VOLUME 54, NUMBER 13, JULY 5, 2019

AMERICAN PSYCHIATRIC ASSOCIATION

PSYCHIATRIC NEWS

PSYCHNEWS.ORG

ISSN 0033-2704

Ted Grudzinski

SEE STORY BELOW

Patrice Harris, M.D., M.A., a long-time APA member who has been active at both the local and national levels of APA, is sworn in as the 174th president of the AMA by Jack Resneck, M.D., chair of the AMA Board of Trustees.

3

MH parity among topics discussed at Hill visit by APA president.

4

Psychiatrist tapped to serve on AMA's ethics council.

8

What can psychiatrists learn from historical diagnoses?

Psychiatrist Patrice Harris, M.D., M.A., Inaugurated 174th AMA President

The inauguration was the highlight of a meeting that also included a crucial victory for the APA delegation—approval of a resolution urging AMA to advocate for aligning the regulations that govern privacy of substance use treatment with HIPAA. ***BY MARK MORAN***

"We are no longer at a place where those with mental illness and addiction are hidden and ignored, but we are not yet at a place where mental disorders are viewed without stigma and truly integrated into health care," said long-time APA member Patrice Harris, M.D., M.A., in an address last month after her inauguration as the AMA's 174th president.

Harris, a former member of the APA Board of Trustees and chair of the AMA's board, was sworn in during a ceremony at the AMA's House of Delegates meeting in Chicago. Administering the oath of office was Jack Resneck, M.D., chair of the AMA Board of Trustees. She was elected last year by the House of Delegates.

Her inauguration in June marks a new milestone in the growing strength of psychiatry and the APA delegation within the House of Delegates. At the same meeting, Rebecca Brendel, M.D., J.D., director of the master's degree program at the Harvard Medical School Center for Bioethics, was appointed to the AMA's powerful Council on Ethical and Judicial Affairs. And Laura Halpin, M.D., Ph.D., a child psychiatry fellow at the University of California, Los Angeles, was elected by the House to the Council on Science and Public Health (see story on page 4).

APA CEO and Medical Director Saul Levin, M.D., M.P.A., said Harris's ascent through the ranks of the AMA to the presidency is an example of why involvement in organized medicine is important and what it can accomplish for physicians and patients. "We are honored and delighted to have a psychiatrist and long-time APA member leading the house of medicine as president of the AMA. Her work over the years at APA and the AMA will add value to her new role as the face of the AMA."

Last month's meeting was also the occasion of a crucial victory for the APA delegation: The House of Delegates overwhelmingly approved a resolution, sponsored by the Section Council on Psychiatry and endorsed by a broad coalition of physicians, calling for the alignment of regulations governing the privacy of records pertaining to substance use disorders—42 CFR Part 2—with the Health Insurance Portability and Accountability Act (HIPAA).

The 42 CFR Part 2 regulations were first passed in the 1970s to protect medical confidentiality, but the regulations are an impediment to coordination of care when physicians are unable to access records about a patient's history of treatment for substance use disorders. (Further coverage of this and other business at the AMA will appear in the next issue of *Psychiatric News*.)

Harris, who is the first African

see **Harris** *on page 4*

PERIODICALS: TIME SENSITIVE MATERIALS

PSYCHIATRIC NEWS

Psychiatric News, ISSN 0033-2704, is published biweekly on the first and third Friday of each month by the American Psychiatric Association. Periodicals postage paid in Washington, D.C., and additional mailing offices. Postmaster: send address changes to Psychiatric News, APA, Suite 900, 800 Maine Avenue, S.W., Washington, D.C. 20024. Online version: ISSN 1559-1255.

SUBSCRIPTIONS
U.S.: individual, $158. International: APA member, $214; nonmember, $237. Single issues: U.S., $27; international, $47. Institutional subscriptions are tier priced. For site licensing and pricing information, call (800) 368-5777 or email institutions@psych.org.

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AMERICAN PSYCHIATRIC ASSOCIATION

APA, Coalition Lobby Lawmakers on MH Parity, Drug Treatment Records

Physicians met with key lawmakers last month to urge passage of a new mental health parity law and discuss amendments to rules governing addiction treatment records and more funding for gun safety research. ***BY LINDA M. RICHMOND***

Craig Obey

APA President Bruce Schwartz, M.D. (right), talks with Sen. Patty Murray (D-Wash.) last month on Capitol Hill. The Hill visit was a joint effort by America's Frontline Physicians: The Group of Six, which represents more than 560,000 members. With them are (from left) Douglas DeLong, M.D., of the American College of Physicians and Gary LeRoy, M.D., of the American Academy of Family Physicians.

Leaders from America's Frontline Physicians: The Group of Six, of which APA is a member, flew into Washington, D.C., last month to meet with half a dozen lawmakers on Capitol Hill on behalf of its 560,000 physician and medical student members.

During his first visit to the Hill as APA president, Bruce Schwartz, M.D., spoke with lawmakers about the importance of passing the Mental Health Parity Compliance Act (see box on page 18); he also met with the staff of Sen. Bill Cassidy (R-La.) to thank them for their help in securing the bill's introduction.

Other pressing health issues raised by the Group of Six included amending rules governing addiction treatment records, combating vaccine misinformation and rising drug prices, and funding public health research on gun safety. "Politicians on both sides of the aisle were extremely receptive to our concerns about 42 CFR Part 2, the need for parity enforcement, and funding for research on gun violence," Schwartz said, summing up the day.

see **Group of Six** *on page 18*

IN THIS ISSUE

5

12

18

5 | HHS Changes HIPAA Violation Penalties
The annual maximum penalties were previously capped at $1.5 million for every tier of violation. Now the annual limit is different for each tier of violation.

12 | Can Smartwatch App Help Reduce Nightmares?
The app monitors the heart rate and movement of people wearing the smartwatch as they sleep and rouses them with a mild vibration if a nightmare is detected.

16 | Guideline on Opioids Has Been Misapplied, Experts Caution
The authors of a CDC guideline on prescribing opioids for chronic pain describe how the misapplication of the guideline can have harmful effects on patients.

18 | Medications Can Reduce Symptoms of Cannabis Withdrawal
Medications can reduce irritability, anxiety, and sleep problems in patients going through withdrawal, but there is little evidence that easing withdrawal promotes abstinence.

DEPARTMENTS

6 | PSYCHIATRY & INTEGRATED CARE
15 | CLIMATE CHANGE & MENTAL HEALTH
19 | MED CHECK
20 | JOURNAL DIGEST

Coverage of APA's 2019 Annual Meeting and the Association's 175th anniversary continues in this issue. If you weren't able to attend or missed a session on your itinerary, check out Annual Meeting on Demand at http://apa.ondemand.org.

Psychiatrist Appointed to Powerful AMA Ethics Council

Rebecca Brendel, M.D., J.D., will serve on a council that occupies a special place within the AMA and all of medicine. Its opinions and policies are used around the world in ethical decision-making and public policy. **BY MARK MORAN**

Psychiatrist and ethicist Rebecca Brendel, M.D., J.D., was appointed to the AMA's important Council on Ethical and Judicial Affairs (CEJA) during last month's meeting of the AMA House of Delegates in Chicago.

Brendel was appointed by incoming AMA President and psychiatrist Patrice Harris, M.D., M.A. Brendel is director of the master's degree program at the Harvard Medical School Center for Bioethics and chair of the APA Committee on Ethics.

(Also at the meeting last month, Laura Halpin, M.D., Ph.D., a child psychiatry fellow at the University of California, Los Angeles, was elected by the House to the AMA's Council on Science and Public Health.)

CEJA occupies a special place within the AMA's governance and in all of medicine; it is the body that maintains and updates the AMA's 165-year-old Code of Medical Ethics. CEJA's opinions and policies are used not only around the country but also the world in ethical decision-making, medical licensing board determinations, and public policy. APA's code of ethics is modeled on the AMA code with "annotations especially applicable to psychiatry."

At last month's meeting, the House of Delegates approved a CEJA report on physician-assisted suicide. (Further coverage of the report and other business at the AMA meeting will be published in the next issue of *Psychiatric News*.)

Psychiatrist Jeremy Lazarus, M.D., who was appointed to the council last year and is a former AMA president, told *Psychiatric News*, "The council is one of the chief pillars of the AMA and has been since the organization was first formed in 1847. The development of an ethical code of conduct is one of the keys, along with education, to what makes medicine a self-regulating profession."

The council is an independent body, not part of the AMA's political process; its members are appointed by the AMA president and approved by the House of Delegates. CEJA members cannot be voting members of the House, but they can speak for the council on the House floor.

"As a delegate to this House, I have seen and experienced the ability of our great profession to overcome deep personal and political differences to advocate for the advancement of medicine, the well-being of our patients, and the promotion of public health more broadly," Brendel said in an acceptance speech on the floor of the House of Delegates. "Our ethics are the backbone of our professional integrity, and, at this critical time of unprecedented advances and diversity in biomedicine and society, our AMA must navigate a course forward that is both faithful to the core values of medicine and inclusive of progress and possibility.

"As a member of CEJA, I promise to bring a prepared and open mind, ready to advance the work of the council in providing thoughtful guidance to our AMA. I look forward to working with fellow CEJA members and AMA staff on important ethical issues before the field of medicine today toward an even better tomorrow."

Psychiatrist James Sabin, M.D., outgoing chair of CEJA, is a longtime friend

see **Brendel** *on page 21*

Carlos Cardona

Top: Psychiatrist and ethicist Rebecca Brendel, M.D., J.D., has spoken at APA and other meetings about confidentiality, patient autonomy, and the role of psychiatrists in assessing competency in patients requesting physician-assisted death. **Right:** Psychiatrist Laura Halpin, M.D., Ph.D., will bring a research background in the neurobiology of addiction to her work on the Council on Science and Public Health.

Harris

continued from page 1

American woman president of the AMA, said during her address that diversity and inclusion are critical to closing the gap in health disparities and that her presidency will focus on health equity and increasing the diversity of the physician workforce.

"We face big challenges in health care today, and the decisions we make now will move us forward in a future we help create," she said. "We are no longer at a place where we can tolerate the disparities that plague communities of color, women, and the LGBTQ community. But we are not yet at a place where health equity is achieved in those communities."

Harris also vowed to elevate mental health as a part of overall health and to increase the understanding of the impact of childhood trauma on health. "From my work with patients who've been abused, neglected, diagnosed with a mental illness, subject to childhood trauma, who are homeless or unemployed, I have learned that often-overlooked health determinants have an effect on one's health over a lifetime," she said.

During her presidential year, Harris will continue to chair the AMA's Task Force to Reduce Opioid Abuse, which she has chaired since its inception in 2014.

Harris served as director of health services in Fulton County, Ga., and head of the Fulton County Department of Behavioral Health and Developmental Disabilities. As chief health officer for Fulton County, she spearheaded efforts to integrate public health, behavioral health, and primary care.

First elected to the AMA Board of Trustees in 2011, she has held the executive offices of AMA board secretary and AMA board chair. In addition to her leadership of the opioid task force, Harris has been active on AMA task forces and committees dealing with such issues as health information technology, payment and delivery reform, and private contracting.

continued on facing page

At the AMA House of Delegates (from left): Rebecca Brendel, M.D., J.D., newly appointed to the AMA's Council on Ethical and Judicial Affairs; newly inaugurated AMA President Patrice Harris, M.D., M.A.; APA CEO and Medical Director Saul Levin, M.D., M.P.A.; and Kristin Kroeger, APA chief of Policy, Programs, and Partnerships.

HHS Adjusts Penalties for HIPAA Violations

New annual limits reflect the level of culpability when violations occur and whether corrective action was taken.

BY TERRI D'ARRIGO

The Department of Health and Human Services (HHS) has changed the annual maximum penalties for violating the Health Insurance Portability and Accountability Act (HIPAA). The annual maximum penalties were previously capped at $1.5 million for every tier of violation. Now the annual limit is different for each tier, with only violators who demonstrate willful neglect and failure to correct violations facing a potential $1.5 million annual penalty (see table). The new penalties went into effect in April.

In a notice published in the April 30 *Federal Register*, HHS cited "inconsistent language" in the Health Information Technology for Economic and Clinical Health (HITECH) Act, which established the tiers in 2009, as the impetus for the changes.

"Upon further review of the statute by the HHS Office of the General Counsel, HHS has determined that the better reading of the HITECH Act is to apply [the new] annual limits," Roger Severino, director of the HHS Office for Civil Rights, wrote. "HHS expects to engage in future rulemaking to revise the penalty tiers in the current regulation to better reflect the text of the HITECH Act."

The tiers are defined as follows:

- **Tier 1:** The person did not know and, by exercising reasonable diligence, would not have known that the person violated the provision.
- **Tier 2:** The violation was due to reasonable cause and not willful neglect.
- **Tier 3:** The violation was due to willful neglect that was corrected in a timely manner.
- **Tier 4:** The violation was due to willful neglect that was not corrected in a timely manner.

APA offers HIPAA guides for members, including "APA's HIPAA Privacy Rule Manual: A Guide for Your Psychiatric Practice" and "APA HIPAA Security Rule Manual." They are posted at https://www.psychiatry.org/psychiatrists/practice/practice-management/hipaa. **PN**

Robert K. Chin/Alamy

New Penalty Tiers Under Notification of Enforcement Discretion

	Minimum Penalty/ Violation	Maximum Penalty/ Violation	Annual Limit
Tier 1: No Knowledge	$100	$50,000	$25,000
Tier 2: Reasonable Cause	$1,000	$50,000	$100,000
Tier 3: Willful Neglect—Corrected	$10,000	$50,000	$250,000
Tier 4: Willful Neglect—Not Corrected	$50,000	$50,000	$1,500,000

Source: Department of Health and Human Services

"Notification of Enforcement Discretion Regarding HIPAA Civil Money Penalties" is posted at https://s3.amazonaws.com/public-inspection.federalregister.gov/2019-08530.pdf.

