



PSYCHIATRIC NEWS

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SEE STORY BELOW AND ON PAGE 2

This staircase was a feature of what is now known as Western State Hospital in Staunton, Va. Its second superintendent was Francis Stribling, one of APA's founders, who refused to admit Black patients to the hospital while enslaving Blacks to serve white patients. Racism in American psychiatry goes back to the profession's beginnings in this country. APA held a town hall last month to address structural racism within APA and psychiatry.

Cover Photo © Tom Kirsch/opacity.us



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Medical academia still tainted by sexual misconduct.



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Funds from opioid suits should go to expanding treatment, urges APA.



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Expert panel offers guidance on use of clozapine during pandemic.

Black Psychiatrists Call on White Colleagues To Dismantle Racism in Profession, APA

Frank, open dialogue; proactive self-examination; and measurable action are key to conquering racism and establishing true equality, experts say. BY TERRI D'ARRIGO

On June 15, APA President Jeffrey Geller, M.D., M.P.H., hosted the first of a series of member town hall meetings to address structural racism in APA's history, among colleagues, in psychiatric practice, and in the education of medical students and psychiatry residents. A distinguished

panel of Black psychiatrists and a guest physician spoke to more than 500 APA members about what must be done to dismantle the processes and institutions that confer advantages upon white people and impede the lives and livelihoods of Black people, not only in APA and the profession of psychiatry,

but in the nation as a whole.

Geller began with a discussion of racism dating back nearly to the inception of American psychiatry (see page 2). He described two alleged diseases theorized by nonpsychiatrist physician Samuel Cartwright in the mid-1800s: *drapetomania*, the desire to flee from servitude, and *dysaesthesia aethiopica*, a lack of work ethic.

"Cartwright's theories were embraced in the slave states and mocked in the free states, including in medical journals," Geller said. "APA was silent, and that is our shame. They were silent then, and we have been silent for 176 years."

Danielle Hairston, M.D., president of the APA Caucus of Black Psychiatrists and the psychiatry residency training director at Howard University College of Medicine, stressed that racism in psychiatry is not a thing of the past and that it still plagues the profession.

"Please don't say that you're sorry for

what Black people are going through right now. We've been going through this forever," she said. "Systemic racism is etched in stone into every aspect of life in America, and medicine and psychiatry are not exceptions, but complicit."

Hairston answered a question posed by a member, "How can we support Black residents and students?"

"You can start by validating that racism exists and validating their experiences. When a student or trainee is telling you something [racist] is happening, listen," she said. "The revolution and the answer will not be cultural competency and diversity training. When there are no Black residents in your program, ... do something about that. Do something to prioritize diversity, discuss sponsorship and mentorship, and invest in diversity as part of your recruitment."

Walter E. Wilson Jr., M.D., M.H.A., a member of APA's Council on Minority Mental Health and Health Disparities and a second-year fellow in child and adolescent psychiatry at Vanderbilt University, highlighted disparities in the criminal justice system and incarceration. He noted that although Black

see **Racism** on page 22

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FROM THE PRESIDENT

Structural Racism in American Psychiatry and APA: Part 1

BY JEFFREY GELLER, M.D., M.P.H.

This article covers October 12, 1773, to June 12, 1862.

Cup Foods, on the corner of 26th Avenue South and East Lake Street in Minneapolis, is a neighborhood grocery store. On May 25, George Floyd, a regular at the store, got more than the pack of cigarettes he went in to buy. Minneapolis police officers served death to George Floyd, a 46-year-old Black man, who, in all likelihood, unknowingly paid for his cigarettes with a counterfeit \$20 bill. And then the cycle repeated with the murder of Rayshard Brooks.

After Floyd's murder, you participated in or read about protests that occurred not only from coast to coast, but also worldwide. Surely you have received an email from every organization to which you belong, and probably just as many to which you don't, expressing their outrage. It's the thing to do. What will people think if some organizations don't do it? What's worse, all manner of commercial enterprises have spewed out their chagrin. If they all meant what they said, they'd do something, such as have fair and transparent background checks for Black workers and pay them equita-



ble wages with good benefits. Where does APA fit into the latest lethal reminder that racism is still rampant and that, as Al Sharpton stated at Floyd's memorial, "Time is out for empty words and empty promises"? And where does APA go from here? To better answer these questions, it's helpful to know where we've come from.

18th Century

The history of American psychiatry and the history of Black Americans is the history of slavery and segregation in America for over 200 years, right on through the end of the Civil War; the passage of the 14th and 15th Amendments; the Civil Rights Act of 1964, which included a provision for equal access to public places; and up to the present. The history of American psychiatry and segregation extends well into the lifetime of over 100 million Americans living today.

On October 12, 1773, the Public Hospital for Persons of Insane and Disordered Minds in Williamsburg, Va., the first public freestanding psychiatric hospital in British North America, admitted its first patients. From its opening through the 19th century, the relationship between the hospital and Blacks is both remarkable and perplexing. Unlike most of the hospitals that were later built in the South, the Williamsburg asylum admitted both free Blacks and enslaved Blacks and housed them in the same hospital building. However, enslaved people could be admitted only if their admission did not interfere with the admission of a white person, and their care had to be paid for by their owners. Moreover, the asylum needed slave labor to operate and paying patients to make ends meet. So the Williamsburg asylum accepted slaves in payment for care and treatment and advertised this fact.

