaningless unless all insurance networks have adequate numbers of psychiatrists on their panels, he said.

As a practical matter, training must align with needs, said Patrick Runnels, M.D., an associate professor of psychiatry at Case Western Reserve School of Medicine in Cleveland and co-chair of the National Medical Director Institute.

"That process should start in medical schools, beginning with stronger and longer rotations in psychiatry to expose medical students to the range of practice in psychiatry today," he said.

In residency, trainees need more exposure and experience with telepsychiatry, medication-assisted treatment for substance use, and collaboraton with other professionals. Experience with updated integrated care models and time in Federally Qualified Health Centers should be required for all residents, said Runnels, who is also program director for community psychiatry at University Hospitals Cleveland Medical Center.

"The biggest opportunity to expand the workforce is to reduce the portion of psychiatric providers who practice exclusively in cash-only practice," said the report. "APA and the National Council need to work with their members to implement a wide range of incentives that promote the engagement of psychiatric providers with outpatient and inpatient psychiatric programs that accept commercial, Medicare, and Medicaid coverage that pays for the majority of Americans with psychiatric health care needs."

The report's conclusions will be pushed out through professional associations and advocacy as a step toward placing its recommendations into action, said Parks. PN

"The Psychiatric Shortage: Causes and Solutions" is posted at https://www.thenationalcouncil.org/wp-content/uploads/2017/03/Psychiatric-Shortage_National-Council-.pdf.

CLINICAL & RESEARCH NEWS

Marriage Equality Laws Linked to Drop in Teen Suicide

Experts say marriage equality laws are likely a proxy for other changes in attitudes that create a more tolerant and accepting atmosphere for teens who identify as belonging to a sexual minority.

BY MARK MORAN

Marriage equality laws appear to be associated with a reduction in the proportion of high school students reporting suicide attempts, according to a report published February 20 in *JAMA Pediatrics*.

Researchers and psychiatrists who commented on the study for *Psychiatric News* said that the report points to how social policy that reflects greater tolerance and reduced stigma may improve mental health. Though it would be difficult or impossible to prove that marriage equality laws directly influence suicide rates, experts say it is likely that such laws reflect cultural values and attitudes prevalent in those states that create a more tolerant and accepting environment for young people.

"[U]nderlying state characteristics are likely to influence both state same-sex marriage policies and the prevalence of suicide attempts, and states have different baseline levels of suicide attempts," Julia Raifman, Sc.D., of the Johns Hopkins Bloomberg School of Public Health and colleagues wrote. "We addressed both of these issues by controlling for state, which accounts for time-invariant state characteristics such as cultural and political differences and controls for baseline state differences in the prevalence of suicide attempts."

The researchers analyzed data on more than 700,000 public high school students who participated in the Youth Risk Behavior Surveillance System (YRBSS) from 1999 through 2015. They looked at changes in suicide attempts among the students before and after the implementation of state policies in 32 states permitting same-sex marriage and year-to-year changes in suicide attempts in 15 states without such policies. A secondary analysis examined how same sex-marriage laws affected suicide attempts among high school students who self-identified as belonging to a "sexual minority."

Same-sex marriage equality policies were associated with a 0.6 percentage point reduction in suicide attempts—equivalent to a 7 percent decline in the proportion of all high school students reporting a suicide attempt within the past year. Among students who identified as belonging to a sexual minority, the absolute decrease in suicide was 4.0 percentage points—equivalent to a 14 percent relative decline in the proportion of adolescents who were sexual minorities reporting suicide attempts in the past year.

"Marriage equality is a proxy for many changes in attitudes that create a matrix of social support for LGBT young people," said Marshall Forstein, M.D.

APA President Maria A. Oquendo, M.D., Ph.D., an expert in suicide, said the study points to the importance of environmental factors in risk for suicide. "We know that LGBT youth have significantly higher suicide rates, and this study supports the importance of advocating for policies that promote tolerance and acceptance," she said.

APA CEO and Medical Director Saul Levin, M.D., M.P.A., concurred. "As a gay

continued on next page

continued from previous page

man and a gay psychiatrist, I am acutely aware of the effect of stigma and of the value of policies affirming tolerance and respect," he said. "I'm proud of APA's record of support for marriage equality, and the new report underscores the importance of that advocacy."

Marshall Forstein, M.D., president of the APA Assembly Caucus of Lesbian, Gay, Bisexual, Transgender and Questioning/Queer Psychiatrists, said he believes marriage-equality laws are a marker for a host of social factors that create a more tolerant atmosphere for sexual minority youth, which, in turn, can help to diminish stigma and reduce the risk of suicide. "Marriage equality is a proxy for many changes in attitudes that create a matrix of social support for LGBT young people," he said. "Increasing social tolerance creates the environment for increasing self-esteem."

Forstein said it is likely, for instance, that states that have passed marriage-equality laws are more likely to be home to legislators or other high-profile people who have "come out" and communities that are more accepting of gay-friendly families.

Brian Hurley, M.D., representative to the AMA Section Council on Psychiatry from GLMA: Health Professionals Advancing LGBT Equality, agreed. He explained that the *JAMA Pediatrics* study tests a hypothesis based on the "minority stress model." That model asserts that sexual or other minorities experience unique stressors, including stigma and discrimination, that may contribute to risk for suicide. The hypothesis is that social policies that reduce stigma and discrimination may ameliorate that risk.

"The *JAMA* report lends support to the minority stress hypothesis," he told *Psychiatric News*. "The findings don't prove that marriage equality directly reduces suicide risk, but it does suggest that marriage equality is associated with a host of contextual factors in states with such laws that create less minority stress."