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She also chaired the AMA Council on Legislation and co-chaired the Women Physicians Congress.

She served as trustee-at-large on the APA Board of Trustees from 2001 to 2004. In addition, she was president of the Georgia Psychiatric Physicians Association and founding president of the Georgia Psychiatry Political Action Committee.

Harris succeeds Barbara McAneny, M.D., as president. At the inauguration, McAneny said the AMA would be "in good hands" with Harris.

"We met as delegates of this House over scope-of-practice issues, bonded together over a mutual concern for the health of poor people, and collaborated to make sure that the policies we wrote were respectful of the needs of all," McAneny said. "Patrice has managed a health care department in a large diverse city, run a private practice of child psychiatry, and served on many boards and commissions. … As chair of the Task Force to Reduce Opioid Abuse, Patrice has changed the way the country looks at the role of physicians, from recipients of blame to agents of change. And she has used her position to prove the AMA is more inclusive than ever before and has broken through another glass ceiling.

"She is truly a steel magnolia, and people best not forget it," McAneny said.

Ken Certa, M.D., a member of the Section Council on Psychiatry and Harris's campaign manager during her presidential campaign (and several other elections) noted that it was then APA President Daniel Borenstein, M.D., who appointed Harris to the section council in 2000.

"Twenty years ago, our AMA made a decision that enabled specialty societies, like APA, to add delegates proportionate to size," Certa told *Psychiatric News*. "When deciding how to increase the delegation, our APA president wisely chose a smart, hard-working, personable, and already accomplished young woman from Atlanta. It was an inspired choice."

(Borenstein also appointed Certa and several others.)

"Patrice had already been a rock star in psychiatry, having served in the Georgia district branch and on the APA Board as a young physician member," Certa said. "Her transition to AMA was seamless. She has predictably been a tireless advocate for American medicine, which of course means our specialty of psychiatry.

"Several years ago, I was given the easiest job on earth, to serve as campaign manager for Patrice as she sought to join the AMA Board of Trustees," Certa said. "She was such an obvious choice. … I could not imagine a reason not to vote for her." **PN**

Experts Describe Community Approaches To Reducing Gun Violence

Speakers touched on the positive impact of urban revitalization projects but also discussed some cautionary outcomes related to mental illness on college campuses. **BY NICK ZAGORSKI**

David Hathcox

Stephan Carlson, M.D., discusses how community remediation strategies like cleaning up vacant lots and abandoned buildings offer an easily implementable and cost-effective approach to reducing gun violence.

At an APA Annual Meeting session on the public health impact of gun violence on America's youth and young adults, presenters shared recent developments that are both positive and negative. The session was sponsored by the American Society for Adolescent Psychiatry.

On the plus side, session chair Stephan Carlson, M.D., an assistant professor of psychiatry at New York Medical College, highlighted a pair of ideas that are helping at-risk urban communities proactively address the problem of gun violence among youth.

The first approach Carlson discussed is urban remediation, which involves using inexpensive methods to renovate unused city lots, abandoned buildings, and other blighted neighborhood areas. Residents in these communities frequently note that gangs tend to congregate in these vacant, abandoned sites. "For residents who live around the vacant areas, that means spending less time outside, less time socializing with neighbors, and less time being a community," he said.

The renovations may seem like minor cosmetic adjustments, but many studies published over the past couple of years from communities across the United States have found that urban-remediation efforts can both reduce gun violence and other crimes like vandalism and increase time that residents spend outdoors.

The second strategy, known nationally as Cure Violence, borrows from principles of infectious disease control to prevent and respond to violence. The program focuses on detecting problems early, identifying individuals at high risk, and changing social norms to reduce future outbreaks.

For example, community residents with some forensic background are trained to serve as violence disruptors who can help deescalate tense situations before any guns are drawn. If gun violence does occur, the disruptors and other personnel work to get the community aware and involved positively through, for example, neighborhood meetings to discuss the incident and identify solutions to prevent a repeat event.

As with urban remediation, Cure Violence has shown meaningful results in numerous communities. One case example is the Brooklyn neighborhood of Brownsville. In addition to training violence disruptors and holding neighborhood meetings, the Brooklyn program offered access to mental health services for individuals at risk of violence as well as those who had witnessed a violent encounter.

Carlson noted that after implementation of the project, homicides dropped by 18% between 2010 and 2013 in Brownsville. In comparison, the nearby Brooklyn neighborhood of Flatbush, which had not implemented a Cure Violence program, experienced a 69% increase

see **Gun Violence** *on page 19*

PSYCHIATRY & INTEGRATED CARE

Wider Implementation of Collaborative Care Is Inevitable

CAROL ALTER, M.D., ANDREW CARLO, M.D., HENRY HARBIN, AND MICHAEL SCHOENBAUM, PH.D.

This month's column, written by some of the nation's experts in mental health policy and payment, summarizes recent information on billing codes and other factors affecting the implementation of evidence-based collaborative care programs.
—Jürgen Unützer, M.D., M.P.H.

The Collaborative Care Model (CoCM), an approach to integrating behavioral health care and primary care, has been tested and found to be effective in more than 80 randomized, controlled trials—many more than any other behavioral health care integration approach (and indeed more than most interventions across all of medicine). In 2017, the Centers for Medicare and Medicaid Services (CMS) released new billing codes for CoCM under Medicare, providing an unprecedented reimbursement opportunity for practices nationwide. Since then, most national, commercial health plans and several state Medicaid programs also have added CoCM payment and coverage.

Similar to Medicare's 2015-initated codes for chronic care management, evidence of CoCM billing–code uptake has been slow to accumulate, largely due to the need to change staffing (including hiring a care coordinator and a psychiatric consultant), clinical workflows (including proactive tracking of patient outcomes via a patient registry and treatment adjustment informed by case consultation), and billing practices. This slow uptake and awareness of the steps needed for implementation have led to concerns that CoCM may not be widely adopted—or even be widely adoptable.

In our view, such conclusions would be premature for several reasons. First, U.S. health care is generally quicker to adopt discrete technological innovations, especially those involving commercial intellectual property (for example, new pharmaceutical products), than care processes like CoCM, partly explaining the slow uptake. Second, some of the systems nationwide that implemented CoCM before codes were available have continued to furnish CoCM without necessarily using or needing the new codes. Third, as public and private payers move increasingly toward value-based purchasing, there is a growing recognition that inadequate treatment of behavioral health conditions is a major driver of medical spending in both publicly and commercially insured populations. Consequently, programs such as the Medicare Shared Savings Program and Comprehensive Primary Care Plus (CPC+) require attention to behavioral health care delivery for clinical as well as economic reasons. (The CPC+ guidelines recognize CoCM as a best practice for clinical integration of behavioral health care.)

Importantly, CoCM remains the only specific behavioral health integration approach shown to improve patient outcomes. Another potential driver for CoCM adoption has been expanding requirements to use measurement-based care for patients with behavioral condi-

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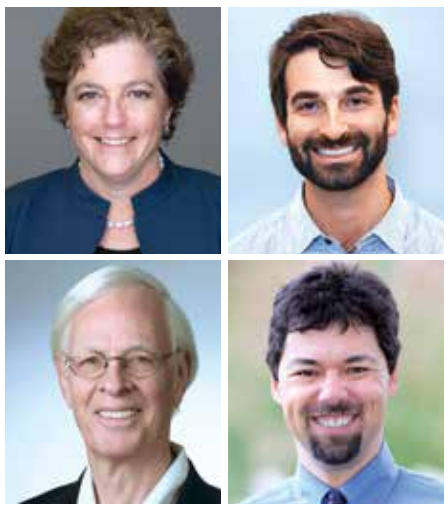


Carol Alter, M.D., is a health care consultant, an associate clinical professor in the Department of Psychiatry at Georgetown University, and former chief medical officer at Mindoula Health based in Silver Spring, Md. Andrew Carlo, M.D., is a second-year fellow at the University of Washington's Geriatric Mental Health Services Research Fellowship. Henry Harbin is a health care consultant and former CEO of Magellan Health, based in Scottsdale, Ariz. Michael Schoenbaum, Ph.D., is a senior advisor for mental health service, epidemiology and economics at the National Institute of Mental Health. Jürgen Unützer, M.D., M.P.H. (not pictured), is a professor and chair of psychiatry and behavioral sciences at the University of Washington and founder of the AIMS Center, dedicated to "advancing integrated mental health solutions."

Gender Bias, Discrimination Common in Academic Psychiatry

Despite comprising half of the residency positions for the past 20 years, only about 10% of chairs and 29% of full professors are women. **BY LINDA M. RICHMOND**

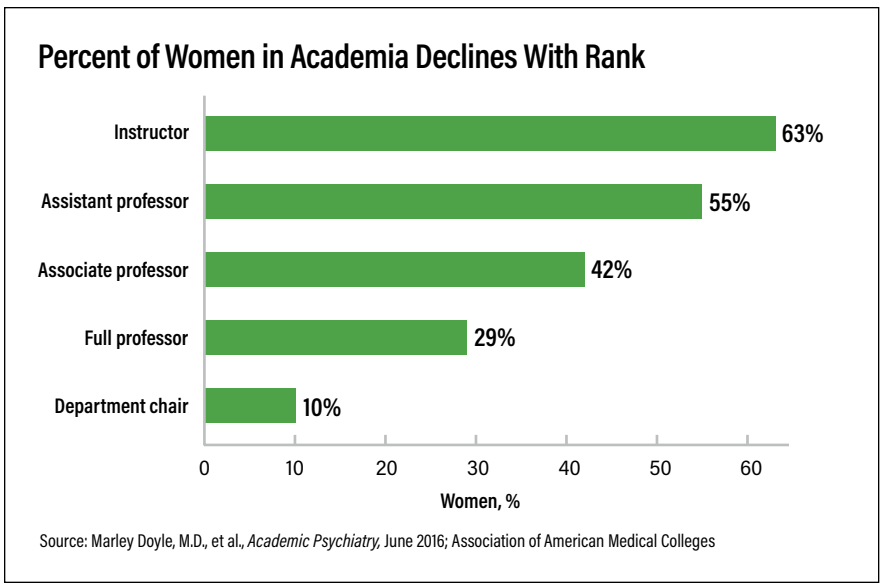
Women in the United States have made much progress in medicine since 1849, when the first woman obtained a medical degree. But 170 years later, a wide gender gap persists in compensation, advancement, and research funding, according to presenters at an APA Annual Meeting session on gender bias in academic medicine.

Admissions of women to medical schools have more than doubled since the passage of Title IX of the Education Amendments of 1972, which prevents federally funded, higher-learning institutions from discriminating on the basis of gender. In fact, women made up 53% of medical school admissions in 2017 and have accounted for roughly half of residents in psychiatry for the past 20 years.

Despite the strong representation of women psychiatrists in residency training and early career positions, women faculty in tenured or executive leadership positions have not experienced similar gains, said speaker Latoya Frolov, M.D., M.P.H., a fourth-year psychiatry resident at the University of California, San Francisco (UCSF).

"Based on generational changes, seniority, and the number of women in psychiatry, we would expect about one-third of psychiatry department chairs to be women," Kristen Berendzen, M.D., Ph.D., a fourth-year psychiatry resident at UCSF, told attendees. However, just 10% of psychiatry department chairs are women, and only about 30% of full professors in psychiatry are women (see chart).

Unequal pay is another inequity that women physician faculty including psychiatrists encounter. A 2016 *JAMA Internal Medicine* study of more than 10,000 physician faculty salaries found that women physicians were on average paid $20,000 less a year, even after researchers adjusted for a variety of other factors, including years since residency completion, faculty rank, specialty, and indicators of productivity such as clinical hours worked. A salary survey of 65,000 full-time physicians by Doximity found that in 2017 women earned $105,000 less on average, even after adjusting for hours worked, geographic location, provider specialty, and years in practice.



Source: Marley Doyle, M.D., et al., *Academic Psychiatry,* June 2016; Association of American Medical Colleges

Berendzen also cited various studies revealing a gender gap in research funding. For example, a 2012 study found that fewer than one-third of research grants go to women, and the average size of grants awarded to men surpasses those awarded to women.

Among medical students, women face gender bias in their performance evaluations. Berendzen pointed to a study of nearly 90,000 clerkship evaluations from core clinical rotations at two medical schools. Published in May in the *Journal of General Internal Medicine*, the findings revealed gender-based differences in the language used to evaluate the students, even among students who received the same grade. Evaluations of women students were more likely to include descriptors of personality traits such as "lovely," while evaluations of male students tended to focus on competency-related attributes such as "scientific" and "knowledgeable."

Women also continue to experience sexual harassment and discrimination, said Berendzen. A 2018 study in the *Journal of General Internal Medicine* found that as many as two-thirds of academic women researchers surveyed said they had experienced gender bias or sexual harassment with negative effects on their confidence and career advancement.

"More women than ever are entering medicine, but at all levels of training and practice, they continue to experience harassment and discrimination," Berendzen said. "The #MeToo and #TimesUP movements have created a platform to challenge inappropriate gender-related treatment in the workplace."

Another significant issue that women in medicine continue to face is a lack of family-friendly policies in training programs and at work, Berendzen said. "Family-leave policies are not standardized across institutions, and they are discretionary, meaning they are allowed only at the discretion of management or the institution."

Women in psychiatry also cited the absence of mentorships and role models—obstacles reported by women in other areas of medicine as well.

In the spirit of problem-solving, audience members broke into small groups to brainstorm solutions to these issues. They came up with the following ideas:

- **Adopt family-friendly policies.** Policies such as allowing part-time

see **Gender Bias** *on page 11*

continued from facing page

tions. The Joint Commission now requires accredited behavioral health programs to use validated rating tools to track patient outcomes. In response, health systems accredited by The Joint Commission are beginning to implement measurement-based care and CoCM in particular.