John Minson Galt, who was the physician head of the asylum from 1841 to 1862 and one of APA's founders, did not

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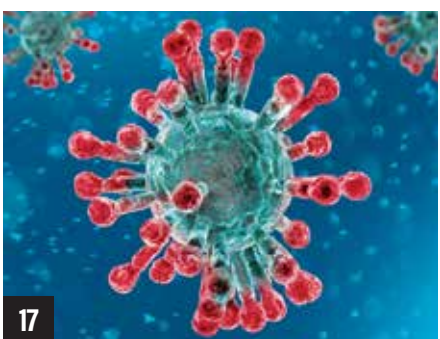
During her final speech as president, psychiatrist Patrice Harris, M.D., M.A., described the role physicians can play in moving the country forward.

4 | Suicide Rates Among Black Youth Rising

A variety of factors, including limited access to treatment and exposure to discrimination, may be behind this disturbing trend, experts say.

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APA's COVID-19 Resource Center

This regularly updated site brings together a number of resources from APA and other authoritative sources to help members stay informed of changing government regulations and other practice-related news and care for their patients and themselves. It can be accessed at psychiatry.org/coronavirus.

continued from facing page

expect many Blacks to present for admission. Insanity was thought to be a disease of civilized people, and Africans and their descendants were considered a “primitive” population. The assumption of the time was that enslaved people lived a simple life in which decisions were made for them, while white people were exposed to the stress and strain of daily decision making about property, business, education, religion, and health care. Galt thought Blacks were “immune” to insanity “because they are removed from much of the mental excitement to which the free population is necessarily exposed in the daily routine of life.” Such beliefs expose the ignorance of white psychiatrists. How could they think that living a life in which you were owned by someone who could sell your family on a whim, who could punish you for anything he decided was a transgression, who could prohibit you from practicing customs and a religion of your choice, and who controlled every aspect of your living conditions was stress free?

In 1792 Benjamin Rush, considered the father of American psychiatry and the best known physician throughout America in his era, proclaimed that Black skin was actually a disease. Rush was a remarkable mix of contradictions. He was an ardent abolitionist who owned a slave. He spoke out on the position that Blacks were of equal intelligence and morality as whites. Nonetheless, he created a disease called *negritude*, a disease whose cure was turning a Black person white. In support of his belief, Rush produced a Black man who was turning white. A contemporary explanation for this is that this man had vitiligo. Rush prescribed scrubbing the skin long and hard.

The 1840s

The U.S. census of 1840 brought to the nation’s attention the relationship between slavery and insanity. The census had a new category that year: “insane and idiotic.” The census reported that in free states, there was one insane or idiotic person for every 144.5 Blacks; the ratio for whites was 1 to 867. However, in slave states, the ratio of insanity for Blacks was 1 to 1,558. Also, the farther north one went, the higher the ratio of insanity in Blacks, and the farther south one went, the lower the ratio. The ratio of insanity among Blacks in Maine was 1 in 14, while in Louisiana the ratio was 1 in 4,310. John McCune Smith, the first Black licensed to practice medicine in the United States, and Edward Jarvis, a physician and father of American biostatistics, wrote scathing rebuttals highlighting fundamental methodological flaws. John C. Calhoun, who had resigned his position as vice president to become a senator from South Caro-

lina, supported the findings of the census, proclaiming, “Here is the proof of the necessity of slavery. The African is incapable of self care and sinks into lunacy under the burden of freedom. It is a mercy to him to give this guardianship and protection from mental death.” John McCune Smith’s conclusion was different: “Freedom has not made us

alienists came from freestanding psychiatric hospitals, some public and some private. General medical hospitals wanted to segregate patients and could do so by placing them in separate rooms or wards. At least one of the superintendents at that meeting believed the country needed to have hospitals where only white patients

Of the original 13 members of APA, most were from New England or New York. One of APA’s founding members was an ardent segregationist who felt admitting Blacks to his hospital was repugnant. That psychiatrist was Francis Stribling from western Virginia. The most active voice in favor of integrated facilities was John Galt from eastern Virginia. Some superintendents endorsed segregation by using different buildings for Blacks.

Stribling was one of the most influential of the original 13 APA members, and the members apparently charged ahead with segregation policies. Stribling developed a set of requirements for institutions to serve Black patients that conveniently resulted in their need to be treated in Galt’s asylum in Williamsburg. Stribling saw no contradiction in adamantly refusing to allow a Black patient into his hospital while permitting enslaved Blacks to move freely about his hospital to serve well-to-do white patients.

In volume 2 of the *American Journal of Insanity* (now the *American Journal of Psychiatry* [AJP]), the editor, Amariah Brigham, provided overviews of each asylum, drawing from materials produced by their superintendents. He poked at Stribling, commenting, “We notice that colored persons are not received as patients into the Western Asylum” (Stribling’s hospital) and then quoted extensively from Stribling’s hospital report. Stribling went on at great length as to why the asylum needed to own slaves. As to the question of why he did not admit Black patients, he said, “We have never found it practicable [sic] to admit them.” No member of the Association asked for an explanation of this meaningless reason. No one challenged Stribling’s racism.