Hurley also said that while the vast majority of LGBT people are not suicidal, the study demonstrates the ways that sexual orientation can impact mental health outcomes. "[O]ne implication of the study for individual psychiatrists is that speaking to patients about their sexual orientation is a relevant part of a safety assessment and is clinically important," he said. PN

An abstract of "Difference-in-Difference Analysis of the Association Between State Same-Sex Marriage Policies and Adolescent Suicide Attempts" is posted at http://jamanetwork.com/journals/jamapediatrics/fullarticle/2604258.

High Service Use Seen in Medicaid Patients Who Later Died by Suicide

Patients with co-occurring mental illness and general medical conditions who later died by suicide were likely to have made medical and/or behavioral health visits within one month of death.

BY MARK MORAN

Medicaid patients who died by suicide in one state sample were very likely to make general medical and/or mental health visits shortly before their death, and those whose visits were within 30 days of suicide were more likely to have individual and co-occurring behavioral and general medical conditions.

The latter group was also more likely to be Medicaid-eligible because of disability, according to a report published last month in *Psychiatric Services in Advance*. The study was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA).

Lisa Dixon, M.D., editor of *Psychiatric Services*, said data from a closed system such as Medicaid can be used to generate risk algorithms to guide prevention services.

The report, which looked at Ohio state Medicaid data, is significant in at least two ways: it points to individual characteristics related to service use prior to suicide, and it suggests the value of using data from a circumscribed patient population to develop predictive models.

"The condition-specific suicide rates underscore that Medicaid enrollees with psychiatric disorders, especially in combination with substance use disorders and chronic general medical conditions, are a group at particularly high risk of suicide," wrote the researchers, who are affiliated with Ohio State University, University at Albany, and SAMHSA. "Findings highlight the substantial public health significance of using Medicaid enrollment to designate a 'virtual boundary' around a subpopulation of U.S. health care consumers for purposes of targeted suicide prevention and intervention."

Data for the study came from the Medicaid claims files of the Ohio Department of Mental Health and Addiction Services and death certificate files by the Ohio Department of Health. The two databases were linked using a deterministic, multistep algorithm based on combinations of an individual's Social Security number, last name, first name, birth month, and birth year.

A total of 1,338 Ohio Medicaid enrollees aged 19 to 65 died by suicide in the study period. Data were extracted from Medicaid claims files for each of the 1,338 individuals in the year prior to suicide and included general medical, mental health, and substance use treatment visits to outpatient programs, inpatient facilities, or emergency rooms.

ICD-9-CM codes were linked with encounters, allowing for categorization of reasons for visits by primary diagnosis. These diagnoses were grouped into two categories: general medical visits and mental health or substance use treatment visits.

Most decedents (83 percent) made a general medical or mental health visit within one year of suicide, with half doing so within 30 days and 27 percent within one week before death. In the year before suicide, the median number of visits was 16, indicating a subgroup with intensive service utilization.

Decedents whose visits were proximal to suicide (within 30 days) rather than distal (31 to 365 days) were more likely to have individual and co-occurring behavioral and general medical conditions and to be Medicaid eligible through disability. Also in the year before suicide, decedents with serious psychiatric disorders were more likely than those without such disorders to make only mental health visits, and those with chronic general medical conditions were more likely than those without such conditions to make only general medical visits.

"Data on the frequency of visits indicate that a portion of decedents were intensive service users, and these individuals had severe clinical profiles," the researchers stated. "Decedents who had more problems, as measured by all types of co-occurring conditions, were more likely than those without co-occurring conditions to have made visits within a month of suicide. In addition, decedents who received care in the month prior to suicide tended to be seen in settings consistent with their clinical profiles—those with serious psychiatric disorders were more likely than those without such disorders to make mental health visits, and those with chronic general medical conditions were more likely than those without such conditions to make general medical visits."

Lisa Dixon, M.D., editor of *Psychiatric Services* and a professor of psychiatry at Columbia University and the New York State Psychiatric Institute, said the study is rich with data potentially informative about predictors for suicide.

"At the clinical level, the frequency with which individuals had health care visits in the week, month, and year prior to suicide underscores the fact that there may be opportunities for identification and risk and prevention," she told *Psychiatric News*. "We can see the importance of the specific patient characteristics that may increase risk such as the co-occurrence of general medical, substance use, and mental health disorders.

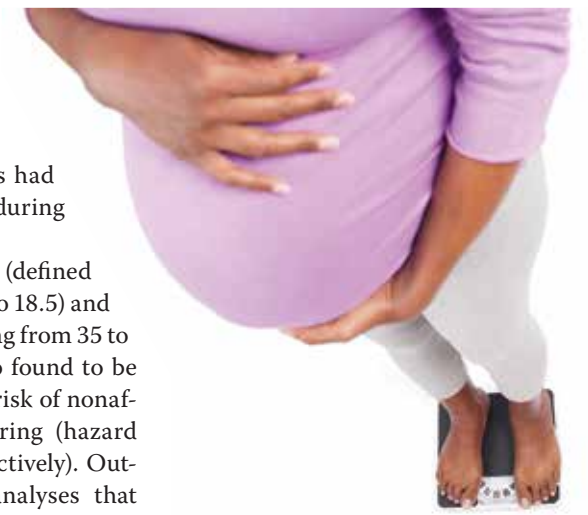
"At the same time, since we cannot absolutely predict who will die by suicide, this paper has implications for the power of a system-level approach," she said. "The patterns that emerged suggest the value of algorithms that might be able to identify those at greatest risk and do screening and prevention procedures within the group of individuals covered by Medicaid." PN

"Service Use in the Month and Year Prior to Suicide Among Adults Enrolled in Ohio Medicaid" is posted at http://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201600206.

CLINICAL & RESEARCH NEWS

Inadequate Weight Gain During Pregnancy May Increase Risk of Psychosis in Offspring

The American College of Obstetricians and Gynecologists recommends that women of normal weight gain between 25 and 35 pounds during pregnancy.



iStock/RuslanDashinsky

BY VABREN WATTS

While previous research has shown prenatal exposure to famine is associated with a twofold increased risk of nonaffective psychosis in offspring, less is known whether low weight gain during pregnancy alone increases this risk.