Additionally, major employers have started demanding that CoCM be included in their health insurance benefits. In 2018 the National Alliance of Healthcare Purchaser Coalitions, which represents over 12,000 employers and 40 million covered lives, recommended that health plans "turn on and promote all four [current procedural terminology] collaborative care codes with no associated copays and to review their plans for promoting, providing technical assistance, and training to bill for collaborative care codes."

While interest in providing and billing for CoCM has increased, those who have been tasked with implementing CoCM have encountered a number of challenges. One of the authors of this article—Andrew Carlo, M.D.—and colleagues at the University of Washington recently conducted a qualitative investigation of early adopters of the CoCM billing codes. Some of the issues specific to CoCM included documentation requirements and connecting registry information to the medical record. Despite these expected, early stage implementation challenges, health care professionals and health systems have been satisfied with CoCM service overall, especially the ability to more effectively manage behavioral disorders in primary care.

In addition, CoCM programs have been creative about identifying other sources of funding to pay for start-up costs (for example, local and institutional grants). A CMS grant awarded to APA is supporting the training of thousands of clinicians in CoCM psychiatric consultation.

Several companies now offer CoCM implementation support, including assistance with staffing, workflow design, documentation, and billing. Three organizations providing these services report that they are working with hundreds of primary care practices and that demand is high for implementation of the model in health systems and practices of all sizes. Other models of behavioral health integration, particularly those focused on co-locating behavioral health clinicians in primary care practices, emphasize ease of implementation and provider satisfaction. So far, these do not have—but also may not require—specific billing codes.

The evidence supporting the clinical and economic impacts of CoCM remains compelling. As health systems assess their population health strategies, they are increasingly recognizing that behavioral health must be addressed in more than just specialty settings. New billing codes for CoCM provide an unprecedented opportunity to financially sustain evidence-based behavioral health integration. Many health systems and practices are delivering the service and are beginning to receive reimbursement. Organizations such as APA, the AIMS Center, and other private entities can play important roles in the implementation of the necessary clinical, operational, and economic components of this highly effective clinical service. **PN**

APA has compiled an interim list of payers that have either indicated they have approved coverage for psychiatric collaborative care management (CoCM) codes (CPT codes 99492-99494), or for whom APA has confirmation that a claim has been paid. Because the list is dynamic, it is important to confirm coverage on a payer-by-payer basis. The list can be accessed at https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/Professional-Topics/Integrated-Care/CoCM-Payers-June-2019.pdf.

The Lincolns: Retrospective Diagnosing Raises Questions Worth Pondering

The case of Mary Todd Lincoln's involuntary hospitalization especially highlights the difficulty of retrospective diagnosis, say two psychiatrist-historians.

BY MARK MORAN

This Currier & Ives lithograph depicts President Abraham and Mary Todd Lincoln and their sons Robert (second from left) and Thomas.

Studying the putative psychiatric symptoms of Abraham Lincoln; his wife, Mary Todd Lincoln; and that of other historical figures raises fascinating and important questions about the nature of psychiatric diagnosis, how those diagnoses are viewed through various cultural lenses, and how they may change over time.

So said psychiatrists David Casey, M.D., and his son Brian Casey, M.D., both of the University of Louisville, at the APA 2019 Annual Meeting session "The Melancholy of the Lincolns: What We Can Learn About Psychiatric Diagnosis Through the Cases of the President and His Wife."

"The historical record may be incomplete or distorted, and the reporters may be biased," said Brian Casey. "Manifestations of psychiatric disorders may change over time as cultures evolve—a concept that speaks to the culture-bound nature of syndromes." And there is the problem of "reification," which refers to the tendency to look for the familiar and attempt to fit an historical case into a contemporary paradigm.

Given the problems with retrospective diagnosis, David Casey suggested that the contemporary historian/clinician can render only the most tentative judgments. "I propose that only a general, syndromal diagnosis is usually supportable," he said.

The father-son psychiatrists, both avid students of history, outlined the life stories of the Lincolns and what is known—or assumed—about their psychiatric symptoms. (David Casey is president of the Innominate Society of Louisville, a medical history society.)

Lincoln experienced a harsh childhood on the American frontier with a father who was physically abusive and disavowed his son's scholarly ambitions. Lincoln suffered several traumas including the death of his mother and a beloved sister. He is believed to have experienced at least two prolonged periods of depressive symptoms—one after the loss of his sister and a second after breaking off his first engagement to Mary Todd.

He and Mary Todd Lincoln suffered the loss of a son, Edward, before he became president; and while they were in the White House—when Lincoln was presiding over a bloody civil war and the most tumultuous period in American history—they lost a second son, Willie. After her husband's assassination, Mary Todd Lincoln suffered the loss of a third son, Thomas.

The case of Mary Todd Lincoln, who was involuntarily committed to an Illinois psychiatric hospital after the assassination, continues to attract controversy. She had long been a flamboyant character, and she exhibited delusional and suicidal behaviors, especially following the assassination. She has been retroactively diagnosed by some with bipolar disorder.

Independent of her symptoms, she was a controversial figure. The president's wife was the daughter of a wealthy slaveholder, and she hosted the widow of a Confederate officer in the White House—for which she was widely condemned both in Washington, D.C., and throughout the North. Moreover, she had enemies in Congress who investigated her for spending lavishly on redecorating the White Hose. After Willie's death, Mary held seances in the White House, inviting public ridicule.

Mary was committed to Bellevue Place in Illinois in 1875 by her son Robert with the help of several doctors who testified to her insanity. She was released four months later to the care of her sister Elizabeth.

Brian Casey said Mary Todd Lincoln's case also has been viewed through the prisms of feminism and anti-psychiatry. More generally, her case raises the question: Can we really apply modern diagnostic constructs to historical figures?

"Our diagnostic ideas also evolve over time," he said. "Applying *DSM-1, -2, -3, -4,* or -5 criteria may yield different opinions as to whether Mary Todd Lincoln did or did not have bipolar disorder, and Emil Kraepelin's concept of manic-depression came long after Lincoln's death. Recent publications and depictions of Mary reveal as much about the authors as the subject—including the application of modern views on psychiatry." **PN**

APA Raises $15,000 for Victim Assistance Project

David Hathcox

As part of the annual APA Gives Back program, APA President Altha Stewart, M.D. (left), presented a donation of $15,000 to this year's recipient, the Young Women's Freedom Center, at the Opening Session of APA's 2019 Annual Meeting. Executive Director Jessica Nowlan accepted the check on behalf of the center.

Now in its 10th year, the APA Gives Back program provides an opportunity for APA, its members, and Annual Meeting attendees to support a community mental health organization in the city hosting the Annual Meeting. APA matches donations dollar for dollar. Since 2010, APA, members, and attendees have donated $170,000 through the program.

For 25 years the Young Women's Freedom Center has been providing support, advocacy, and opportunities for healing for women and girls of color who are impacted by poverty or who were formerly incarcerated. The center provides economic opportunities coupled with progressive leadership development through internships, employment, and engagement in advocacy and organizing work. They are working to build a movement of formerly incarcerated or marginalized young women to lead local campaigns and statewide policy initiatives and to advocate for all women and girls. Jessica Nowlan entered the organization seeking help for her own needs 20 years ago, and today she serves as the organization's leader.

The Young Women's Freedom Center has offices in San Francisco, Oakland, and San Jose, Calif.

"We are pleased to be able to show our support for the important work of the Young Women's Freedom Center to support young women of color and transform the systems that keep them stuck in cycles of poverty, violence, and incarceration," Stewart said. "The organization strives to address social determinants of health and mental health and demonstrates a passion for improving the lives of all women, especially those trapped in systems that are not designed to meet their often-complex needs."

More information about the Young Women's Freedom Center is posted at https://www.youngwomenfree.org/.

MH Care of American Indian, Alaskan Native, and Native Hawaiian Population Has Long History, Uncertain Future

Psychiatry's emphasis on the connection between physician and patient dovetail well with the culture and history of indigenous peoples. This article is part of a yearlong series marking APA's 175th anniversary. **BY AARON LEVIN**

Traditional treatments for illnesses of all kinds were part of the cultural milieu of American Indians, Native Alaskans, and Native Hawaiians for millennia before the arrival of Europeans, said Roger Dale Walker, M.D., a professor of psychiatry at Oregon Health and Science University School of Medicine, at a session that was part of APA's 175th anniversary history track at the 2019 Annual Meeting in May.

The early colonists recorded the extensive knowledge that Native Americans had of the medicinal uses of plants, roots, and barks, said Walker, who is of Cherokee origin. He showed a drawing published in a book in 1588 of an Indian village with a garden devoted to growing medicinal plants. Their medicine was a science founded on long-time observation and experience and positive outcomes.

During the 19th century, some indigenous people adopted—on a small scale—the era's reigning asylum model. King Kamehameha V founded the O'ahu Insane Asylum in 1866, an institution run by Native Hawaiians that existed until 1930. The Cherokee National Council established the Cherokee Home for the Insane, Deaf, Dumb, and Blind, which opened in 1877 in what is today Oklahoma. In 1898, a U.S. senator from South Dakota successfully obtained federal funding to establish the Hiawatha Asylum for Insane Indians, which operated in Canton, S.D., from 1902 to 1934. The Morningside Hospital in Portland, Ore., held a contract to care for Alaska Natives with mental illness from 1904 to 1968.

While several American Indians became physicians in the late 1800s, indigenous psychiatrists are a 20th-century phenomenon. Herbert Fowler, M.D. (1919-1977), was the first Native American to complete a residency in psychiatry, said Walker. Fowler, who was one-quarter Sioux Indian, established the first mental health clinic on an Indian reservation in 1958 on the Ute Reservation in Utah and served as director of that clinic for six years. He was also the grandson of Charles Eastman, one of the earliest Native American physicians.

Daniel Dickerson, D.O., M.P.H., now an associate research psychiatrist at the University of California, Los Angeles, was the first Alaska Native psychiatrist. Naleen Andrade, M.D., a professor and former chair of psychiatry at the University of Hawai'i John A. Burns School of Medicine, was the first Native Hawaiian woman to become a psychiatrist. H. C. Townsley, M.D. (Creek), became the first American native director of mental health programs at the Indian Health Service in 1976.

David Hathcox

Roger Dale Walker, M.D., who is of Cherokee origin, notes that early American colonists recorded Native Americans' medicinal use of plants, roots, and barks.

Johanna Clevenger, M.D. (Navajo), was the first chair of APA's Committee of American Indian, Alaskan Native, and Native Hawaiian Psychiatrists and the first Native American woman president of the Association of American Indian Physicians, a post she held twice—in 1982 and 1992. James Thompson, M.D. (Delaware), served as APA deputy medical director and director of APA's Division of Education, Minority, and National Programs from 1998 to 2002. Thompson restructured that office and expanded recruitment programs for minority medical students.

"We must acknowledge the contributions and sacrifices of those who came before us," said panelist Mary Hasbah Roessel, M.D. (Navajo), of Santa Fe, N.M.

Her choice to become a psychiatrist came in part as a result of her family's acquaintance with the psychiatrist Karl Menninger, M.D., and her recognition that psychiatry focuses on a holistic approach to patient care, one that combines mind, body, and spirit with interpersonal relationships.

"Navajos were the first psychotherapists," Roessel recalled Menninger telling her. During her training in medical school at the University of Minnesota, Menninger sent her letters of encouragement. Such mentoring, she said, is important in disseminating knowledge and support from generation to generation.

Caring for the mental health needs of indigenous patients calls for an understanding of both their culture and history, said Roessel. Recognition of the effects of centuries of historical trauma inflicted on native populations is key to their care. That trauma includes genocidal warfare, geographic displacement, and the system of residential schools that detached Native American children from their culture and identities.

Challenging the conventional wisdom on those issues, recognizing indigenous knowledge, and integrating indigenous principles into psychiatric practice could help improve care for native peoples, she added.

Such an approach would begin by asking patients to articulate their theory of why there is a problem, said Walker. "Then we would ask if they know how this has been treated in the past in their community, and then how Western medicine might be best incorporated into their daily life pattern."

Traditional healers also employ "talking medicine," which can be considered a form of psychotherapy.

"When approached for assistance, Native medicine people are active in getting a good history, listening to the person's description of the problem,

see **Native Americans** *on page 20*

O'ahu Insane Asylum, ca. 1870, opened in Kapālama in 1866 and served long-term psychiatric patients. Its first patients were transferred to the hospital from the jails where mentally ill people had previously been kept.

The Hiawatha Asylum for Insane Indians in Canton, S.D., also known as the Canton Indian Insane Asylum, was open from 1903 to 1934. Many inmates were placed there for "misbehavior" or disagreements with Indian agents.

Winners of Resident/Medical Student Poster Competition Announced

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

David Hathcox

Gathering for a photo after the announcement of the winners of the Resident/Medical Student Poster Competition were (from left) Jacqueline Feldman, M.D., chair of APA's Scientific Program Committee; Sally Huang; Michael Yee, M.D.; Altha Stewart, M.D., APA president; Tia Mansouri, M.D.; Saul Levin, M.D., M.P.A., APA CEO and medical director; Sophia Banu, M.D., Huang's mentor; and Emma Makoba, M.D. Makoba accepted the award for Annie Hart, M.D.