Stribling went further, arguing that services for “colored persons” are

see *Structural Racism* on page 6

1851] Facts from the Census. 155

STATISTICAL TABLE FROM THE U. S. CENSUS OF 1840.

States.	Total White populat'n	Insane and Idiots.	Proportion	Total Color'd pop'n.	Insane and Idiots.	Proportion
Maine.....	500,438	537	1 in 950	1,355	94	1 in 14
New Hampshire.....	284,036	486	1 " 584	538	19	1 " 28
Massachusetts.....	729,030	1,071	1 " 662	8,669	200	1 " 43
Vermont.....	291,218	398	1 " 731	730	13	1 " 56
Connecticut.....	301,856	498	1 " 606	8,159	44	1 " 185
Rhode Island.....	105,587	203	1 " 520	3,243	13	1 " 249
New York.....	2,378,890	2,116	1 " 1,108	50,031	194	1 " 257
New Jersey.....	351,588	369	1 " 952	21,718	73	1 " 293
Pennsylvania.....	1,676,115	1,946	1 " 861	37,952	187	1 " 256
Delaware.....	58,561	52	1 " 1,126	19,524	28	1 " 697
Maryland.....	317,717	387	1 " 821	151,515	141	1 " 1,074
Virginia.....	740,968	1,052	1 " 704	498,829	381	1 " 1,309
North Carolina.....	484,870	580	1 " 835	268,549	221	1 " 1,215
South Carolina.....	259,084	376	1 " 689	335,314	137	1 " 2,440
Georgia.....	407,695	294	1 " 1,387	283,697	134	1 " 2,117
Ohio.....	1,502,022	1,195	1 " 1,257	17,345	165	1 " 105
Kentucky.....	590,253	795	1 " 742	189,575	180	1 " 1,053
Louisiana.....	158,457	55	1 " 2,873	193,954	45	1 " 4,310

This table appears on page 155 of the October 1851 issue of the *American Journal of Insanity* in the article titled “Startling Facts From the Census.”

mad; it has strengthened our minds by throwing us upon our own resources.”

In the wake of the 1840 census, APA—named at the time the Association of Medical Superintendents of American Institutions for the Insane—was formed when Samuel Woodward of Worcester, Mass., and Francis Stribling of Staunton, Va., convened a meeting of 13 superintendents. All these

were treated. From his point of view, segregating sections of an asylum was unacceptable. This issue arose concurrently with the spread of Moral Treatment. Moral Treatment included the concept that patients of higher social status should not be caused distress by having to associate with patients of lower social status. That lower class group, of course, included Blacks.

Consider Becoming an APA Officer or Trustee



As chair of APA’s Nominating Committee, APA Immediate Past President Bruce Schwartz, M.D., is seeking to diversify the elected leadership of APA and invites all members to consider running for one of the open offices and trustee positions in APA’s 2021 election: **president-elect; secretary; early-career psychiatrist trustee-at-large; minority/underrepresented representative trustee; Area 1, 4, and 7 trustees; and resident-fellow member trustee-elect.**

Members may self-identify their interest to serve. If selected by the Nominating Committee, you will be invited to run as a candidate in the upcoming election. To self-nominate, submit a completed nomination form available at psychiatry.org/election by Tuesday, September 1. If you are not interested in running for office at this time, **nominate a colleague** at election@psych.org. All nominees must submit a completed nomination form by the deadline.

This is your chance to serve APA, your colleagues, and psychiatry and ensure that the professional issues of most importance to you are addressed. More information about APA’s election and nomination requirements are posted at psychiatry.org/election.



Outgoing AMA President and Psychiatrist Vows to Work for Equity and Justice

Harris emphasized the AMA's consistent stand against misinformation about COVID-19.

BY MARK MORAN

"Our country—indeed our world—is being challenged as never before," said outgoing AMA President Patrice Harris, M.D., M.A., in her farewell address during AMA's virtual House of Delegates meeting last month. Physicians and the public are being "[c]hallenged by a novel virus for which there is not yet a specific treatment or vaccine, challenged by a lack of resources and personal protective equipment [PPE], challenged by a political climate that is highly polarized, challenged by the rampant spread of misinformation and disinformation."

While nationwide protests were raging against police brutality in the aftermath of the killing of George Floyd, Harris—who was the first African American woman president of the AMA—vowed to continue to work for "equity and justice within the walls of our exam rooms, the health delivery system, the halls of Congress, and our justice system."

Harris, who is still chair of the AMA Task Force to Reduce Opioid Abuse, also



Outgoing AMA President and psychiatrist Patrice Harris, M.D., M.A., says that physicians can "demonstrate how to understand more and fear less" and be "the voices our country can trust in this time of trial."

vowed to work "to ensure that mental health is integrated into overall health and that there is action to address the physical and psychological consequences of early traumatic experiences."

Early in her remarks, Harris asked for a moment of silence to remember those who died from COVID-19. "Three months ago, all of our lives, indeed our

way of life, changed dramatically. In the United States, more than 1.7 million people have become infected with COVID-19, and more than 100,000 have died. I want us to pause on that just a moment because these are people ... with families and loved ones who are grieving them, and they deserve a moment of pause."

Resuming her talk, Harris referenced remarks in her November 2019 address at the AMA Interim Meeting in Orlando, Fla.—before the pandemic hit the United States—in which she said physicians would always "match the moment," rising to every occasion and continuing to earn public confidence in an era of mistrust.