A study published February 22 in *JAMA Psychiatry* suggests extremely low weight gain during pregnancy (weight gain of less than 18 pounds) may increase the risk of psychosis in offspring, even in a well-nourished population.

The study "contributes to an increasingly robust body of convergent evidence for a role of prenatal nutritional deficiency in the early origins of psychosis and strengthens the argument for examining prenatal nutritional supplements and dietary patterns as a means of prevention," Ezra Sesser, M.D., Dr.P.H., and Katherine Keyes, Ph.D., of the Psychiatric Epidemiology Training Program at Columbia University Mailman School of Public Health wrote in an accompanying commentary published in *JAMA Psychiatry.*

Gestational weight gain ranging from 25 pounds to 35 pounds in women with normal BMI (ranging from 18.5 to 24.9) is considered healthy, according to guidelines by the American College of Obstetricians and Gynecologists.

For the study, Renee Gardner, Ph.D., of the Karolinska Institutet in Stockholm and colleagues analyzed data from Swedish health and population registries, focusing on 526,042 individuals who were born in Sweden from 1982 through 1989 and their mothers. The offspring were tracked from age 13 to the end of 2011 (age 22 to 29). Gestational weight gain of the mother was calculated as the difference in maternal weight between the first prenatal visit (baseline) and delivery.

At the end of the study period, 2,910 offspring had an ICD-9 or ICD-10 diagnosis of nonaffective psychosis, which included 704 with narrowly defined schizophrenia.

Among the individuals with psychosis, 184 (6.32 percent) had mothers with extremely inadequate gestational weight gain (less than 17.6 pounds for mothers with normal BMI). In comparison, the mothers of 23,627 (4.52 percent) individuals without psychosis had extremely low weight gain during pregnancy.

Mild maternal thinness (defined as BMI ranging from 17.0 to 18.5) and class 2 obesity (BMI ranging from 35 to 40.0) at baseline were also found to be associated with a modest risk of nonaffective psychosis in offspring (hazard ratio=1.21 and 2.15, respectively). Outcomes were similar in analyses that adjusted for confounding factors such as socioeconomic status.

While Gardner and colleagues suggested that malnutrition is a potential mediating factor for inadequate gestational weight, they pointed out that other factors may also be involved. "Severely inadequate gestational weight gain may ... be indicative of an existing maternal medical condition, such as endrocrinologic disorders, malabsorption, anorexia nervosa, bulimia nervosa, or hyperemesis gravidarum," they wrote. "Insufficient weight gain can also occur in otherwise healthy individuals owing to insufficient medical guidance or by a drive to conform to societal (but not medical) standards of appropriate weight gain."

The researchers emphasized that more research is needed to understand the association between conditions that lead to insufficient maternal weight gain and the risk for nonaffective psychosis in offspring.

The study was funded by the Swedish Research Council. PN

An abstract of "Association of Gestational Weight Gain and Maternal Body Mass Index in Early Pregnancy With Risk for Nonaffective Psychosis in Offspring" is posted at http://jamanetwork.com/journals/jamapsychiatry/fullarticle/2604308.

PSYCHIATRY & PSYCHOTHERAPY

Becoming a Competent Psychotherapy Supervisor: How Do I Get There From Here?

This is the second in a two-part series on psychotherapy supervision.
Part 1 is posted at http://psychnews.psychiatryonline.org/doi/full/10.1176/appi.pn.2017.1b10.

BY KATHERINE G. KENNEDY, M.D.

"What can I offer my supervisee? I barely know anything!"

How does a newly minted psychiatrist, fresh out of residency, transform into a sage and competent psychotherapy supervisor? Halsted's traditional medical training method of "see one, do one, teach one," fails here: simple know-how is not enough to master the complicated skills and cultivate the professional identity of a seasoned psychotherapy supervisor. Learning how to teach requires more than clinical experience. What do we know—and not know—about the internal development and personal evolution of the psychotherapy supervisor?

A body of literature exists, perhaps forgotten, on descriptive models of psychotherapy supervisor development.

That golden age of inquiry began in 1983, blossomed over the ensuing 10 years, and continued to have an impact as institutions became aware of the need to facilitate the development of supervisors. Five models emerged, more similar than not, each conceptualized as a series of three or four sequential stages. Unfortunately, little empirical research on these models occurred, despite widespread opinion that better knowledge about how supervisors develop their teaching skills should contribute to a deeper understanding of the overall process of supervision. To get a sense of the affective, cognitive, and behavioral scope of these models, consider the four-stage model proposed by C. Edward Watkins, Ph.D., published in 2012 in the *American Journal of Psychotherapy* (vol. 66, no. 1).

Watkins termed his first stage "Role Shock." In this stage, freshman supervisors are beset by uncertainty and self-doubt and fear being a fraud or a phony. Anxious and overwhelmed, they cling to their personal experiences as a supervisee for guidance. To conceal inadequacies, they may exhibit critical, rigid, or controlling behaviors toward their supervisees, potentially hampering supervisees' independence and inhibiting their self-disclosures.

During the second stage, called "Role Recovery/Transition," sophomore supervisors feel more grounded and experience less anxiety and dread. "As I began to feel increasingly more self-assured, I found I could listen more easily to my supervisee talk about his patients. I could finally think." There is a dawning awareness of their clini-

see ***Psychotherapy*** *on page 19*

Katherine G. Kennedy, M.D., is in private practice in New Haven, Conn. She is also a member of the Committee on Psychotherapy of the Group for the Advancement of Psychiatry (GAP), member of the APA Council on Advocacy and Government Relations, trustee of the Austen Riggs Center in Stockbridge, Mass., and assistant clinical professor at the Yale University School of Medicine. This column is coordinated by GAP's Committee on Psychotherapy.