This year's winners were Annie Hart, M.D., of Icahn School of Medicine at Mount Sinai for "The Practice, Enhancement, Engagement, Resilience, and Support (PEERS) Curriculum: Improving Medical Student Resilience and Well-Being" (Curriculum Development and Education); Sally Huang of Baylor College of Medicine for "Refugee Resettlement Research in Texas: A Unique Collaboration Between Medical Professionals, Trainees, and the Community" (Community Development and Service Projects); Tia Mansouri, M.D., of SUNY Health Science Center at Brooklyn for "Burnout in Resident and Fellow Physicians in a Metropolitan Academic Medical Setting" (Psychosocial and Biomedical Research Projects); Trevor Scudamore, M.D., of Upstate Medical University for "Mindful Melody: Exploring the Use of Music to Reduce Agitation on an Acute Inpatient Psychiatric Floor" (Patient-Oriented Care and Epidemiology); and Michael Yee, M.D., of the Icahn School of Medicine at Mount Sinai for the poster "Severe Mania Triggered by Gonadotropins in an Ovarian Hyperstimulation Protocol for Egg Harvesting" (Clinical Case Studies). **PN**

Winners of APAF Advancing Minority MH Awards Honored at Annual Meeting

The APA Foundation (APAF) honored a number of organizations for their innovative services for minority and underrepresented communities. ***BY CATHERINE F. BROWN***

The 2019 APA Foundation Awards for Advancing Minority Mental Health were announced at a reception at APA's 2019 Annual Meeting in San Francisco.

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

Here are brief descriptions of this year's winners:

- **APDC's Asian Elder Wellness Program:** Since 1980, Asian Pacific Development Center (APDC) has provided culturally appropriate and integrated behavioral health cand community-based services to Asian American Pacific Islander (AAPI) immigrants and refugees in Colorado. In 2012, APDC established the Asian Elder Wellness Program, which is a group-based, culture-specific program that provides mental health screening, counseling, and whole-health education for AAPI adults ages 60 and over. It serves over 250 individuals in the Denver and Aurora metropolitan areas, including those of Bhutanese, Burmese, Cambodian, Chinese (Cantonese- and Mandarin-speaking), Japanese, Karen, Karenni, Lao, and Vietnamese backgrounds—ranging from newly resettled refugees to second- and third-generation elders.

- **CAFY Counseling & Family Center:** Community Advocates for Family & Youth (CAFY) has served victims of crimes and their families for over 15 years in Prince George's County, Md., in partnership with the county's Police Department. CAFY provides a holistic, trauma-informed approach to its clients who have been impacted by crime. Between 2009 and 2017, CAFY provided services to approximately 10,895 referrals. CAFY's services includes victim assistance, legal consultations, and mental health services.

- **Hong Fook Mental Health Association:** Established in 1982, Hong Fook Mental Health Association champions culturally competent care and provides a continuum of mental health services from "promoting wellness" to "managing illness" in Asian and other communities, with four offices across the Greater Toronto Area. Hong Fook serves East and Southeast Asian communities in six languages. In the fiscal year 2017, Hong Fook served 5,246 individuals with mental health needs and reached out to 18,229 community members.

- **La Clínica del Pueblo:** Since 1983, La Clínica has played a vital role in addressing the physical and mental health needs of the underserved Latino population in the Washington, D.C., metropolitan area, with a special focus on delivering high-quality, culturally appropriate, and patient-centered health services. La Clínica's mental health services are among the only culturally and linguistically competent services in the area and are unique in their understanding of the challenges and needs of the immigrant and low-income Latino community. Annually, La Clínica serves more than 4,500 patients with primary and behavioral health services that integrate culturally competent therapies with traditional therapy sessions.

- **Mary's Center's School-Based Mental Health Program:** For 30 years, Mary's Center has been providing culturally and linguistically appropriate services to nearly 50,000 socially and medically vulnerable individuals at eight health care locations throughout Washington, D.C. Historically, Mary's Center focused on serving low-income immigrant families and the

continued on facing page

David Hathcox

Accepting the 2019 APA Foundation Awards for Advancing Minority Mental Health are (from left) Javier Blas, a mental health therapist at the Mary's Center's School-Based Mental Health Program; Bonnie Wong, M.S.W., executive director of the Hong Fook Mental Health Association; Shanti Das, founder and executive director of Silence the Shame; Belen Saravia, mental health program coordinator at La Clínica del Pueblo; S. Eri Asano, Ph.D., director of behavioral health services at the Asian Pacific Development Center's Asian Elder Wellness Program; and Onki Cheng, behavioral health clinician and community navigator at the Asian Pacific Development Center's Asian Elder Wellness Program.

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communities in which they live. In 2013, Mary's Center piloted the School-Based Mental Health (SBMH) program at the request of several D.C. public and charter schools to provide bilingual support for Latino students. In six years, the SBMH program has been expanded to 19 schools with approximately 48,000 students to provide high-quality, on-site, culturally responsive, and trauma-informed behavioral health services.

- **Silence the Shame:** This organization was established to empower and enrich the lives of those in underserved communities around mental health, youth empowerment, and poverty. Its mental health programs support people with mental illness in leading more productive and autonomous lifestyles, while promoting mental wellness through awareness, advocacy, and education. It seeks to normalize conversations surrounding mental health to eliminate stigma associated with mental illness and increase access to mental health resources and treatment. By utilizing iconic figures and influencers for African American communities and other communities of color, Silence the Shame has begun to break down barriers to safely discuss mental health issues without fear of judgement or isolation **PN**

More information on the APA Foundation's Awards for Advancing Minority Mental Health is posted at https://apafdn.org/impact/community/awards-for-advancing-minority-mental-health.

Spurlock Award Recognizes Former APA/APA Foundation Fellow for Global Work

APA President Altha Stewart, M.D. (right), presents the 2019 Jeanne Spurlock Minority Fellowship Achievement Award to Pamela Y. Collins, M.D., M.P.H., at the Minority Fellows and Alumni Reception at APA's 2019 Annual Meeting in San Francisco. Collins is a professor of psychiatry and behavioral sciences and professor of global health at the University of Washington (UW), where she directs the UW Global Mental Health Program.

Collins was honored for her leadership in global mental health, cultural psychiatry, and mental health disparities. In a letter of nomination for the award, Francis Lu, M.D., director of cultural psychiatry at the University of California, Davis, said Collins' work has had a direct impact on building resources for mental health in underserved communities around the world.

In her role as leader of the UW Global Mental Health program, Lu said Collins "provides leadership in the service of a diverse group of faculty, trainees, and students in the expansion of research, training, collaborative partnerships, and advocacy with an ultimate goal of reducing the burden of mental disorders in low-resource settings locally, regionally, and globally."

The Jeanne Spurlock, M.D., Minority Fellowship Achievement Award, established in 1999, recognizes the achievements of former fellows of the APA/APA Foundation minority fellowships program who have made significant contributions to the profession and/or the minority community. It is also intended to encourage continued involvement in the fellowship program.

David Hathcox

The award honors Jeanne Spurlock, M.D., the founder of the Minority Fellowship Program and director of APA's Office of Minority and National Affairs, now the Division of Diversity and Health Equity. She was a pioneer in the field of child psychiatry and studying aspects of culture and race that play a role in the development of mental illness.

Gender Bias

continued from page 7

and flexible career paths for women could increase women physicians in the workforce. Organizations also could provide at least 12 weeks of fully paid maternity leave, lactation rooms, on-site childcare, and paid sick leave to care for children or elderly family members—responsibilities women are more likely to take on.

- **Require institution-wide managerial training to address implicit or unconscious bias, discrimination, and sexual harassment.** Organizations should provide implicit bias training for all managers, and performance evaluations should include feedback on how well managers are providing mentorship, sponsorship, and promotion opportunities for women. "There should be a message for management: Your promotion could be impacted if you don't mentor or promote women," one attendee said.

- **Create fair rotation for "housekeeping"-type responsibilities.** Women in academic medicine are more likely than men to serve on committees and provide mentorship, activities that may not necessarily help them advance their careers. Several attendees recommended creating a rotation for these responsibilities so the work is more evenly distributed among men and women.

- **Create safe reporting mechanisms for harassment.** Organizations should implement third-party reporting systems for sexual harassment or assault so that women can come forward without fearing retribution.

- **Provide networking opportunities for all women.** Then APA President Altha Stewart, M.D., who attended the session, pointed out that the head of human resources at her organization hosts a regular support group for all women faculty members so they can network, problem solve together, and encourage senior faculty to mentor women. "When we are together, we are stronger," said one attendee. **PN**

"Sex Differences in Physician Salary in U.S. Public Medical Schools" is posted at https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2532788. "Differences in Narrative Language in Evaluations of Medical Students by Gender and Under-represented Minority Status" is posted at https://link.springer.com/article/10.1007%2Fs11606-019-04889-9. "Eliminating Gender-Based Bias in Academic Medicine: More Than Naming the 'Elephant in the Room'" is posted at https://link.springer.com/article/10.1007/s11606-018-4411-0.

Digital Nightmare Therapy Receives Breakthrough Designation

A smartwatch app known as NightWare vibrates when disturbed sleep is sensed, reducing the frequency of trauma-related nightmares. **BY NICK ZAGORSKI**

TECH TIME

In May the Food and Drug Administration (FDA) granted breakthrough therapy status to NightWare—a smartwatch-based therapeutic for trauma-related nightmares and nightmare disorder. The app monitors the heart rate and movement of people wearing the smartwatch as they sleep and rouses them with a mild vibration if a nightmare is detected. This vibration is not strong enough to wake users, according to NightWare Inc., makers of the smartwatch app.

Nightmare disorder, which is listed as a condition in *DSM-5*, is characterized by vivid and repeated nightmares that severely impact sleep quality. Though it can occur in anyone, nightmare disorder is commonly associated with posttraumatic stress disorder (PTSD); epidemiological studies have suggested 70% to 80% of people with PTSD experience recurrent nightmares.

"We don't fully understand the function of dreams, but it's been suggested that dreams help people depower the effects of trauma," said Daniel Karlin, M.D., the chief medical officer at NightWare Inc. Karlin is an assistant professor of psychiatry at Tufts University. "In people with PTSD, however, the nightmares feel so real that they serve to reinforce past trauma, which exacerbates the disorder.

"You then reach this point where you experience unwanted flashbacks during the day and unwanted dreams at night, and there's nowhere to escape," Karlin continued. Nightmares contribute to the misuse of alcohol among people with PTSD and also contribute to suicidal ideation, he added.

For a long time, prazosin (a drug that treats blood pressure) was the frontline choice to treat nightmare disorder, but a study of over 300 veterans with PTSD published in *The New England Journal of Medicine* (*NEJM*) in February 2018 found that this medication was not any more effective than a placebo drug (https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2018.pp3b1).

NightWare was initially conceived during a software hackathon sponsored by the Department of Veterans Affairs (VA). The mobile app (currently the software only works with Apple products though there are plans to expand compatibility) assesses data from a smartwatch's biometric sensors and "learns" an individual's sleeping patterns over a few days. After this learning period, the app will monitor sleep patterns and vibrate if it detects disturbed sleeping. The vibration shifts the person from his or her disturbed rapid eye movement (REM) sleep into a non-dream, deep sleep state. This process is also "learned": If the vibration elicits no effect, it will try again with more intensity and if the vibration wakes the person, then the next attempt will be less intense.

As for users, all they must do is use their finger to press START on the NightWare app before they go to bed each night.

NightWare's effectiveness was demonstrated in an open-label study of 20 veterans who used the device for one month. At study's end, 18 of the 20 participants showed noticeable improvements (average improvements of 4.5 points in their sleep quality, as measured by the Pittsburgh Sleep Quality Index). These improvements were double what was reported by patients on prazosin in the *NEJM* study.

NightWare Inc. will soon begin testing the smartwatch app in two, large, randomized studies. The first is a proposed 240-person, placebo-controlled study to take place at the Minneapolis VA (using a sham, non-vibrating version of the app as the control), while the second will be a 400-person, virtual clinical trial in which anyone can ask to enroll online. As with the pilot, both randomized studies will last one month and measure sleep quality as the primary endpoint.

NightWare's newly granted breakthrough designation will help speed the FDA review and clearance process, which will enable this device to reach the market quickly, if all goes as planned.

"We want to generate strong data so doctors will be confident that this device really works," Karlin told *Psychiatric News*. He added that once the trials are completed, all the participants can continue to use the app in an open-label mode. This will provide long-term data on NightWare's effectiveness and adherence rate, which can be easily monitored remotely. **PN**

NightWare

By measuring biometric parameters like heart rate and body movements, the NightWare app identifies stressful sleep that might indicate a nightmare and nudges a person into better slumber.

"Trial of Prazosin for Post-Traumatic Stress Disorder in Military Veterans" is posted at https://www.nejm.org/doi/full/10.1056/NEJMoa1507598.

Intimate Partner Homicide Least Studied, Most Common Form of Family Murder

Up to half of female homicide victims are killed by an intimate partner; many of the men who commit these crimes are in treatment for depression, substance use, or pathological jealousy at the time of the crime.
BY LINDA M. RICHMOND

By far the most common form of familial homicide is men who kill their female intimate partner; and because some of these men are often in treatment at the time of the crime, there may be opportunity for prevention, said Alec Buchanan, M.D., Ph.D., who spoke at an APA Annual Meeting session on the dynamics and risk factors for murder in the family.

Intimate partner homicides committed by men account for about 1,500 of the 14,000 annual homicides in the United States, he said. "It has only been in the latter half of the last century that intimate partner homicide was consistently regarded as both a criminal act and social and societal problem."

Buchanan, a professor of psychiatry at Yale University School of Medicine and a member of the Group for the Advancement of Psychiatry (GAP) Committee on Psychiatry and the Law, was joined by several other co-authors of their book *Family Murder: Pathologies of Love and Hate*.

Up to half of women who are murdered are killed by a past or present male intimate partner, which is the most personalized form of homicide, said Buchanan.

"Many of the other forms of familial violence have been subject to extensive psychiatric study. That's not the case for intimate partner violence, which has been little studied from a psychiatric perspective," Buchanan said. "So most of the literature comes from sociology and criminology."

Women who are from ethnic and racial minority groups and living in poverty are disproportionately affected by such crimes, he said. Both victims and perpetrators tend to be younger and the crimes tend to be more violent, with victims sustaining multiple wounds, compared with other forms of homicide. These crimes tend to happen late at night and behind closed doors, often in the bedroom.