"Little did any of us realize at the time how dramatically we would be put to the test," she said. "But 'match the moment' we have. Physicians are working long hours in offices and hospitals, sleeping in their basements or hotels so they do not infect family members, working overtime to develop vaccines and treatments, countering the endless false narratives circulating across media channels, and reopening medical practices so we can meet the postponed health needs of our patients."

APA CEO and Medical Director Saul Levin, M.D., M.P.A., said Harris was the right leader for this time.

"We applaud Patrice for the completion of a successful year as the leader of the AMA," Levin said. "She served during a trying time in medicine as the COVID-19 pandemic began to arrive on our shores. She led the AMA as it pushed for resources for doctors on the front lines and for regulatory changes in Washington to help deliver care to those in need. She was an advocate for promoting evidence-based approaches

see Harris on page 28

Alarming Black Youth Suicide Trend Must Be Addressed, Experts Say

With the rate of suicide increasing among Black youth, they need support from psychiatrists to build resiliency and identify opportunities for advancement. BY KATIE O'CONNOR

The National Institute of Mental Health (NIMH) recently held a webinar that addressed a new and distressing trend: the increasing rate of suicide among Black youth.

According to NIMH, Black youth under age 13 are twice as likely to die by suicide as their white peers, and the suicide death rate among Black youth has been increasing faster than in other racial/ethnic groups.

"Quite frankly, I'm alarmed," said Michael Lindsey, Ph.D., M.S.W., M.P.H., one of the participants. "I'm scared for a lot of Black kids and their families, because suicide has somehow become an option for how they reconcile their emotional, psychological pain."

The webinar was part of the NIMH Office for Disparities Research and Workforce Diversity webinar series and was held in association with the Office of Behavioral Health Equity at the Substance Abuse and Mental Health Services Administration.

In an interview with *Psychiatric*

News, Tresha Gibbs, M.D., a member of APA's Council on Children, Adolescents, and Their Families, said psychiatrists must work to help Black youth, particularly during the pandemic and especially due to these disturbing trends. Gibbs is also the medical director of outpatient psychiatry at the New York City Children's Center.

"In our field, we help people maintain hope and strengthen their resiliency," Gibbs said. "Let's focus in and help more Black youth survive to see adulthood. Let's create a better world for them so it's a world they want to live in."

Risk Factors Outlined

The webinar participants pointed to a variety of risk factors for suicidal ideation and behavior among Black youth, such as depression, anxiety, and attention-deficit/hyperactivity disorder, as

well as family conflict. Black youth in particular may not have access to treatment and are more likely to experience discrimination, the participants said.

Unfortunately, the media amplifies and reinforces negative images of Black youth, explained Michelle Durham, M.D., M.P.H., an assistant professor of psychiatry at Boston University School of Medicine.

To adults, Durham explained, news reports involving discrimination and

continued on facing page

The Pandemic's Impact

The COVID-19 pandemic is shining a light on long-standing inequalities as the pandemic has a disproportionate impact on Black people (see *Psychiatric News*, <https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2020.5b5>).

"We have a long history in the U.S. of Black and brown people not having the same starting point as our white counterparts," Michelle Durham, M.D., M.P.H., said. "Those inequities are just exacerbated in times like this."

Generally, African American youth struggle with grief and experience more losses than other youth, Tresha Gibbs, M.D., said. Those losses include experiencing the death of a loved one and losing opportunities for advancement, employment, and even safety in the community.

"Grief is a hugely important thing to address in Black

youth," she said. "Being aware of the fragility of life at every moment is a really difficult way to grow up."

As many youth are likely to struggle during the pandemic due to isolation and losing connections, there might also be new opportunities for some, especially if they are able to spend more time with their families, Gibbs said. Psychiatrists might also be able to develop important connections with their patients' families. "One thing we've noticed in our center is that during the pandemic, the amount of contact we have had with parents has increased, in part because they become a mediator between the child with the phone or video," Gibbs said. "We really need to take this opportunity to provide as much psychoeducation as possible to decrease stigma around the work of mental health professionals."