Amygdala Activity May Predict Future Cardiovascular Events

Researchers find a biological link between effects of stress on the amygdala and later cardiovascular events.

BY AARON LEVIN

Higher emotional stress as measured by resting metabolic activity of the amygdala is associated with greater risk of subsequent cardiovascular disease events, according to a study published online January 11 in *The Lancet*. The findings "provide novel insights into the mechanism through which emotional stressors can lead to cardiovascular disease," wrote researchers led by Ahmed Tawakol, M.D., an associate professor of medicine at Massachusetts General Hospital and Harvard Medical School.

Tawakol and colleagues hypothesized that activity in the amygdala in response to stress increases arterial inflammation both directly and by way of activity in bone marrow.

"What is novel here is the bridging of multiple areas of research," said Peter Gianaros, Ph.D., a professor of psychology and psychiatry and director of the Behavioral Neurophysiology Lab at the University of Pittsburgh. Gianaros has also studied the relationship between the amygdala and cardiovascular disease but was not involved with Tawakol's study.

"It builds on threads of prior research that pointed in this direction and makes strong connections with research on the neurobiology of stress as well as with clinical cardiology," said Gianaros. "Now we have the proof of concept and a vision of the future."

The amygdala is known to be a key component of the brain's stress network. Past studies in mice suggested that amygdala activity in response to stress accelerates cytokine production and atherosclerosis, but whether the same was true of humans was unknown.

Tawakol and colleagues examined data originally derived from cancer screening imaging studies of 293 patients. Using positron emission tomography/computed tomography (PET/CT) scans, they analyzed activity in the amygdala and in bone marrow, as well as arterial inflammation.

During the median follow-up of 3.7 years, 22 patients experienced a cardiovascular disease event—including heart attacks, strokes, angina, or other events. Each increase of one standard deviation in resting amygdala activity predicted a 1.6 risk of a cardiovascular event. The results were significant even after adjusting for established cardiovascular risk factors.

Greater amygdala activity was also associated with increased bone marrow activity, which the authors said led to increased arterial inflammation followed by cardiovascular disease events.

"[T]he brain's salience network, bone marrow, and arterial inflammation together form an axis that could accelerate the development of cardiovascular disease," concluded Tawakol and colleagues. "Furthermore, our findings raise the possibility that efforts to attenuate psychosocial stress could produce benefits that extend beyond an improved sense of psychological well-being and could beneficially impact the atherosclerotic milieu."

Clinicians might eventually screen for and treat chronic stress just as they do for other cardiovascular risk factors, they suggested.

Realistically, clinical applications are still well down the road, and much needs to be done to move the field forward, said Gianaros.

"We'll need to set norms and thresholds for amygdala activity and see cost reductions in the methods used to assess it," he said.

For instance, it would be helpful to know more about what factors contribute to elevated amygdala activity, how people vary in their appraisal of stressors, and whether the amygdala sensitizes individuals to stressors in the environment or if the increased activity is a result of repeated stressors, he said.

"This rigorous study is a good example of how multidisciplinary work can lead to potential breakthroughs or make connections that don't happen when working in silos," said Gianaros. PN

An abstract of "Relation between resting amygdalar activity and cardiovascular events: a longitudinal and cohort study" is posted at http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)31714-7/abstract.

JOURNAL DIGEST

BY NICK ZAGORSKI

iStock/dimarik

Migraines Triple the Odds Of Anxiety Disorder

Adults who have migraines have three times the prevalence of generalized anxiety disorder (GAD) compared with adults who are migraine-free, reports a new study appearing in the journal *Headache*.

The study also found that among people with migraines, men had a higher risk of GAD than women—the opposite of what is seen in the general population.

"It is unclear what might cause the increased vulnerability among men with migraines to have higher odds of GAD in comparison to women with migraines," wrote Esme Fuller-Thomson, Ph.D., of the University of Toronto and colleagues. "This may be a result of the fact that men are less likely than women to take medication to treat their migraine and therefore the disorder may be more painful and less controllable, which could result in anxiety. In addition, among those with migraines, men are more likely to report depression than women."

The researchers analyzed data contained in the 2012 Canadian Community Health Survey–Mental Health (CCHS-MS), including 2,232 adults who reported experiencing migraines and 19,270 with those who did not.

The researchers found adults aged 20 and older who reported migraines have a greater prevalence of past year GAD (6 percent versus 2 percent).

Besides being male, low income, having a university degree, and not having someone to talk to about important decisions were also associated with higher odds of anxiety in people with migraines. People who did not list having an "advisor or confidant to discuss important matters" had around five times the risk of anxiety, the authors reported. This connection shows how social support can play an important protective role in the mental health consequences of chronic pain disorders.

Fuller-Thomson E, Jayanthikumar J, Agbeyaka S. Untangling the Association Between Migraine, Pain, and Anxiety: Examining Migraine and Generalized Anxiety Disorders in a Canadian Population Based Study. *Headache*. 2017; 57(3):375-390. http://onlinelibrary.wiley.com/doi/10.1111/head.13010/abstract

iStock/Wavebreak

IPT Found Effective for Patients With Sexual Trauma History

Patients who have a history of sexual trauma may be more likely to respond to interpersonal psychotherapy for posttraumatic stress disorder (PTSD) than other common psychotherapies, according to a study published April 4 in *Depression and Anxiety*. The findings suggest that helping patients to build trust in the aftermath of a trauma may be particularly beneficial for patients who have been victims of sexual assault.