These homicides are often preceded by less serious violence, and prior arrests for domestic violence have been seen in up to 80% of cases, Buchanan said. "Knowledge of the relationship is critical to understanding what happened," he said. The perpetrators of such crimes tend to self-report fighting about real or suspected affairs. What escalates the situation tends to be social isolation, longstanding physical abuse, and alcohol and drug use.

Such crimes result from both a culture of patriarchy and control of women as well as the psychopathology of the perpetrator, Buchanan said. Some perpetrators may see their victims as part of themselves and, as such, see their partner's desire to separate as a threat to themselves.

Many of the perpetrators are in psychiatric treatment for depression, substance use, or pathological jealousy at the time of the crime, possibly presenting an opportunity for psychiatrists to recognize potential cases

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How to Treat Binge Eating by Patients With Bipolar Disorder

Managing eating problems in patients with bipolar disorder can be challenging, as medications used to stabilize mood and weight often produce side effects counterproductive to the other disorder. **BY NICK ZAGORSKI**

David Hathcox

Joel Yager, M.D., suggests that mood stabilizers such as lamotrigine or topiramate are preferred for patients with bipolar disorder who might be at risk of binge eating and/or obesity, as these medications are not associated with weight gain as a side effect.

Binge eating and weight problems are common challenges for patients with bipolar disorder. It's an underappreciated connection, but one with significant clinical implications. A panel at APA's Annual Meeting in San Francisco explored factors that increase the risk of weight problems among patients with bipolar disorder and recommended medications to reduce the risk.

According to some studies, 25% to 30% of people with bipolar disorder also have binge-eating disorder, with younger and female patients having the greatest risk of co-occurrence. However, this number may underestimate the overlap between these two diagnoses, as the threshold for binge-eating episodes required for a diagnosis of binge-eating disorder was lowered in *DSM-5*, explained Susan McElroy, M.D., a professor of psychiatry at the University of Cincinnati College of Medicine and a leading researcher on bipolar disorder and eating disorders. (The requirements to diagnose a patient with binge-eating disorder were lowered from a minimum of two binge eating episodes per week for six months to one episode per week for three months).

Part of the reason binge-eating disorder might be common in patients with bipolar disorder is that both disorders are associated with having periods of poor impulse control. "You tend to see lots of addictive-like behaviors in patients with bipolar disorder," noted session chair Joel Yager, M.D., a professor of psychiatry at the University of Colorado School of Medicine.

But medications also contribute to this co-occurrence. "We know many drugs used to treat bipolar disorder [valproate, lithium, antipsychotics] can cause weight gain, but it's less well known that these drugs can induce binge eating or make existing binge eating worse," said McElroy. "It's important to address such problems since conditions like obesity are often more upsetting to bipolar patients than the mood swings and contribute to medication nonadherence."

Managing eating problems in patients with bipolar disorder can be challenging, as medications used to stabilize mood and weight often produce side effects counterproductive to the other disorder.

"I think it's better to try and prevent weight problems in at-risk individuals [with bipolar] rather than treat problems after they occur," said Yager. He suggested mood stabilizers such as lamotrigine or topiramate, which have weight loss, as opposed to weight gain, as a side effect (the former tends to be more effective for mood symptoms, while the latter has a stronger weight-loss effect). The anticonvulsant zonisamide used off label is another possibility.

If a patient is already stable on another medication like lithium or valproate and then develops weight problems, then a second medication for weight loss could be recommended, he said.

There are five FDA-approved medications for obesity, four of which target receptors in the brain. Of these, naltrexone-buproprion and phentermine-topiramate can sometimes induce mania or psychosis and should be avoided, McElroy advised. Lorcaserin, a serotonin receptor agonist, and liraglutide, a diabetes medication, have better side-effect profiles. However, lorcaserin can cause euphoria, and there have been reports that liraglutide may increase suicidal thoughts in some patients. The fifth weight-loss drug, orlistat, reduces fat absorption in the gut and has no known psychiatric effects, but it can cause diarrhea and other gastrointestinal problems.

And what about the stimulant lisdexamfetamine, the only approved medication for binge-eating disorder? McElroy said that while this medication is effective, it should not be given to individuals with bipolar disorder until their mood symptoms are stable; this reduces the risk of lisdexamfetamine triggering mania and ensures that any binge-eating symptoms are not due to untreated bipolar disorder. "If a patient is still binge eating after they are euthymic, then you can safely use lisdexamfetamine," she said. **PN**

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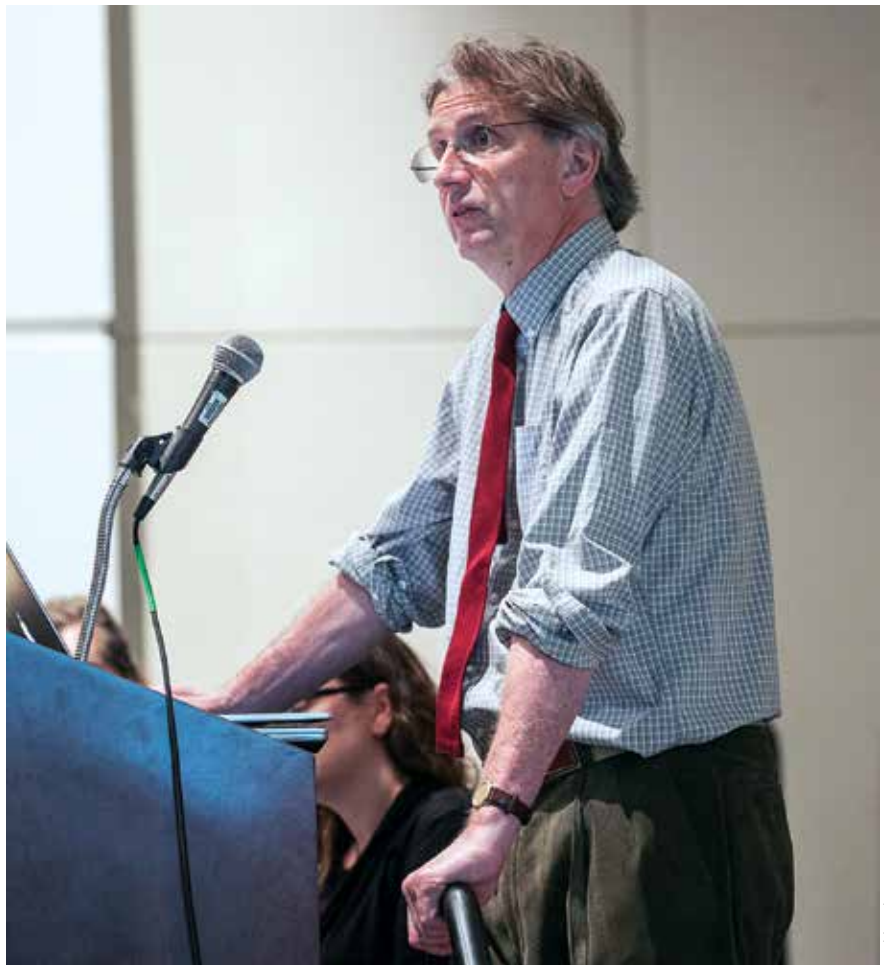
and intervene. Risk factors for violence include past threats, past violence, current access to weapons, escalation of violence or jealousy, violent fantasies, and depression.

For many patients, the risks posed by anger issues and delusions of infidelity decrease as the patient ages, Buchanan said. "The same is not true, however for pathological jealousy, for which the risk seems to continue into old age."

When it comes to prevention of such crimes, the use of protective orders is controversial because they often don't serve as a deterrent and are frequently broken with no legal consequences. In fact, one-third of women murdered by an intimate partner had a protective order in place at the time, Buchanan said. Court-ordered treatment is now commonly deployed, but evidence of its effectiveness in preventing intimate partner violence and homicides is mixed.

What has been the most effective are changes in law-enforcement practice in some high-poverty areas that have made the police far more responsive to intimate partner violence, Buchanan said. **PN**

APA members may purchase the book *Family Murder: Pathologies of Love and Hate* at a discount at https://www.appi.org/Family_Murder.



David Hathcox

Alec Buchanan, M.D., Ph.D., tells attendees that it has been only in the latter half of the last century that intimate partner violence has been consistently regarded as both a criminal act and a societal problem.

Modeling Nutritional Wellness May Help Your Patients Lose Weight

As the obesity epidemic expands, psychiatrists must go beyond telling patients how to lose weight to helping them live a healthy and fit life. Applying mindfulness to eating is one technique that can benefit both physicians and their patients.

BY LINDA M. RICHMOND

iStock/nensuria

"Physician heal thyself."

As this New Testament proverb suggests, an important step in helping patients lose weight is for their physicians to embrace and model a healthy lifestyle, too, said Robert Barris, M.D., a psychiatrist at Nassau University Medical Center in East Meadow, N.Y.

"We have to embody [health] as health care practitioners," said Barris during a session on nutritional wellness at APA's 2019 Annual Meeting in San Francisco. "We can't just show up to work sleep deprived, having eaten all the wrong foods, and having had too much coffee and then counsel patients on wellness. As healers we have to own it."

Although physicians are less likely to be obese than the average American, the 2007 Physicians' Health Study found that 40% of the 19,000 doctors studied were overweight and 23% were obese.

A separate study found that a physician's body mass index (BMI) may be strongly correlated with how he or she diagnoses and counsels patients about diet and eating habits. Among primary care physicians surveyed, 30% of those with normal BMI engaged their obese patients in weight-loss discussions. That number dropped to 18% among overweight or obese physicians. Furthermore, 89% of physicians said they would initiate a weight-loss conversation with their patient when the patient's weight met or exceeded their own, but that number dropped to 11% when the patient weighed less than the doctor. These findings, by Sarah Bleich, Ph.D., and colleagues, were first published in September 2012 in the journal *Obesity*.

It is helpful to view the obesity epidemic through the lens of the addiction model, Barris explained to attendees. In this model, individuals lack control in the face of food and continue to overeat despite severe health, social, legal, and financial consequences. Patients who are unsuccessful at reducing consumption then feel guilt, remorse, and distress, which drives more eating.

"Ultimately, we are dealing with the eternal battle in life between the prefrontal cortex and the midbrain pleasure center," Barris said. "Where mindfulness is important is in activation of the prefrontal cortex to maybe make more enlightened decisions." Such mindfulness must be practiced again and again, he said.

Lifestyle modification is such an important topic in psychiatry, Barris said, but how can physicians approach it without coming off as nags? "Discussions around food or weight require a

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certain lightness of touch," he said. "Who hasn't messed up and eaten something they didn't intend to? I think it's important that our humor and humanness be brought into it."

Two powerful techniques that have helped patients lose weight are motivational interviewing and food journaling, Barris said. "In psychiatry, we need to be well versed in motivational interviewing." He noted that most physicians don't address patients' smoking or overeating, for a variety of reasons. "We need skillfulness to navigate this shared journey with our patients—to work in collaboration."

Instead of telling patients *how* they can eat better or *what* foods to eat, he advised physicians to discuss with patients their reasons for improving their health and wellness. "As doctors we must ask our patients 'why do you want to be well or eat healthy?'" he said.

To model and encourage more exercise, Barris regularly asks his residents and medical students to take the stairs with him rather than waiting on the elevator, and he leads his patients on brisk walks around the halls when checking in with them.

Barris also leads his patients, residents, and medical students in group mindfulness sessions involving food. For these, each participant receives a small serving of raisins or almonds and is instructed to approach the items mindfully. Participants are asked to consider the smell and feel of the item in their hands, to wonder at their own ability to bring the items to their lips, and to consider where it was grown and the farm workers who picked it. He asks participants to consider giving thanks before and after consuming the food and to think about what they will do with the energy the food provides, such as using it to smile at someone or express a kind word to another person.

Barris said that today's focus on "normal" values for lipids, BMI, and blood pressure, which are becoming increasingly relaxed, should instead be shifted to "optimal" values. "Do you want normal or optimal health?" he asked. He "went after" his own health five or six years ago by eliminating animal products from his diet and becoming an avid exerciser after his blood pressure started creeping up. He refused to accept his physician's response that "this is 'normal' for a man my age." **PN**

"Impact of Physician BMI on Obesity Care and Beliefs" is posted at https://onlinelibrary.wiley.com/doi/full/10.1038/oby.2011.402.

Researchers Want More Attention Paid to Late-Life Neurocognitive Disorder

The disorder known as LATE mimics Alzheimer's disease but primarily affects the frontal and temporal lobes of the brain and begins at a much later age in life. ***BY NICK ZAGORSKI***

While Alzheimer's disease receives a great deal of public attention, there are numerous pathways by which the brain can be stripped of its ability to process and remember information. Understanding these various mechanisms of dementia and their subtle differences in symptoms is needed to improve diagnosis and treatment for patients.

In the June issue of the journal *Brain*, an international group of experts convened by the National Institute on Aging (NIA) described a class of dementia known as limbic-predominant age-related TDP-43 encephalopathy, or LATE. As suggested by the name, LATE is a late-life dementia that typically manifests in people ages 80 and older.

The expert group hopes their report on LATE—which provides an overview of known clinical features, some recommendations for conducting brain autopsies, and key areas for future research—will help raise awareness of this understudied disorder that has come to light only over the past decade.

In patients with LATE, the protein TDP-43 (transactive response DNA-binding protein of 43 kilodaltons size), which regulates the expression of hundreds of genes in the brain, becomes misfolded in neurons. This misfolding leads to the accumulation of toxic TDP-43 clumps, akin to the amyloid-beta plaques seen in the brains of patients with Alzheimer's.