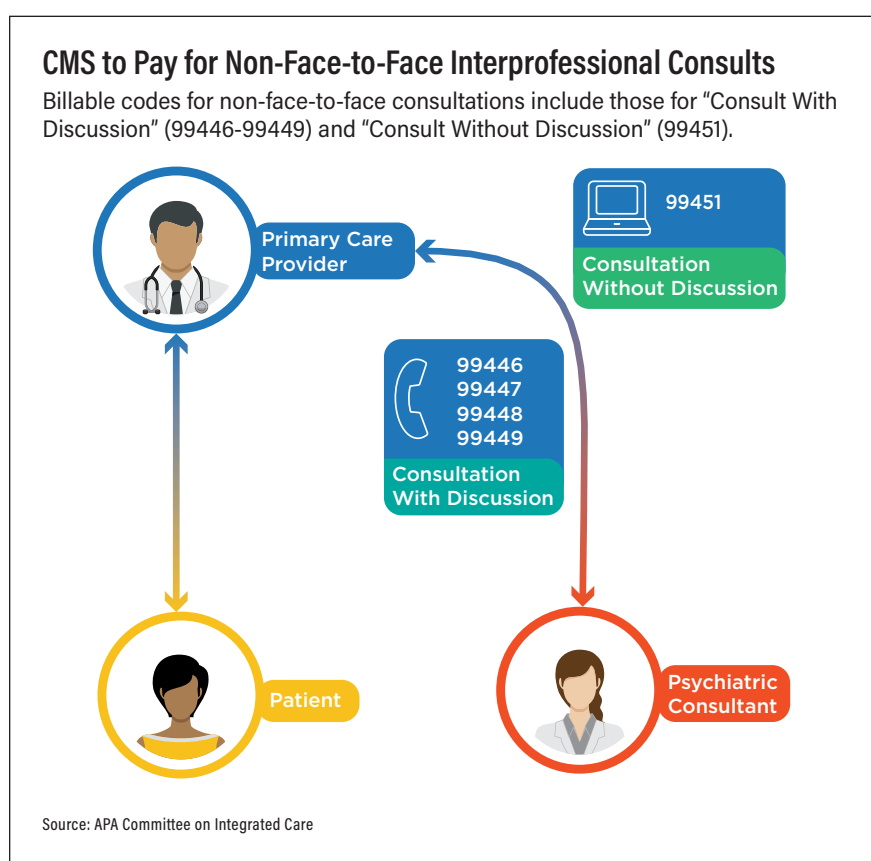
Integrated Care Committee Provides Guides To Interprofessional Consultation Codes

Medicare now pays for non-face-to-face interprofessional “curbside” consultations by psychiatrists with primary care and other physicians. The psychiatrist guide explains how to use the codes, and the patient guide explains how they are important for care.

BY MARK MORAN

A guide for psychiatrists on how to use CPT codes to bill for non-face-to-face consultations with primary care and other physicians—along with a one-page guide on the consultation and billing process for patients—is now available from APA’s Committee on Integrated Care.

The guides refer to the kind of non-face-to-face “curbside” consultations that many psychiatrists regularly provide—answers to impromptu requests from primary care and other physicians for advice about managing psychiatric conditions or possible psychiatric complications related to medical treatment. The Centers for Medicare and Medicaid Services (CMS) issued the codes in 2019 and began paying for the consults this year.



“Payment for Non-Face-to-Face Services: A Guide for the Psychiatric Consultant” is a four-page how-to

guide for using CPT codes that psychiatrists can use to bill for interprofessional consultations using tele-

phone, internet, or electronic health records. The codes explained in the new guide are 99446-99449 (Consult With Discussion) and 99451 (Consult Without Discussion).

Psychiatrists should note, however, that these codes cannot be used by those who are working in a collaborative care model; their time is billed by the primary care practice using codes 99492-99494.

“The CPT code book can be wordy, confusing, and overwhelming,” said Shannon Kinnan, M.D., a member of the committee who helped draft the guides. “We wanted to break it down in an easy-to-use guide so psychiatrists who are consulting with primary care and other physicians will know how they can bill for their services, and patients can understand why the consultation is an important part of their care.”

The guide for psychiatrists describes each set of codes and the circumstances in which they can be used, recommendations for documentation, and time guidelines and approximate reimbursement for each amount of time spent in consultation. The guide also provides two case examples, including a patient scenario presented by a primary care or other physician, the response by the consulting psychiatrist, and how the response is documented and billed.

“Consult With Discussion” (99446-99449) codes are codes that can be used

see **Consultation Codes** on page 28

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racism are painful, so imagine school-age youth who are still in the developmental stages of childhood hearing,

disorders that go undiagnosed.

“Just imagine that you’re a little kid. You’re growing and developing, and you’re looking at the adults in your life to be trusting, caring people,” Durham

we’ve been wondering is: Are these protective factors less [protective] now, as the rates are increasing? There’s a lot we don’t know.”

“Part of being a Black American is having this sense that your freedom can be lost at any moment,” Gibbs said. “But the Black community has been resilient, and the majority of kids come through as survivors. Yet these issues have a big impact on them.”

Gibbs encouraged mental health professionals to ensure they recognize the impact of collective community trauma experienced by Black people

their ability to control their futures and their lives,” she said.

Psychiatrists must continue to advocate to improve access to care and expand the diversity of the workforce, Durham said. She pointed out that many psychiatrists who work in academic institutions need to prioritize improving their community-based partnerships.

“We have to listen to our communities,” she said. “Just because some people don’t have initials after their names doesn’t mean they don’t know what their communities need.” **PN**



The reality is that a lot of Black youth will know more people who are sick and who have passed due to COVID-19 than other youth.

—Tresha Gibbs, M.D.

seeing, and being confronted with these images. “It sends a message that maybe ‘I’m not good enough, that I’m not accepted, I’m bad, I’m not wanted,’” she said.

Compounding the problem are huge gaps in access to care for Black youth and lack of diversity within the mental health workforce. “We don’t want to have to explain to a health professional what it feels like to be discriminated against,” Durham said.

Gibbs pointed out that Black youth also experience disparities in diagnosis. While their externalizing disorders may be more readily identified, many are struggling with mood and anxiety

said. “Yet we’ve seen this time and time again in school systems, in the community, and in the different settings where kids are just trying to be kids: Adults already see these 5- or 6-year-old little boys as men.”