John C. Markowitz, M.D., a research psychiatrist at the New York State Psychiatric Institute, and colleagues compared the outcomes of 110 unmedicated patients who had chronic PTSD and a score >50 on the Clinician-Administered PTSD Scale (CAPS) and were assigned to three types of therapy over a 14-week period: weekly interpersonal psychotherapy (IPT), prolonged exposure (PE: standard, reference treatment), or relaxation therapy (RT: active control condition).

As was previously reported in the *American Journal of Psychiatry*, the authors found IPT had a higher response rate (defined as >30 percent CAPS reduction) than RT (63 percent vs. 38 percent), and nonsignificantly lower dropout than competing treatments (IPT=15 percent, PE=29 percent, RT=34 percent). Among patients with comorbid major depressive disorder (MDD)—50 percent overall—PE dropout trended higher than in IPT.

Thirty-nine (35 percent) patients in the trial reported sexual trauma, 68 (62 percent) reported physical trauma, and 102 (93 percent) interpersonal trauma. Baseline CAPS scores did not differ by the presence or absence of trauma types, the authors noted in the current report. "Although all therapies had equal efficacy among patients without sexual trauma, sexually traumatized patients [had less positive outcomes] in PE and RT than in IPT," they wrote.

Markowitz JC, Neria Y, Lovell K, Van Meter PE, and Petkova E. History of Sexual Trauma Moderates Psychotherapy Outcome for Posttraumatic Stress Disorder. *Depress Anxiety.* April 4, 2017. [Epub ahead of print] http://onlinelibrary.wiley.com/doi/10.1002/da.22619/full

iStock/ChristopherBernard

Children With Sleep Apnea May Be At Risk of Developmental Delays

Children with moderate or severe sleep apnea show noticeable reductions in gray matter in several areas of the brain that control cognition and mood, according to a study appearing in *Scientific Reports*.

"Regardless of the origin of these volume reductions, altered regional grey matter is likely impacting brain functions, and hence cognitive development potential may be at risk in children with OSA [obstructive sleep apnea]," the authors wrote. The findings reinforce the importance of early detection and treatment of this common sleep disorder.

For this study, which was published on March 17, researchers took high-resolution MRI scans of 16 children aged 7 to 11 with OSA and nine matched controls without OSA. In addition to the scans, the children had their sleep patterns evaluated in a sleep laboratory and were given neurocognitive tests.

The researchers compared the brain scans of children with OSA to those without OSA. (The brain scans of 191 healthy children from the Pediatric MRI database were also included in the analysis). They found that children with OSA had less gray matter in the frontal and prefrontal cortices, parietal cortices, temporal lobe, and the brainstem The changes in brain volume were not related to the severity of the sleep apnea as measured in the sleep lab, nor to the children's neurocognitive scores.

"The mechanisms underlying such extensive MRI changes, the exact nature of the gray matter reductions, and their potential reversibility remain virtually unexplored and should prompt intensive future research efforts in this direction," the study authors concluded.

Philby M, Macey P, Ma R, et al. Reduced Regional Grey Matter Volumes in Pediatric Obstructive Sleep Apnea. *Sci Rep.* March 17, 2017; 7:44566. http://www.nature.com/articles/srep44566

iStock/MichaelRothPhotography

Suicide Risk After Violent Attempt Found Highest in First 30 Days

An article published March 21 in *AJP in Advance* suggests that people who survive violent self-harm events, particularly those involving self-inflicted firearm injuries, are at the greatest risk of suicide in the 30 days following the initial self-harm event.

For the study, Mark Olfson, M.D., M.P.H., and colleagues extracted Medicaid data on adults aged 18 to 64 with clinical diagnoses of deliberate self-harm (n=61,297). The self-harm cohort was followed forward from the index date for 365 days, date of death from any cause, or end of available data,

continued on next page

Residents' Forum

continued from page 6

brief counseling at follow-up visits. As a precaution, we scheduled more frequent follow-ups compared with other patients being treated for the same condition; however, adverse side effects were not reported.

Before initiating medication for smoking cessation, we asked patients to set a target quit date (TQD) around a time with no anticipated stressors (for example, not around holidays or special events), and around a time with a lot of social support. The medications helped with impulse control and craving reduction while the brief counseling offered during office visits provided reassurance, coping skills strategies, and guidance on long-term abstinence. The outcomes have been astonishing—patients' psychiatric conditions are better controlled despite no regimen changes, they are able to engage more in their medical care, and those who had other comorbid substance use problems were able to reduce and even cease use.

Tobacco use is the number one cause of preventable death among our patients. Most patients attempt to quit unaided, but the data strongly support pairing behavioral support with FDA-approved cessation medications for patients who want to quit. As trainees, we need to familiarize ourselves with the most effective cessation treatments and offer them to all suitable smokers. PN

LETTERS TO THE EDITOR

Health: Inherent to Life, Liberty, and Pursuit of Happiness

We urgently need a bipartisan consensus to achieve and implement a quality and sustainable health care system for all Americans on a par with health care systems of other high-income economies.

Life, liberty, and the pursuit of happiness are enshrined in the Declaration of Independence and in the American think-big, can-do spirit. Health is the *sine qua non* for accomplishing all of these and is essential for longevity and quality of life. Health at both the individual and population levels is an invaluable asset for economic and social development and for sustaining robust economies and democracies. Health is also essential to a nation's security and prosperity.

While the Obama administration's Affordable Care Act (ACA) was an imperfect piece of legislation, in need of revision and fine-tuning, it has nevertheless made health care accessible to millions of Americans who did not have such access to care. The American Health Care Act (AHCA), introduced by the Trump administration last month and withdrawn because of insufficient votes to pass it, would have reversed this enhanced access to care for many Americans. The Congressional Budget Office had projected that under the AHCA, 24 million Americans would have lost access to health care over the next 10 years.