The presence of misfolded TDP-43 is not unique to LATE; TDP-43 dysfunction in the frontotemporal lobes is a main feature of a class of disorders known as frontotemporal dementia (FTD). In FTD, the toxic TDP-43 clumps appear in brain regions involved in personality and behavior. In LATE, the toxic TDP-43 clumps appear in brain regions involved with memory such as the amygdala and hippocampus, like what occurs in Alzheimer's disease. As such, LATE is pathologically similar to FTD but clinically similar to Alzheimer's. Patients with LATE tend to experience a more gradual memory decline over time than those with Alzheimer's disease. However, if LATE manifests in older patients with Alzheimer's, it accelerates memory loss.

While many questions about LATE remain, all evidence suggests that this disorder is common among the oldest adults. Current analyses of autopsied brains suggest that at least 20% and perhaps as many as 50% of people 80 years and older have LATE-like neuropathology.

With the first wave of baby boomers approaching their 80s, focusing more attention on LATE "is an opportunity to get ahead of the game for a disorder that could have a huge public health impact," said Peter Nelson, M.D., Ph.D., a professor of pathology at the University of Kentucky and co-chair of the NIA working group studying LATE.

The confirmation of LATE in older adults could also hold significant implications for Alzheimer's disease, Nelson added. Since these two conditions are virtually identical from a clinical perspective, it is likely that

see **LATE** *on page 17*

CLIMATE CHANGE & MENTAL HEALTH

When Disaster Strikes: A Psychiatrist's Firsthand Experience

BY RAHN KENNEDY BAILEY, M.D.

This article is part of a regular series on the mental health impact of climate change by members of the Climate Psychiatry Alliance.

Rahn Kennedy Bailey, M.D., is the executive director and chair of the Department of Psychiatry and Behavioral Medicine at Wake Forest School of Medicine. He is the minority/underrepresented trustee on APA's Board of Trustees.

Interestingly, my personal narrative involves many harrowing experiences with adverse weather. From 1986 to 1990, I attended medical school in Galveston, Tex. Galveston is a coastal city with an infamous weather-related distinction: In 1900, a hurricane ravaged the city, killing upward of 6,000 individuals. Overall, it was the deadliest natural disaster in U.S. history. Due to this historical catastrophe, the residents in the area tended to be justifiably precautious. When a hurricane was forecast, most inhabitants dutifully reported to the designated hurricane shelter. As luck would have it, the hurricane shelter was the local hospital.

This was the backdrop of my medical school years. Those days gave me hard, firsthand experience dealing with displaced, anxious, and traumatized people. Little did I know that the practical knowledge I gained then would serve me well some years later.

Indeed, there have been quite a few deluges since medical school. During the many severe weather events that I have experienced, I have been both a first responder and an evacuee. During Hurricane Katrina in 2005, I was one of the first individuals to provide medical aid to the many unfortunate individuals who sought refuge in the Houston Astrodome. Because of that work, I was named "Doctor of the Year" by the National Medical Association.

However, I must stress that I also have been helpless during extreme weather events. A few weeks after Hurricane Katrina, I found myself taking to the road. Like many other evacuees, my family and I decided that fleeing to nearby Dallas would be the most prudent way to deal with the imminent arrival of Hurricane Rita. Unfortunately for us, roughly a million motorists joined us in this exodus. The drive from Houston to Dallas, which normally takes under four hours, took us 31 grueling hours.

Professionally, I have seen loss, fear, and exasperation and have helped many cope with the challenges of extreme weather; personally, I have been tested by environmental perils as well. It is my belief that weather conditions are getting more extreme. As unexpected acts of nature unfold, many survivors may endure psychological distress long after the streets are cleared, houses are rebuilt, and utilities are restored.

As the weather becomes more extreme and unpredictable, more people will face abrupt and unexpected loss. Addressing climate change is a progressive and proactive stance that the whole of psychiatry should take. It is hoped that by dampening the extremeness and rapidity of climate change, we can prevent some of the psychological stress that goes along with experiencing natural disasters and weather-related catastrophes. **PN**

CDC Clarifies Opioid Prescribing Guidelines

In a commentary in The New England Journal of Medicine*, the guideline's authors address how the recommendations have been misapplied in practice and policy.* **BY TERRI D'ARRIGO**

When the Centers for Disease Control and Prevention (CDC) released its "Guideline for Prescribing Opioids for Chronic Pain" in 2016, the intent was to provide recommendations to prescribers who would then apply the recommendations to the care of their patients on a case-by-case basis. Since then, policies and practices emerged that interpret the guideline as a hard-and-fast rule, in effect encouraging abrupt tapering and sudden discontinuation of opioid medications, including those used in medication-assisted treatment (MAT) for opioid use disorder. Reports began to surface in the media of patients being cut off from opioid medications with little to no support and turning to street drugs to get relief of chronic pain or opioid withdrawal, sometimes with fatal consequences—outcomes the CDC neither promoted nor intended.

In a commentary in *The New England Journal of Medicine* (*NEJM*), the authors of the original guideline addressed these reports and the ways the guideline has been misapplied, clarified the guideline's key points, and reiterated CDC's original intent. Deborah Dowell, M.D., M.P.H., and colleagues stated that misapplying the recommendations to populations that fall outside the scope of the guideline (for example, patients with pain associated with cancer, surgical procedures, or acute sickle cell crises) and to the dosage of opioid agonists used in MAT is "likely to result in harm to patients."

The authors also clarified the oft-misinterpreted recommendation that clinicians avoid increasing opioid dosage to ≥90 morphine milligrams equivalent per day, which has prompted de-prescribing and rapid tapering by some clinicians and served as the basis for prior authorization and claims denials by insurance companies.

"This [recommendation] does not address or suggest discontinuation of opioids already prescribed at higher dosages … [or] apply to dosing for medication-assisted treatment for opioid use disorder," the authors wrote.

Other key points in the commentary include the following:

- Policies should allow clinicians to make clinical decisions according to each patient's unique circumstances.

- Although some situations such as a nonfatal overdose may necessitate rapid tapers, the guideline does not support stopping opioid use abruptly.

- Dismissing patients from care can adversely affect patient safety, represents patient abandonment, and results in missed opportunities to provide potentially lifesaving information and treatment.

"We're glad the CDC is taking action to ensure that pain patients have access to critical medication."
—Saul Levin, M.D., M.P.A.

APA CEO and Medical Director Saul Levin, M.D., M.P.A., welcomed the commentary by Dowell and colleagues. "It is important to ensure that we balance the treatment needs of patients with pain with our response to the opioid crisis. We were concerned about how the guideline would be implemented when it was released, and we're glad the CDC is taking action to ensure that pain patients have access to critical medication," Levin said.

Andrew Saxon, M.D., past chair of APA's Council on Addiction Psychiatry, agreed, stating that the *NEJM* commentary "provides a much-needed corrective to the overreaction to concerns about opioid prescribing and the opioid epidemic that has harmed some of the 'legacy patients' who, through no fault of their own, ended up on long-term opioid treatment and [now] face challenges reducing their opioid dosages."

"It is going to take some concerted education to get back on a reasonable course for the legacy patients. Until we have better evidence on how to manage them, care for each one has to be individualized," Saxon told *Psychiatric News*.

Saxon advised psychiatrists who work in pain management not to start opioid-naïve patients with chronic pain on opioids unless all other avenues of treating the pain have been exhausted. He also discouraged forced tapers for legacy patients to reach a specific dosage.

"Some of these patients will need to remain on higher dosages; some can undergo very slow, modest dose reductions; and some may need to be treated for opioid use disorder," Saxon said. He added that psychiatrists in pain management should be trained and prepared to treat opioid use disorder with buprenorphine. "High demand exists for this treatment, and psychiatrists can deliver it particularly well because of their combined pharmacotherapy and psychotherapy skills." **PN**

"No Shortcuts to Safer Opioid Prescribing" is posted at https://www.nejm.org/doi/full/10.1056/NEJMp1904190. CDC's "Guideline for Prescribing Opioids for Chronic Pain" is posted at https://www.cdc.gov/drugoverdose/prescribing/guideline.html.

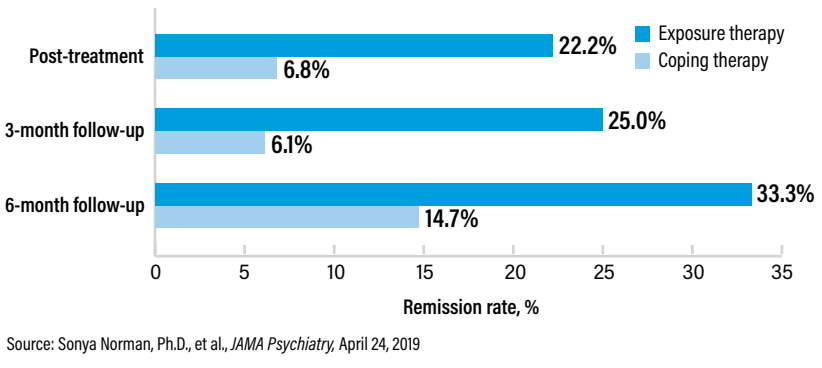
Alcohol Misuse No Reason to Avoid Exposure Therapy for PTSD

The results of a clinical study conducted among veterans refutes the idea that patients with both posttraumatic stress disorder and alcohol use disorder will drink more if asked to re-experience their trauma as required by exposure therapy. **BY NICK ZAGORSKI**

Prolonged exposure—a therapeutic approach that has people relive traumatic experiences in a controlled setting—is considered a first-choice treatment for posttraumatic stress disorder (PTSD). Yet people with PTSD who also have alcohol use disorder (AUD) are often not offered exposure therapy because of concerns that the stress of exposure therapy could cause these patients to increase their drinking.

A clinical study published April 24 in *JAMA Psychiatry* refutes this idea, demonstrating that veterans with both PTSD and AUD can tolerate and benefit from exposure therapy. In fact, exposure therapy outperformed the treatment these patients are frequently offered: coping skills therapy, an approach that teaches patients skills to manage their trauma and prevent drinking relapse.

This study included 119 veterans (107 men) with PTSD and AUD who were randomly assigned to receive 12 sessions of either integrated exposure therapy or integrated coping skills therapy (the "integrated" tag means the therapies focused on both PTSD and AUD symptom management). The participants were asked to attend at least one session a week but were allowed up to six months to finish their designated therapy.



Source: Sonya Norman, Ph.D., et al., *JAMA Psychiatry,* April 24, 2019

The participants experienced an average of eight traumatic events during their life, including combat trauma, sexual trauma, serious illness, or exposure to a disaster. Many of the participants also misused other substances in addition to alcohol. As lead author Sonya Norman, Ph.D., a professor of psychiatry at the University of California, San Diego, and a staff psychologist at the Veterans Affairs San Diego Healthcare System, explained, this group is a good representation of a "complicated patient."

At the end of the study, participants in both treatment groups showed significant reductions in their PTSD severity (measured with the Clinician-Administered PTSD Scale for *DSM*-5, or CAPS-5). However, the prolonged exposure group had greater CAPS-5 reductions, with an average score of 25.8 (down from 43.2 at baseline) compared with 32.9 (down from 42.1) in the coping skills group. More veterans receiving exposure therapy also achieved PTSD remission (22.2% vs. 6.8% in the coping skills group), defined as a CAPS-5 score of less than 12 (see chart).

That 1 in 5 of the prolonged-exposure group achieved remission is encouraging, Norman said. "There was a time when therapists believed these severe cases of PTSD were akin to a chronic illness: Symptoms could be managed but you could not treat the underlying disorder. Now we know that we can effectively treat [these] patients."

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Speech Analysis May Help Diagnose PTSD

Special voice analysis software found that veterans with posttraumatic stress disorder had a significantly flatter and more monotonous way of speaking than veterans without PTSD. **BY NICK ZAGORSKI**

There is a growing interest in using speech recognition software to help diagnose psychiatric problems. Such technology can provide objective data related to the quality or content of a patient's speech that can supplement the subjective information gleaned from a clinical interview.

While much speech analysis research has focused on Alzheimer's disease and schizophrenia, a study by investigators at New York University (NYU) Langone Health and the Stanford Research Institute (SRI) has now demonstrated that speech patterns can accurately identify people with posttraumatic stress disorder (PTSD). These findings were reported in *Depression and Anxiety*.

NYU Langone Health

Charles Marmar, M.D., believes that speech and voice recognition hold great promise in psychiatry, as the tools needed to collect audio are inexpensive, readily available, noninvasive, and can be used remotely.

"The tools you need to collect audio data are cheap, abundant, noninvasive, and don't even require the subject to be in the same room as you," said lead study investigator Charles Marmar, M.D., the Lucius N. Littauer Professor and chair of the Department of Psychiatry at NYU School of Medicine. "It seems natural that speech samples can be used in psychiatry as blood tests are in other medical fields."

Marmar became interested in using speech analysis for PTSD after doing telephone-based therapy with his patients. "I realized that their voices were conveying so much information beyond their actual words," he said.

He organized a multidisciplinary team of clinicians, mathematicians, and engineers to study the speech of 129 male veterans of the Iraq and Afghanistan wars. The participants were all assessed for PTSD using the Clinician-Administered PTSD Scale for *DSM-IV* (CAPS-IV), considered a gold-standard diagnostic tool; 52 of the veterans screened positive for PTSD and 77 did not.

The CAPS interviews for each participant were recorded and analyzed with special software developed by NYU's collaborators at SRI (SRI was the institute that created Apple's voice assistant Siri). The software compared over 40,000 different audio markers including rhythm, volume, tone, and affect (how a voice changes in response to emotional stimuli). As Marmar told *Psychiatric News*, "We looked at the physics of the speech, not the lexicon."

The analysis revealed a set of 18 speech-related features that were different between veterans with and those without PTSD. Using these features as diagnostic criteria, the software could distinguish individuals with or without PTSD with 89% accuracy.

Most of these differences related to tone and affect, in that veterans with PTSD had speech that was flatter and more monotonous than those without PTSD. Slow speech and long hesitations were also more common among veterans with PTSD.