Building Resiliency, Finding Solutions

The webinar participants touched on some of the protective factors against suicidality in Black youth “such as cohesion within families, community cohesion, and religious activities,” said Rhonda C. Boyd, Ph.D., an associate professor of psychiatry at the Perelman School of Medicine at the University of Pennsylvania. “One of the things



Racism can be a barrier to care as well as a risk factor for suicidality. Black youth may be more likely to be labeled as “bad” kids when they’re really just experiencing the symptoms of mental illness. —Michelle Durham, M.D., M.P.H.

in the United States. “Every time there is an incident in which a Black person is unjustly killed, it reverberates in the Black community and among Black youth particularly as they think about

“Responding to the Alarm: Addressing Black Youth Suicide” is posted at <https://www.nimh.nih.gov/news/media/2020/responding-to-the-alarm-addressing-black-youth-suicide.shtml>.

Sexual Misconduct Perpetrators Often Permitted to Remain in Academia

Forty percent of identified faculty in academic medicine who were accused of sexual misconduct between 1982 and 2019 remained in academia, a study finds.

BY KATIE O'CONNOR

Past APA President Nada Stotland, M.D., M.P.H., has seen the same outcome over and over again: The perpetrators of sexual misconduct in academic medicine go unpunished and are often permitted to continue their careers unencumbered.

"Unless you've been around the block for few decades and been involved in women's issues and their careers, you would never believe that people get away with it," she said.

According to a study published April 21 in *JAMA*, a significant portion of people—mostly men—who were accused of sexual misconduct resulting in institutional or legal action that proved or supported guilt between 1982 and 2019 remained in academia.

Magdalena Espinoza, M.D., a faculty associate in the Department of Internal Medicine at UT Southwestern Medical Center, and colleagues conducted internet searches to identify faculty accused of sexual misconduct in academic settings. They used both Google and FindLaw, a public database of federal and state court decisions, using keywords such as sexual misconduct or sexual harassment and medicine, physician, instructor, college, and others. The authors then performed additional searches to determine the accused faculty member's name, characteristics, targets, institutional actions, and outcomes.

They identified 125 faculty accused of sexual misconduct between 1982 and 2019 affecting at least 1,668 targets. Nearly all (97.6%) were male, and 91.5% targeted females only. About 33% of the faculty were from *U.S. News & World Report* top 50-ranked colleges or universities; most were full professors, chairs, directors, or deans; and 72% targeted subordinates.

About half of the accused faculty resigned or retired, 20.8% were terminated, and 8.8% were sanctioned by funding sources or boards governing clinical practice. "We identified 50 accused faculty who remained in academia, of whom 40% held positions at a different teaching institution," the authors wrote.

The study included only faculty who had received media attention or were involved in legal proceedings. The public documents likely do not capture the full extent of misconduct that occurred during the study period due to the lack

of transparency in investigations, the authors noted.

"Although disturbing, the results are not surprising, as they echo findings published by the National Academies of Sciences, Engineering, and Medicine in 2018 that reported that close to half of women medical students have been sexually harassed," wrote Julie Ann Frelschlag, M.D., and Katherine Files, M.B.A., both of Wake Forest Baptist Health in an accompanying commentary.

What is surprising and concerning, they continued, "is that faculty perpetrators in the biomedical and



The most important thing for victims of sexual misconduct to remember is that it is not their fault, and they should seek support from others, says Nada Stotland, M.D., M.P.H.

health sciences were to a degree immune to consequences."

The Decades-Long Fight Continues

"This article for the first time highlights what happens in academia, and it's honestly no different from what happens in the entertainment industry or sports industry," said Geetha Jayaram, M.D., M.B.A., immediate past president of the Association of Women Psychiatrists and a professor of psychiatry and behavioral sciences at the Johns Hopkins School of Medicine.

For many women in academic medicine, the fight to end sexual misconduct has been long and frustrating. Women physicians have been speaking out about the problems for decades, said Maureen Sayres Van Niel, M.D., who is the APA Assembly's representative to the Caucus of Women Psychiatrists.

"And yet we're still talking about them today," she said.

"There's a sense of frustration among women physicians because we've been fighting this battle for so long," said Warachal Faison, M.D., president of the Association of Women Psychiatrists and senior medical director of neuroscience



"This problem needs to be consistently and systematically addressed until we see real change in academia," says Geetha Jayaram, M.D., M.B.A.

and pain at Pfizer. "It's up to all of us, men and women, to have a voice in this, to stand up and speak out."

Changing institutions is vital to address sexual misconduct in academic medicine, as is increasing the number of women in leadership positions. Though more women now enter medical school than men, only 42% of faculty members and 20% of department chairs and deans are women, Frelschlag and Files pointed out in their commentary.

Women physicians often feel powerless to change the culture in academic medicine, Jayaram said. Often sexual misconduct is not reported because women are rightfully concerned that there will be retaliation against them that will stall their careers.

Stotland offered advice for women in academic medicine: If they are the targets of sexual misconduct, they should carefully assess the situation and ensure they're making clear-eyed decisions about whether it's in their best interest to report the behavior. Unfortunately, as the *JAMA* study outlines, reporting seldom results in sanctions against the perpetrators, but it does carry the potential to jeopardize the victims' careers.