It is clear that the U.S. health care system needs to be reformed. According to the Centers for Medicare and Medicaid Services, health care spending in this country grew 5.8 percent in 2015, reaching $3.2 trillion, or $9,990 per person. As a share of the nation's Gross Domestic Product, health spending accounted for 17.8 percent. In 2014, the Commonwealth Fund reported that among the 11 high-income countries it studied, practically all provided access to health care to all their citizens for lesser budget allocations, and their health systems' performance, in aggregate, were superior to that of the United States on all indices, inclusive of access, quality, and sustainability.

In the 2018 Congressional elections, we hope the candidates will put Americans first; rekindle the American tradition of the think-big, can-do spirit; apply that innovative, winning spirit to authentic health care reform; emulate the bipartisan example of President Ronald Reagan and Speaker Tip O'Neill; accept that American exceptionalism may also learn from other health systems how to best achieve total health care for all across the life cycle; and work together for our country and our people to update and build upon the ACA or present an enhanced, bipartisan alternative.

ELIOT SOREL, M.D.
Washington, D.C.

continued from previous page

whichever came first. A total of 243 deaths by suicide took place during the follow-up period.

The researchers reported that during the first year following the index self-harm event, the suicide rate for the follow-up cohort was 439.1 per 100,000 person-years—37 times greater than the suicide rate of the U.S. general population (11.8 per 100,000 person-years).

Self-harm patients who used violent methods were at a 17-fold increased risk of suicide during the first 30 days after the initial event compared with those who used nonviolent methods, but not during the following 335 days.

"This risk pattern supports concerted efforts to protect patients who attempt suicide by highly lethal methods during the acute period after the self-harm event. During periods of extremely high risk, inpatient admission may facilitate crisis work, intensive supervision, and implementation of complex interventions, and it can help ensure patient safety," the authors wrote. "For patients who own firearms or live in homes with firearms, distributing trigger locks and urging family members to temporarily store household firearms away from the patient's home can be a lifesaving intervention."

Olfson M et al. Suicide Following Deliberate Self-Harm. *Am J Psychiatry.* March 21, 2017. [Epub ahead of print] http://ajp.psychiatryonline.org/doi/abs/10.1176/appi.ajp.2017.16111288

see ***Journal Digest*** *on page 21*

APAPAC

continued from page 9

the time appreciate what APA does for us and what APAPAC advocacy does to help us and our patients. It was then I began to learn how our practices and our patients are affected by politics."

Bazzi was moved to action. "I felt that as someone who had the privilege of training in psychiatry, I needed to get involved and become active in APAPAC," she said. She was nominated for membership on the APAPAC Board of Directors by APAPAC Board Chair Charles Price, M.D., and was appointed by APA President Maria A. Oquendo, M.D., Ph.D.

For Bazzi, supporting APAPAC is an investment in the future. "If you opt out of participating, that's your one protest—and it's your last chance," she said. "If you join and express your ideas and say what you think, then you become part of a process that is always ongoing, and you become a part of a larger group of fellow psychiatrists working for the same thing."

She urged members to have a conversation with staff representatives of APAPAC and learn how they, too, can support APAPAC.

"APA is a member organization at the end of the day," she said. "I have never met a group as open and willing to change according to what the members want." PN

More information about APAPAC is posted at www.psychiatry.org/psychiatrists/advocacy/apapac. Bazzi invites members to contact her at bazzi.lama@gmail.com.

Psychotherapy

continued from page 16

cal abilities, a waxing in confidence, a lessening of dependence on memories of their own supervisors, and the burgeoning of a supervisory identity.

The third stage, labeled "Role Consolidation," is marked by stable self-reliance, a solid theoretical frame of reference, well-developed clinical skills, a larger capacity for self-reflection, and a deeper appreciation for the dynamics between the supervisee, patient, and supervisor. "I enjoy doing supervision. I like to help my supervisees better understand how to sit with and listen to their patients. I try to help them become more self-aware and reflective and better able to consider how changes in their interventions can make a difference in how their patients respond."

The final stage, "Role Mastery," augurs in an exemplary skillset, a fully integrated professional identity, and a superior level of self-awareness. These are the senior supervisors, those fully committed to lifelong learning, who are most able to apprehend the subtle complexities of a case and communicate its import succinctly and effectively. They are able to help their supervisees flourish and grow.

Understanding this developmental process—and that this growth requires, at the very least, a healthy capacity for self-reflection, proficient psychotherapeutic skills, and actual supervisory practice—may be helpful. For example, new supervisors may be reassured that their anxiety and lack of self-confidence is a shared, common experience. And more advanced supervisors may be inspired toward even higher levels of competence by taking advantage of educational opportunities for supervision. This begs the question: what kind of educational training supports do psychotherapy supervisors need to better develop their supervisory skills and professional identities? And how do those needs vary, depending on one's level, or stage, of supervisory development?

In response to these concerns, an increasing number of academic institutions are addressing the need to help supervisors develop into more effective and competent teachers. For example, through a supervisor evaluation process, supervisees provide valuable feedback about their supervisors' strengths and weaknesses. In addition, many institutions offer a variety of educational opportunities to their supervisory faculty, for example, weekend workshops, small group seminars, semester-long courses, and peer supervision programs. Topics typically covered include supervisory role and responsibilities, models of supervision, the development and maintenance of the supervisory alliance, boundary issues, the dynamics of supervision including parallel process, techniques for providing critical feedback, assessment of supervisees, ethical and legal issues, and diversity issues. Many of these educational endeavors go beyond listening passively to lectures and usually offer a core didactic piece—a research paper, book chapter, PowerPoint, video—followed by group discussion or an activity such as role-playing. Often, an experiential component is included, for example, notes from a supervisory session or full supervision case are presented, with a critique offered by a discussant or master supervisor.

However, there is little empirical research on which of these educational experiences are most helpful to supervisor development. Even less attention has been paid to tailoring an educational experience to a supervisor's particular level of development.