Marmar said these findings reinforce anecdotal reports of how veterans with chronic PTSD tend to speak. (PTSD is also associated with aroused and jittery speech, but Marmar said such speech patterns usually occur when the trauma is more recent. All the participants in this study had been coping with PTSD for years.)

The researchers found that the presence of a traumatic brain injury (TBI) or alcohol use did not skew the results. Many of the veterans with PTSD also had elevated depressive symptoms, but these symptoms were not strongly contributing to the speech differences either, the authors noted.

While the results suggest speech software can objectively differentiate people with PTSD from those without, Marmar and colleagues cautioned that this study did not include any veterans who had a diagnosis of major depression—a disorder also characterized by slow, hesitant, and flat speech. Marmar said that future studies should compare the voice patterns between veterans with PTSD and those with major depression to see if the software retains its diagnostic accuracy.

While speech analysis could be used in multiple settings, Marmar sees this tool initially being deployed in military or first-responder populations. "This would enable us to screen a large group of individuals getting ready to deploy and see which ones are psychologically prepared," he said. "A professional could accomplish that with a CAPS, but a CAPS interview can take a couple of hours if a person has a complicated trauma history."

In addition, though CAPS is generally reliable, the assessment relies entirely on what participants or their family are willing to share, Marmar continued. "Many individuals who serve in the military, police, or fire department want to be able to keep serving, and they may be wary of disclosing their distress," he said. Recording an individual's voice during a nonclinical discussion or debriefing could offer another way to obtain information about individuals who may have PTSD, he said.

The study was supported by a grant from the U.S. Army Medical Research Acquisition Activity and Telemedicine and Advanced Technology Research Center with additional support from the Steven and Alexandra Cohen Foundation. **PN**

"Speech-Based Markers for Posttraumatic Stress Disorder in U.S. Veterans" is posted at https://onlinelibrary.wiley.com/doi/full/10.1002/da.22890.

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Both treatment groups also had similar reductions in alcohol use. Their total number of heavy drinking days (five or more drinks per day for men, four or more for women) decreased by more than half, and they doubled their number of days abstinent from any alcohol.

Though this study specifically addressed alcohol use, Norman thinks that integrated exposure therapy should work for any substance use problem. Many of the study participants were taking multiple substances and still improved, he said.

"I've had people tell me that research studies with exposure therapy all involve perfect patients with one distinct traumatic event and no other medical problems and therefore it couldn't work for real-world patients with complex problems," she told *Psychiatric News*.

"I hope these findings help dispel that myth," she continued.

This study was supported by a VA Clinical Science Research and Development Merit Grant with additional support via training fellowships through the VA Office of Academic Affiliation and the National Institute on Alcohol Abuse and Alcoholism. **PN**

"Efficacy of Integrated Exposure Therapy vs Integrated Coping Skills Therapy for Comorbid Posttraumatic Stress Disorder and Alcohol Use Disorder" is posted at https://jamanetwork.com/journals/jamapsychiatry/article-abstract/2731312.

LATE

continued from page 15

many people, particularly older seniors, diagnosed with Alzheimer's may instead have LATE or a combination of Alzheimer's and LATE. Though this mistake would not currently impact patient care, the inclusion of patients with LATE in clinical trials testing potential Alzheimer's medications may explain why such trials have proven disappointing.

The outstanding questions about LATE present an opportunity for psychiatrists, Nelson concluded. "We need more research to characterize the non-memory correlates of this disorder," he said. Though LATE is primarily defined by cognitive problems, the limited evidence available suggests patients do experience psychiatric symptoms, notably delusions and agitation. These symptoms are also prevalent in Alzheimer's disease, but there may be subtle differences in how they appear that might help distinguish one disorder from the other or confirm that a person has both, he said. **PN**

The full report from the LATE Consensus Working Group is posted at https://academic.oup.com/brain/advance-article/doi/10.1093/brain/awz099/5481202.

Medications May Ease Cannabis Withdrawal But Fail to Achieve Abstinence

Among the many potential compounds that have been tested, n-acetylcysteine appears to be most effective at reducing cannabis use, especially in patients aged 21 and younger. **BY NICK ZAGORSKI**

Marijuana, or cannabis, remains far and away the most commonly used illicit substance. Nearly 41 million people aged 12 or older used marijuana in 2017, according to the latest National Survey on Drug Use and Health. Though some states would dispute the "illicit" term, the fact remains that 1 in 10 adults who use marijuana will develop a dependency; and given its widespread use, psychiatrists will likely encounter a patient with cannabis use disorder (CUD).

Currently no medications are approved for CUD, and behavioral therapy remains the preferred treatment. But some studies have pointed to medications that may benefit patients with CUD. Frances Levin, M.D., the Kennedy-Leavy Professor of Clinical Psychiatry at Columbia University Medical Center, reviewed these options during a session on advances in treating substance use disorders at APA's Annual Meeting in May.

One common approach to treating patients with CUD is to manage their withdrawal symptoms, which can include irritability, anxiety, and sleep problems. Studies show that the anxiolytic buspirone; the insomnia medication zolpidem; and guanfacine, which is approved for attention-deficit/hyperactivity disorder, effectively manage symptoms of withdrawal. However, Levin said there is little evidence that easing withdrawal helps promote cannabis abstinence (as measured by reports of cannabis use by participants with CUD in research studies).

> "These studies did not use a strong-enough dose or treatment length to uncover an observable reduction in cannabis use." —Frances Levin, M.D.

Some preliminary studies suggested that quetiapine, an antipsychotic, and gabapentin, an anticonvulsant—both of which reduce withdrawal symptoms—might also promote abstinence. However, larger randomized studies suggest these medications do not increase abstinence in patients with CUD (though quetiapine may somewhat reduce daily cannabis use).

Another approach to reducing cannabis use by patients with CUD may be to treat them with medications that bind to cannabinoid (CBD) receptors, similar to how nicotine replacement therapy works in smokers. To date, synthetic, CBD-binding drugs like dronabinol or rimonabant have not shown an ability to reduce the subjective pleasure of taking cannabis or promote abstinence. One exception might be the potent CBD agonist nabilone, which has shown efficacy in early studies, but Levin noted the high cost of this medication might limit its use in clinical settings.

Levin suggested that the most promising compound for decreasing cannabis use appears to be n-acetylcysteine (NAC), an antioxidant that can be purchased over the counter. NAC does not directly target CBD receptors but rather helps restore normal levels of the neurotransmitter glutamate, which is believed to be associated with compulsive, drug-seeking behaviors. NAC does not work for all patients, but data suggest that teens and young adults up to 21 years old are more likely to stop using cannabis when given NAC alongside behavioral therapy versus those who receive behavioral therapy alone.

Levin told the audience that that the failure to identify compounds that help patients with CUD achieve abstinence may have more to do with study design than lack of pharmacological efficacy. "In many cases I believe these studies did not use a strong-enough dose or treatment length to uncover an observable reduction in cannabis use," she said. "Unfortunately, there is little enthusiasm from funding agencies to repeat these studies in larger populations."

She suggested future efforts focus on enrolling more specific patient groups—such as adolescents only—or excluding patients with mild CUD since they likely would not benefit as much from treatment.

"We should also address the question of whether abstinence is the ideal outcome when testing medications," she continued. More moderate, "harm-reduction" outcomes like reducing the total number of days cannabis is consumed or the average consumption per day might reveal that some of these available medications can help patients curb their cannabis consumption. **PN**

Group of Six

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In addition to APA, the Group of Six includes the American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American College of Physicians, and American Osteopathic Association.

Schwartz and the other physicians from the Group of Six discussed the need to shore up patient safety risks posed by a regulation known as 42 CFR Part 2, which requires addiction treatment providers to obtain written consent from a patient before sharing any patient information with other treating physicians. The Group of Six is seeking amendments to this regulation to give all treating physicians ready access to a patient's entire medical record, including any substance use treatment history, to avoid life-threatening situations.

One physician told lawmakers about a recent experience of treating a patient in his office and then by happenstance running into that same patient in the substance use disorder treatment facility within the same hospital. The physician had no idea the patient he was treating was receiving medications for substance use disorder, he explained to lawmakers, adding that the segmentation of those records poses real risks.

During their conversations with lawmakers throughout the day, Schwartz and the other physician leaders also shared their experiences of how rising drug prices have impacted their patients.

The Group of Six also indicated their support for finding a solution that would promote greater transparency around billing. At issue is so-called "surprise billing," which arises when patients receive unexpected, sky-high bills because not all their service providers or the hospital in which they were treated were in their health insurer's network. Another related concern is "balance billing," which arises when an insurer pays only a small portion of a service provider's or physician's fees for a particular service.

Momentum around medical billing issues is building on the Hill, with President Donald Trump and lawmakers from both sides of the aisle agreeing that legislation is needed in this area; several bipartisan bills around medical billing are being floated. **PN**

APA Endorses New Parity Enforcement Legislation, Urges Speedy Passage

APA has endorsed the Mental Health Parity Compliance Act, a bipartisan bill introduced in the Senate last month that would enhance the transparency and accountability of insurers' coverage of mental and substance use disorders in compliance with the federal parity law.

That law, the Mental Health Parity and Addiction Equity Act of 2008, requires health plans to cover mental and substance use disorders the same as other medical illnesses; however, there is a lack of oversight to ensure that patients are receiving equal coverage of psychiatric conditions under the law. Plans that are subject to the Employee Retirement Income Security Act of 1974 (ERISA), or self-funded employment plans, are outside the enforcement jurisdiction of state agencies. The new legislation, co-sponsored by Sen. Chris Murphy (D-Conn.) and Sen. Bill Cassidy (R-La.), will tighten parity enforcement of these ERISA plans.

"For too long insurers have neglected their responsibility to adequately provide coverage for patients with mental illness or substance use disorders," said APA President Bruce Schwartz, M.D. "This bill will help to ensure those patients be treated like patients with any other illness and end this harmful discrimination."

Insurers have used a variety of means to sidestep the parity law and reduce utilization of mental health services, including inadequate reimbursement rates for psychiatrists and mental health professionals and "skinny" networks; the latter refer to health insurance provider networks that have few mental health professionals available to treat patients. In some cases, health plans have been found to have "phantom networks" that include physicians who are no longer accepting patients, have moved out of a geographic area, or are deceased.

"We wholeheartedly support this bill, and we urge the Senate and the House to take this up soon and pass it," said APA CEO and Medical Director Saul Levin, M.D., M.P.A. "Our patients depend on insurance for their care."

BY TERRI D'ARRIGO

FDA Requests Comments on Opioid Blister Packaging

The Food and Drug Administration (FDA) has asked for public feedback on the potential public health impact of requiring that certain immediate-release opioid analgesics be made available in fixed-quantity, unit-of-use-blister packaging. The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act allows the FDA to require special packaging for opioids and other drugs that pose a risk of abuse or overdose.

The FDA has also requested feedback on which specific opioid products are good candidates for blister packaging and the number of pills that should be included in blister packaging configurations. In addition, commenters are invited to provide feedback on the potential challenges of the proposed requirement.

The comment period ends on July 30. Those wishing to submit a comment may do so by visiting the public docket published in the May 31 *Federal Register*, which is posted at https://www.federalregister.gov/documents/2019/05/31/2019-11283/fixed-quantity-unit-of-use-blister-packaging-for-certain-immediate-release-opioid-analgesics-for.

Vraylar Approved For Expanded Use to Treat Bipolar Depression

Vraylar (cariprazine) has received FDA approval for expanded use in treating depressive episodes associated with bipolar I disorder in adults, Allergan plc and Gedeon Richter Plc. announced in May.

In three clinical trials, participants who took cariprazine demonstrated greater improvements on the Montgomery-Åsberg Depression Rating scale from baseline to week six than those who took placebo. In all three studies, the 1.5 mg dose demonstrated statistical significance over placebo. In a third study, the 3 mg dose demonstrated statistical significance over placebo. Common adverse events reported in the pivotal trials were nausea, akathisia, restlessness, and extrapyramidal symptoms.

Vraylar is also approved for the acute treatment of adults with manic or mixed episodes associated with bipolar I disorder and for the treatment of adults with schizophrenia.

FDA Adds Boxed Warning For Certain Insomnia Drugs

In April the FDA announced that a black-box warning must be added to the prescribing information and patient medication guides for ***Lunesta*** (***eszopicline)***; ***Sonata (zaleplon)***; and ***Ambien, Ambien CR, Edluar, Intermezzo***, and ***Zolpimist (zolpidem)***.

The FDA noted in a Drug Safety Communication that rare but serious injuries have occurred with these medications because of complex sleep behaviors such as sleepwalking, sleep driving, and engaging in other activities while not fully awake. These behaviors have occurred in patients with or without a history of them, and they have occurred at the lowest recommended doses—even after just one dose. The FDA also required that a contraindication be added to the medications' labeling for patients who have already had an episode of any of these complex sleep behaviors. Patients should immediately stop taking these medications if they experience any of these behaviors.

Injuries resulting from drug-related complex sleep behaviors are rare but can be life-threatening. The FDA identified 66 cases of injuries from complex sleep behaviors, including accidental overdoses, falls, burns, near drowning, exposure to extreme cold temperatures and loss of limb, carbon monoxide poisoning, drowning, hypothermia, car crashes, and self-inflicted gunshot wounds.

'Remove the Risk' Seeks To Improve Disposal Of Unused Opioids

As many as 90% of patients who are prescribed opioid medications do not finish taking their medications and many do not dispose of them properly, leaving millions of leftover opioids in homes, where they are accessible to children who may take them by accident and to others who may misuse them intentionally.

To combat the risks of keeping unused opioids in the home, the FDA launched a new awareness campaign called "Remove the Risk." The campaign seeks to educate Americans about the risks of keeping unused opioids and the importance of properly removing and disposing of them. It targets women aged 35 to 64 years because they are most likely to oversee health care in their households.