Women should seek support from women's groups and organizations. "Being in these situations tears down your self-esteem—it makes you think that your work must not be as worthwhile as it almost certainly is," she said. "You need support as you make your decision about reporting." **PN**

Characteristics of Faculty Accused of Academic Sexual Misconduct in the Biomedical and Health Sciences is posted at <https://jamanetwork.com/journals/jama/fullarticle/2764695>. **Sexual Misconduct in Academic Medicine** is posted at <https://jamanetwork.com/journals/jama/fullarticle/2764683>.

Structural Racism

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needed, but, he said, "for many reasons it would be desirable that an institution for colored persons should be entirely distinct from those occupied by insane whites." No one in the Association asked Stribling what those many reasons were. Stribling went on to say this was not his problem—it was a matter for the legislature to deal with. As we shall see, 25 years later and four years before Stribling's death, Virginia opened the first all-Black psychiatric hospital in the nation.

Woodward had his own struggles with how to deal with Black patients. It was generally accepted that Black patients should not lodge with white patients, so Woodward constructed separate housing for Black patients. But this violated other principles of separation in which Woodward believed: Men and women should be housed separately. Patients should be separated by the stages of their diseases, such that convalescing calm patients, incurable patients, noisy and violent patients, and curable patients should all be housed separately. It is not clear whether Black and white patients mixed during the day, but with regard to another hospital population—male and female patients—they were housed separately, yet Woodward wanted them to mix as much as possible during the day.

Housing Black patients separately, in much poorer circumstances than white patients, was the temporary solution adopted in Southern states at a time when states had only one public psychiatric hospital. In these asylums, Black patients and white patients never mixed. The outlier was the Williamsburg, Va., hospital (Galt's hospital). It had 100 patients when APA was formed, 15 of whom were Black and were not segregated from the white patients. It's clear that there was no consensus on integrated or segregated asylums among the 13 superintendents. What does appear to have been tacitly agreed upon is that there would be no confrontations on the subject, at least not officially, as reflected in the Association's minutes.

Psychiatrists found themselves in the position of having to address the issue of integrated or segregated facilities much sooner than not only the rest of medicine, but also most establishments of work and recreation. In most places in the 1840s, integration was de facto. By not objecting to Stribling's proposal, the Association was on record as condoning segregated facilities.

Not only did some of the first cohort of white Southern psychiatrists refuse to admit Black patients to their hospitals, but they influenced those who followed to create more segregated facilities than they were originally

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inclined to do. Stribling influenced Charles Nichols in the design of the Government Hospital for the Insane in Washington, D.C., to house Black patients in separate buildings behind and at some distance from the better facilities for the white patients. Nichols was required to care for Black and white patients as his was the only asylum in

the District, so housing them in separate buildings was, from Stribling's point of view, the "best" he could do. Psychiatric hospitals in the first half of the 19th century have the shameful distinction of being some of America's first officially segregated institutions.

The 1850s-1860s

Only a few years later, in 1851, two "diseases" that must be the absolute

nadir of psychiatric diagnoses were promulgated by Samuel A. Cartwright, a native Virginian who practiced medicine in Alabama, Mississippi, and Louisiana. He was not formally a psychiatrist, but he had spent part of his training apprenticed with Benjamin Rush. His two diagnoses were *drapetomania*—the disorder that purported to explain why slaves run away—and *dysaesthesia aethiopica*—a disorder that supposedly explained laziness

and a lack of work ethic among Blacks. Cartwright believed runaway slaves had a disease because God created Blacks to be "submissive knee benders." In other words, Blacks were genetically programmed to be slaves, and it was an aberration, a disease, if they did not want to be slaves. Cartwright believed that *dysaesthesia aethiopica* was predominantly found in free Blacks and affected

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nearly all of them. According to Cartwright, without a “master,” the Black person was lost.

Cartwright’s theories were embraced in the slave states and mocked in the free states, including in medical journals. APA was silent. So far I have not been able to find any articles in the official journal of APA (*AJP*) that

addresses the assessment, diagnosis, or care and treatment of Black patients in the first three generations of the Association. APA held to its already established pattern of silence on matters related to race.

In 1852, the *American Journal of Insanity* printed an article by Edward Jarvis pointing out the fallacies of the 1840 census, material he had published years before in other journals. Appar-

ently, having failed to influence the thinking of the Association, Jarvis tried again at the 1862 Annual Meeting. It’s worth remembering that Jarvis had no power in the Association as he was not a superintendent or a psychiatrist—so he could not be a member. He started his discussion on the subject of the “colored insane” by talking about his survey of the “insane” and the “Irish insane” in Massachusetts (a subject of

only passing interest to any but the Massachusetts members). His remarks are recorded in the journal in the minutes of the Annual Meeting.

Jarvis referred to the “data” in the census as “a pure creation of the imagination.” He pointed out that many towns had a number of “colored insane” despite not having any colored persons listed in their census. He emphasized that this census “has done

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a tremendous amount of political and scientific mischief.” It took Jarvis over 20 years to get this information about the misleading 1840 census into the journal. This misinformation spread to England, France, and Germany. Jarvis highlighted an article by a Frenchman using a formula based on the “fact” that the rate of insanity in the “Negro” decreases the farther one goes North, suggesting that as one arrived

at the North Pole, one would have more insane people there than there were people. Isaac Ray interrupted Jarvis and changed the subject.