More research would be helpful. Yet it is important to note that the majority of today's psychotherapy supervisors have never received any formal training on how to supervise. Perhaps that's because educational programs for supervisors have been more widely offered only over the last decade. It is hoped that as more innovative educational opportunities become available, more supervisors will take advantage of them. As Watkins' model demonstrates, no matter in what stage a supervisor may be, he or she, along with his or her supervisees and patients, can always progress. Learning how to supervise is a lifelong journey and a continuous education. PN

Match

continued from page 1

the trend toward integrated care and advances in neuroscience have raised psychiatry's profile as the medical profession that treats mind, brain, and body. "This makes our profession attractive to young doctors who want to treat the whole person," he said. "We welcome new trainees to the profession and invite residents to explore membership in APA."

What's Behind the Increase?

In addition to the increasing appeal of the profession, this year's high reflects many factors, including a larger pool of students entering the match. This year's match pool was the largest in the history of the NRMP. A record high 35,969 U.S. and international medical school seniors and graduates vied for 31,757 positions, the most ever offered in the match. The number of available first-year (PGY-1) positions rose to 28,849—989 more than last year.

Psychiatry offered 1,495 first-year positions—111 more than in 2016—and filled all but four. The overall fill rate was 99.7 percent, and 61.7 percent were filled by U.S. seniors. Since 2012, the number of psychiatry positions has increased 378, or 34 percent, and the number of positions filled by U.S. allopathic seniors has increased by 307, according to NRMP.

Also possibly contributing to the increase is a trend in which students are applying to more than one specialty and many more training programs than in the past, a response to the perception of heightened competition. Psychiatry has increasingly become an option for students as a hedge against increased competitiveness in other fields.

Sidney Weissman, M.D., a past president of the American Association of Directors of Psychiatric Residency Training (AADPRT) who has closely followed workforce issues, told *Psychiatric News* that some medical school seniors are applying to scores of programs, many more than did senior physicians who remember applying to a small handful. "All students feel the need to ensure that they match, so they are applying to multiple programs, including specialties they regard as a default—in the same way that applicants for undergraduate colleges have a 'safe school.' " (*Psychiatric News,* February 3).

Commenting on this year's match results, Weissman said he believes the trend is likely to continue into the next decade. "Students recognize reduced training opportunities and heed the advice of medical school deans to apply to more than one specialty," Weissman said. "The average applications for U.S. graduates this year exceeded 40 and for international medical graduates (IMGs), it is over 120. This has placed a great strain on the graduate medical education system's ability to effectively assess every applicant adequately."

Impact of Trump's Executive Order Considered

Another issue that may profoundly affect residency programs is that of immigration and policies adopted by the Trump administration to curb immigration and travel from some countries. Weissman and others with whom *Psychiatric News* spoke agree it is unlikely this year's match was affected by Trump's policies.

But Jacob Sperber, M.D., vice chair for education and training and the psychiatry residency director at Nassau Uni-versity Medical Center, said an issue that does affect training directors and residents alike is when residents from other countries return to their country of origin—for holidays or other reasons—and take the chance of being held up or denied return. In an interview with *Psychiatric News* Sperber said that even prior to the Trump inauguration, some residents have encountered such difficulties, including residents returning from countries not among those listed in the recent revised Executive Order barring immigration from six countries.

Sperber characterized immigration services—including reentry into the U.S. of individuals who hold J-1 visas (the special visas held by many IMG residents)—as a bureaucracy rife with unexplained delays and denials. He said on at least three occasions he has had to write to congressional representatives from New York to help expedite the return of trainees who have been held up on reentry to the United States.

(Sperber chaired a workshop on the issue of immigration at last month's meeting of AADPRT in San Francisco. Coverage of that workshop will appear in a future issue of *Psychiatric News*.)

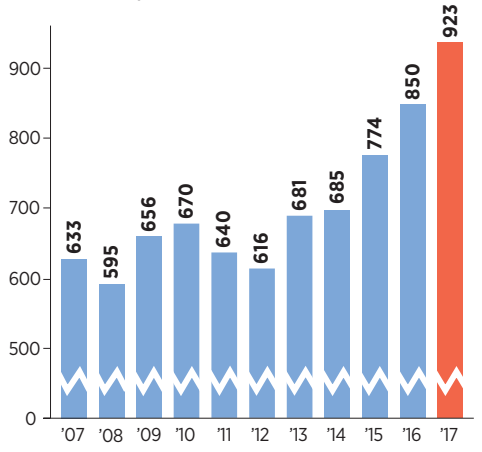
Weissman said the issue could affect the ability of U.S. programs to attract IMGs to psychiatry in the future.

"For over 50 years the United States has relied on IMGs to fill many residency programs and subsequently practice medicine in the United States," Weissman said. "Many IMGs after graduation serve as the major providers of health care in underserved and rural populations. The nation's current political climate as it affects immigrants is of concern. If the United States is seen by many young physicians from around the world as not offering a receptive environment for immigrants they will not wish to immigrate here. U.S. health care at all levels will then suffer from the provision of medical care to research." PN

Information about this year's match is posted at www.nrmp.org.

Psychiatry Match Hits Recent Record High

A total of 923 U.S. senior medical school students matched into psychiatry programs this year, up from 850 last year and from 616 in 2012.



Source: National Resident Matching Program, 2017

Training

continued from page 1

for the support of their broader primary care programs," she told *Psychiatric News*. "It may be that psychiatry residency programs can be the champions for collaborative care, helping general practice settings to be more creative in developing in-depth learning for trainees from all disciplines."