The campaign includes a toolkit of materials in English and Spanish and includes radio, television, and print public service announcements, fact sheets, social media graphics and posts, and website badges. The toolkit is posted at https://www.fda.gov/drugs/ensuring-safe-use-medicine/safe-opioid-disposal-remove-risk-outreach-toolkit.

FDA OKs First Generic Naloxone Nasal Spray

Teva Pharmaceutical Industries Ltd. has won FDA approval for a generic version of its ***Narcan (naloxone hydrochloride)*** nasal spray to stop or reverse the effects of an opioid overdose. Generic naloxone nasal spray is approved for use in children or adults in a community setting by individuals without medical training—including family, friends, and caregivers of people who take opioids—and does not require assembly.

According to an FDA press release, the spray delivers a consistent measured dose when used as directed. It is sprayed into one nostril while the patient is lying on his or her back and can be administered again if necessary.

NeuroSigma's ADHD Device Wins FDA Approval

The FDA has approved the first medical device for the treatment of attention-deficit/hyperactivity disorder (ADHD). The ***Monarch external Trigeminal Nerve Stimulation (eTNS) System*** by NeuroSigma is indicated for children aged 7 to 12 years who are not taking prescription ADHD medications. It is available by prescription only.

While the child sleeps, the device delivers low-level, electrical pulses to the child's trigeminal nerve via wires and a small patch adhered to the child's forehead. The exact mechanism of eTNS is not yet known, but neuroimaging studies have shown that the trigeminal nerve connects to brain regions that are important in regulating attention, emotion, and behavior.

The efficacy of the Monarch system was shown in a clinical trial of 62 children with ADHD. The participants randomly received either eTNS or sham nerve stimulation nightly for four weeks. At the study's completion, the children using the eTNS device had a statistically significant improvement in their ADHD symptoms compared with the sham group, as measured with the clinician-administered ADHD Rating Scale. The device was well tolerated; the most common side effects observed with eTNS were drowsiness, increased appetite, trouble sleeping, teeth clenching, headache, and fatigue. **PN**

Gun Violence

continued from page 6

in homicides during this period.

The goal of keeping communities safe was also broached in the presentation of Connor Darby, M.D., a psychiatrist at the University of California, Los Angeles (UCLA). He focused on the college campus community and some recent state Supreme Court cases that could influence how these institutions approach gun-violence prevention.

Darby discussed two cases that involved civil suits against UCLA and the Massachusetts Institute of Technology (MIT). The former involved a student who was physically attacked by a fellow student with a knife, and the latter involved the suicide of a graduate student. Both the attacker and suicide decedent had a history of mental illness, though school officials did not suspect any imminent threat of violent or suicidal behavior.

In both instances, the state courts ruled that universities have a responsibility to protect students from "foreseeable" acts of violence and that they can be sued if they fail their responsibility. The decisions left some ambiguity as to what constitutes "foreseeable," which Darby noted could lead universities to develop "overreactive" policies to be compliant.

Though the two cases did not specifically involve guns, Darby said that the specter of gun violence will undoubtedly weigh heavily on future decisions made by universities when considering policies to prevent on-campus violence, as firearms are one of the leading causes of death of young people. In fact, the California Supreme Court cited the 2007 Virginia Tech mass shooting as a case where a university failed to act proactively.

One might think that universities could simply prohibit firearms on campus as one protective measure, since there is ample evidence that easy gun access is a risk factor for violence. However, Darby cited other legal cases that ruled that public universities do not have the authority to prohibit carrying legal firearms on campus.

"Does that mean universities might [overreact and] screen out students with a mental health issue to avoid liability or develop more aggressive policies toward such students on campus?" he wondered. **PN**

Information about Cures Violence is posted at http://cureviolence.org/.

JOURNAL DIGEST

BY NICK ZAGORSKI

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Social Media Use Affects Life Satisfaction, But Not Strongly

The relationship between social media use and well-being among youth is more nuanced than previously reported, according to a study published in *PNAS*.

Previous research has found that spending too much time on social media has negative effects on mood, happiness, and other measures of well-being. These results by and large have come from cross-sectional studies, which compare different people at the same time point. For the *PNAS* study, researchers at the University of Oxford and the University of Hohenheim explored changes in life satisfaction of individual youth following social media use.

Using data from a multi-year study of U.K. households, the researchers observed a reciprocal relationship between social media use and feelings of satisfaction among youth aged 10 to 15 years old: Increased social media use led to future reductions in life satisfaction, and improved life satisfaction led to future reductions in social media use. However, the effects in either direction were minor.

The authors also observed sex differences in the effects of social media on life satisfaction. Among boys, increased social media use only affected future life satisfaction, while in females, social media use influenced satisfaction with friends, family, school, schoolwork, and life. Satisfaction with appearance was not influenced by social media for either sex.

Orben A, Dienlin T, Przybylski AK. Social Media's Enduring Effect on Adolescent Life Satisfaction. *Proc Natl Acad Sci USA*. 2019; 116(21): 10226-10228. https://www.pnas.org/content/early/2019/04/30/1902058116.long


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Opioid-Stimulant Deaths More Common in People With Mental Illness

Over half of the people who died from an opioid overdose in Massachusetts from 2014 to 2015 had a mental illness. Opioid users with mental illness also were much more likely to overdose on multiple substances as opposed to opioids alone.

These findings were part of a larger analysis of Massachusetts state toxicology data to explore sociodemographic factors that affect the risk of opioid overdose. The analysis was conducted by investigators at Boston University School of Medicine and colleagues and was published in *Drug and Alcohol Dependence*.

For the study, the researchers analyzed toxicology reports for 2,244 people reported to have died from an opioid-related overdose in Massachusetts from 2014 to 2015. The toxicology reports indicated that 83% of these deaths involved the presence of another substance in addition to opioids, with stimulants being the most common class of drug. People with a mental illness were about 1.5 times as likely as those without mental illness to have an opioid plus stimulant combination in their system at time of overdose. Other groups at increased risk of opioid plus stimulant overdose death included blacks (2.2 times as likely compared with whites) and people with a history of homelessness (1.9 times more likely than people with no history). In contrast, people who had recently been incarcerated were about twice as likely as people who had not been incarcerated to overdose on solely opioids rather than multiple substances.

"Our study draws attention to the heterogeneity of the problem at hand and that there is not a one-size-fits-all approach to addressing the overdose epidemic, which is increasingly driven by polysubstance use," the authors wrote. "The type of opioid, the presence of polysubstance use, and the social context all influence the type of education and prevention approaches that are needed."

Barocas JA, Wang J, Marshall BDL, et al. Sociodemographic Factors and Social Determinants Associated With Toxicology Confirmed Polysubstance Opioid-Related Deaths. *Drug Alcohol Depend.* 2019; 200: 59-63. https://www.sciencedirect.com/science/article/pii/S0376871619301462?via%3Dihub


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Antidepressant Effects Seen In Mice Given Metformin

The diabetes drug metformin helps alleviate depressive and anxious symptoms in mice, according to a study published in the *Journal of Neuroscience*.

Researchers at the University of Toulouse in France and colleagues tested the effects of metformin on mice with insulin resistance as a result of being on a chronic high-fat diet. In addition to metabolic problems, the mice on a high-fat diet displayed anxious and depressive behaviors.

When the researchers gave the mice on the high-fat diet metformin, the mice showed improved body weight, lower fasting glucose levels, and fewer depressive-like behaviors. The antidepressant effects of metformin were similar to those seen if mice on a high-fat diet were given fluoxetine.

Since metformin works in part by reducing the levels of branched-chain amino acids (BCAA), the researchers tested the effects of a dietary intervention: a modified high-fat diet with reduced BCAA. Though mice on this diet still had poor metabolic profiles, they had fewer anxious and depressive behaviors than mice on high-fat diet only. The mice on the modified diet also showed a stronger response to fluoxetine than mice on high-fat diet only.

"These findings lead us to envision that a diet poor in BCAAs, provided either alone or as add-on therapy to conventional antidepressant drugs, could help relieve depressive symptoms in patients with metabolic comorbidities," the authors wrote.

Zemdegs J, Martin H, Pintana H, et al. Metformin Promotes Anxiolytic and Antidepressant-Like Responses in Insulin-Resistant Mice by Decreasing Circulating Branched-Chain Amino Acids. *J Neurosci.* Jun 3, 2019. [Epub ahead of print] http://www.jneurosci.org/content/early/2019/06/03/JNEUROSCI.2904-18.2019.long


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Elevated Testosterone In Women May Play Role in Obesity-Depression Link

There is accumulating evidence that obesity is a risk factor for depression, especially in women. Elevated testosterone levels might contribute to depression in overweight, premenopausal women, according to a study in *Translational Psychiatry*.

Researchers at the University of Leipzig and colleagues analyzed health data from 970 premenopausal and 2,154 postmenopausal women enrolled in a

continued on facing page

Native Americans

continued from page 9

and reviewing past issues," Walker explained in an interview after the meeting. "It is important to listen and let the person talk. The story they tell often leads to the solution. It's a lot like psychotherapy, although the entire family is also involved."

Adopting such a mixed model would require increasing the numbers of native mental health workers, he said.

"American Indian, Native Alaskan, and Native Hawaiian [students] are [represented] in the lowest numbers per capita in medical schools of any ethnic group," said Walker. "We must increase the critical mass of indigenous doctors, including psychiatrists, in the United States."

Only about 30 native psychiatrists, including five or six child psychiatrists, are now at work in the country, estimated panelist Richard Livingston, M.D., a psychiatrist of Cherokee origin in private practice in Little Rock, Ark. "There's a lot of work to do and not a lot of us to do it," he told attendees.

Walker praised APA's steps to recognize indigenous psychiatrists and support their work. He noted that APA in 1980 was the first U.S. medical association to testify before Congress on behalf of American Indian and Alaskan Native health, advocating for increased research, education, and clinical care.

American Indian, Alaskan Native, and Native Hawaiian people still have significant and largely unmet mental health needs, said the panelists, and more efforts should be addressed to draw in a new cohort of Native physicians and psychiatrists, said Livingston. "We need to help young people identify obstacles in their path and then liberate them to find their own road." **PN**

Information and toolkit about working with American Indian, Alaska Native, and Native Hawaiian patients is posted at http://apapsy.ch/indigenous_patients.

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large population study of adults in eastern Germany.

The researchers found that being overweight (BMI >25) was associated with depressive symptoms (assessed with the Centre for Epidemiological Studies Depression Scale) in premenopausal but not in postmenopausal women. Other obesity-related measures such as waist circumference or waist-hip ratio were not associated with depressive symptoms in either group of women. The researchers also found that premenopausal women who were overweight had higher blood levels of free testosterone compared with women of normal weight (BMI between 18.5 and 25).

Additional analysis revealed that premenopausal women of normal weight with elevated testosterone also had a slightly increased risk of depressive symptoms.

"Based on this insight, pharmacological approaches targeting androgen [testosterone] levels in overweight depressed females, in particular when standard anti-depressive treatments fail, could be of specific clinical relevance," the researchers wrote.

Stanikova D, Zsido RG, Luck T, et al. Testosterone Imbalance May Link Depression and Increased Body Weight in Premenopausal Women. *Transl Psychiatry*. 2019; 9(1):160. https://www.nature.com/articles/s41398-019-0487-5

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Menstruation Associated With Worsening Psychosis Symptoms

Women with psychotic disorders may be more likely to be admitted into the hospital in the days immediately before or during menstruation than at other points during their menstrual cycle, according to a meta-analysis appearing in *Schizophrenia Bulletin*. The findings suggest that these women may experience worsening symptoms of psychosis at times when their estrogen levels are low.

Researchers at King's College London and colleagues reviewed 19 studies (comprising 1,193 women diagnosed with a psychotic disorder) that examined exacerbations in psychiatric symptoms in relation to the menstrual cycle. Eleven studies examined psychiatric admission rates, five examined symptom scores, two examined self-reported exacerbation, and one examined both admission rates and symptom scores. To compare findings across studies, the researchers standardized the results to a 28-day menstrual cycle.

They found that psychiatric admission rates were 1.48 times higher during the perimenstrual phase (days before and during menstruation) than during the other days of the menstrual cycle. Four of the six studies that examined symptom scores also suggested that the participants' symptoms worsened during the perimenstrual phase, but the time points when symptoms were assessed varied considerably.

"Further research is needed to characterize the effect of the menstrual cycle on the symptomatology of psychosis, whether there is a subgroup of women who individually have a strong correlation between psychotic symptoms and menstrual cycles, and whether this subgroup is amenable to intervention in the form of hormonal therapy," the authors concluded. **PN**

Reilly TJ, Sagnay de la Bastida VC, Joyce DW, et al. Exacerbation of Psychosis During the Perimenstrual Phase of the Menstrual Cycle: Systematic Review and Meta-Analysis. *Schizophr Bull*. May 9, 2019. [Epub ahead of print] https://academic.oup.com/schizophreniabulletin/advance-article/doi/10.1093/schbul/sbz030/5487599

Brendel

continued from page 4

and colleague. "There couldn't be a better appointment to CEJA than Becca Brendel," he told *Psychiatric News*. "Becca has deep knowledge of clinical practice, ethics, and medical law. She has an excellent understanding of how organizations work, and an exceptional ability to move between ethical deliberation and practical action. She's a great colleague and member of a team.

"While I'm sad that my own term on CEJA has ended, I'm honored and delighted to have Becca taking my place on the council," Sabin said.

Halpin, elected by the House to the Council on Science and Public Health, has served as a delegate to the House of Delegates for nearly five years, first as a medical student and then as a resident. She is delegate to the resident and fellow section (RFS) from APA and serves as the vice speaker of the RFS Governing Council and as a sectional delegate from the RFS to the AMA House of Delegates. She is also an APA/APAF Leadership Fellow and serves as a member of the APA Council on Healthcare Systems and Financing. She is in her first year of a child psychiatry fellowship and plans to focus on substance use disorder research, placing her work directly at the intersection of policy, science, and public health. **PN**