The AADPRT session on CoCM was an extension of the training that APA is providing to psychiatrists and primary care physicians as part of the Transforming Clinical Practice Initiative (TCPI). APA, which was one of just 39 organizations chosen to participate in the initiative, was given a $2.9 million, four-year federal grant from the Centers for Medicare and Medicaid Services to offer online and in-person training on CoCM. The model was developed by the late Wayne Katon, M.D., Jürgen Unützer, M.D., M.P.H., and others at the AIMS (Advancing Integrated Mental Health Solutions) Center at the University of Washington.

Training Builds on Existing Skills

The AADRT program mirrored the APA training, providing an overview of the rationale for collaborative care and the CoCM structure, with special attention to how training directors can adapt the training to teach residents and develop faculty who can pass on CoCM skills.

Hsiang Huang, M.D., says young resident psychiatrists today are receptive to the model of practice that is envisioned in collaborative care.

Ratzliff especially emphasized that training programs do not have to "reinvent the wheel" but can mold what they are already teaching their residents—such as consultation-liaison skills and use of measurement tools, such as PHQ-9—to their application in collaborative care. Central to the role of the psychiatrist in CoCM, for instance, are the "curbside consultation" skills that residents are commonly taught—listening, reflecting on the information provided in a case consult, and making clinical judgments based on that information. "It's a matter of training directors being able to leverage what is already happening in their programs to prepare their trainees for work in a collaborative care model," she said.

Huang said he believes exposure to integrated care early in training is crucial. "I think it is important to have a required integrated care rotation so that all residents graduate with skills in population-based mental health care," he said. "Teaching residents how to use measurement based care, such as using the PHQ-9 for depression management, is a key skill to learn on integrated care rotations, even if a collaborative care experience is not yet in place."

Some training programs have pioneered the introduction of integrated care into their programs, but overall it would appear that as a regular element of residency education, collaborative care is still in its infancy. A February 2105 paper in *Academic Psychiatry* reported the results of a survey of training directors at 52 general psychiatry and 36 child and adolescent programs. The researchers found that many offered integrated care experiences, but few offered these rotations as a regular part of training.

A comprehensive report by APA's Council on Medical Education and Lifelong Learning also was published online

continued on next page

continued from previous page

in *Academic Psychiatry* in February 2015. It offered specific recommendations for undergraduate, graduate, and continuing medical education and perspectives on future directions for interprofessional and interspecialty training. The report noted that new Accreditation Council for Graduate Medical Education "milestones" for psychiatry provide benchmarks that residents are expected to meet by the time they graduate and include those that are uniquely suited for accomplishment in integrated care settings. For example, under the domain of "systems-based practice," the milestones state that "residents should be able to provide integrated care for psychiatric patients through collaboration with other physicians" (*Psychiatric News*, March 6, 2015).

Case Study Shows How to Leverage Resources

In a report in press in *Psychosomatics*, Huang, Marshall Forstein, M.D., and Robert Joseph, M.D., M.S., described the development of an integrated care rotation at the Cambridge Health Alliance (CHA), an accountable care organization located in Massachusetts that comprises three community hospitals and 12 primary clinics. The program had its origin in the late 1980s as a response to the HIV/AIDS epidemic when CHA developed a model in which primary care providers, nurses, social workers, and psychiatrists shared clinical space and worked as a team. CHA was also unique in providing co-located psychiatric consultants at primary care clinics since the 1990s.

In 2013, the program transformed CHA's outpatient C-L component to a formal "integrated care rotation" to offer PGY-3 psychiatry residents a more longitudinal experience of consulting exclusively in primary care clinics. The rotation consists of six months of weekly half-day sessions. In 2014 behavioral care managers were hired, allowing residents to have a case review experience (using a mental health registry) once weekly. In 2015, an integrated care chief resident position for a PGY-4 resident was created.

"Systematic depression screening using the PHQ-9 is part of the workflow across all primary care clinics at CHA," Huang, Forstein, and Joseph wrote. "[P]sychiatry residents have the opportunity to use baseline and longitudinal depression scores to help guide the depression treatment of their patients. Residents who have rotated in primary care often tell us that they bring the practice of measurement-based care to their outpatient psychiatric clinics (where the use of instruments is not routinely done)."

Ratzliff urged department chairs and residency program directors to take advantage of resources available through APA's TCPI grant training and the AIMS Center at the University of Washington.

"We hope educators will see collaborative care as an opportunity and that the AADPRT program is a start to providing training directors creative ways for teaching the psychiatric skills of the future," she said. PN

Information about the TCPI and APA's training is posted at www.psychiatry.org/SAN.

Journal Digest

continued from page 19

iStock/farakos

Similarities in Gene Expression Seen for Chronic Pain and Depression

Chronic pain affects more than 100 million people in the United States, and many of these people have comorbid depression. A study published in *Science Signaling* has now pinpointed molecular changes in the brain that could link these two ailments.

Researchers used a mouse model of pain to monitor gene expression in three areas of the brain: the nucleus accumbens, the medial prefrontal cortex, and the periaqueductal gray. They identified hundreds of genes that significantly changed expression in response to chronic pain in all three regions, including 39 genes that had previously been implicated in depression, anxiety, and/or pain; nine of these genes have been linked with all three conditions.

One gene of interest uncovered was the cytochrome-family gene Cyp2e1; this gene, which is involved in alcohol metabolism and associated with depression, showed reduced expression in all three brain regions.

The researchers also analyzed the gene expression in a mouse model of chronic stress, which mimics human depression. This revealed eight genes that were regulated in a similar manner in response to stress and pain, including another gene, Capn11, that was altered in all three brain regions. PN

Descalzi G, Mitsi V, Purushothaman I, et al. Neuropathic Pain Promotes Adaptive Changes in Gene Expression in Brain Networks Involved in Stress and Depression. *Sci Signal*. March 21, 2017; 10(471). pii: eaaj1549. https://www.ncbi.nlm.nih.gov/pubmed/28325815