Summary

In 1889, the *American Journal of Insanity* published an index for its first 45 volumes. While that goes beyond the time frame of this article, there is no heading for any topic that would have

been related to mental illness in Black Americans in that period.

At the first meeting of the Association, the 13 attendees created 16 committees, one of which was the committee “On Asylums for colored persons.” Galt; Stripling; and William Maclay Awl, superintendent of the Lunatic Asylum of Ohio, were the committee members. At the second meeting, there is mention that Galt presented a paper on the “col-

ored insane.” Nothing was said about the paper, which was never published in the journal. No other paper on the subject appears until beyond the Civil War. In year after year of reports by asylum superintendents about their institutions, only once, Nichols, the superintendent of the Government Hospital for the Insane, in 1857, reports on the number of white insane and the

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number of “colored insane.” No one had done that previously, and no one, including Nichols, did so after that. Looking back, it appears that during APA’s first 40 years, the leadership and the members were guilty of magical thinking, denial, and downright deception with regard to Black people. *AJP* is filled with beautiful, majestic engrav-

ings of Kirkbride’s model for the asylum and its application throughout the United States. There is no engraving, and hardly a mention, of the separate buildings constructed for the “colored insane.” Such renderings were made, as some still exist, but they were never on the journals’ pages. It is not possible that the 13 original members did not know about the controversies around free Blacks and

enslaved Blacks. When APA was established, there were 13 free states and 13 slave states. When new states were admitted, there was an attempt to admit one free state and one slave state to keep the numbers equal. If the superintendents didn’t know about hospital segregation when they created APA, they all quickly learned that some of their colleagues refused to admit people of color to their asylum and insisted there be

segregation by race. Also, during this time, Association members were not opposed to discussing the segregation of the insane population on the basis of certain traits, such as sex, and rejected the idea that their hospitals should be segregated by socioeconomic status. But Association members did not debate segregation by race. A few members said it shall be so, and the rest were silent—silent for a very long time. **PN**

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APA Calls for Opioid Settlements to Fund Workforce Training, Treatment

A 29-page white paper describes existing evidence-based practices that can be expanded to improve treatment of pain and addiction and emphasizes the need for more rigorous enforcement of parity laws.
BY MARK MORAN

Some funds from the class action suits filed against opioid manufacturers should be used to expand the number of health professionals who are trained to treat patients with substance use disorders (SUDs), disseminate evidence-based treatments, and enforce parity laws,

according to APA and six other mental health and addiction specialty groups. APA and its partners made their demand in a letter to the attorneys representing the classes of patients represented in lawsuits filed against pharmaceutical companies for the manufacture and promotion of opioids

that resulted in widespread addiction and overdose. The letter was also copied to Judge Dan Aaron Polster of the Northern District of Ohio, who is presiding over the class action suits. The letter was accompanied by a 29-page white paper outlining the
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scope of the opioid epidemic and an analysis of what is necessary to meet the demand for treatment.

“While opioid addiction is complex, it is treatable and preventable,” APA CEO and Medical Director Saul Levin, M.D., M.P.A., and leaders of the other groups wrote, “but not with current limitations on the workforce trained

in the treatment of substance use disorders, limited access to quality care, and discriminatory insurance coverage for mental health and substance use disorders. Should there be a settlement of the legal cases, we respectfully request that funds be used to expand the workforce qualified to prevent and treat substance use and mental health disorders; disseminate trainings and education regarding evidence-based

treatments to increase adoption of clinical best practices; and enforce mental health and addiction parity and consumer protection statutes in states.”

Also signing the letter were Kevin A. Sevarino, M.D., Ph.D., president of the American Academy of Addiction Psychiatry; Gabrielle A. Carlson, M.D., president of the American Academy of Child and Adolescent Psychiatry; Martha J. Wunsch, M.D., president of the American

College of Academic Addiction Medicine; Paul Earley, M.D., president of the American Society of Addiction Medicine; Paula J. Lum, M.D., M.P.H., president of the Association for Multidisciplinary Education and Research in Substance Use and Addiction; and Kathleen T. Brady, M.D., Ph.D., president of the International Society of Addiction Medicine.

In addition to boosting the workforce and disseminating best prac-


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tices, the 29-page white paper emphasized the need for more rigorous enforcement of parity laws. “State insurance commissions and attorneys general have significant workloads of which parity and consumer health fraud are but a small part. These agencies need additional resources to aggressively and proactively ensure compliance with existing federal and state laws in order to guarantee that

discrimination against those with mental health and SUDs and misrepresentations about insurance coverage do not preclude access to evidence-based care.”
The paper concluded: “There is no silver bullet that will cure those with addiction and co-occurring mental illness or that will cure or prevent another crisis. However, the funding generated from this litigation could

be used to make substantial progress toward controlling the OUD epidemic and ensuring that it or similar substance use consequences do not recur in the future. ... What the litigants can do immediately is use some of the funds that will come out of this litigation to ensure that there is an adequately trained health care professional workforce to continue the research into prevention and treat-

ment of addiction, to treat patients using clinical best practices, and to guarantee that persons with addiction and/or mental illness have access to nondiscriminatory health insurance to afford their treatment.” **PN**

 A copy of “Addressing Access to Care in the Opioid Epidemic and Preventing a Future Recurrence” may be obtained by contacting Ashley Witmer at awitmer@psych.org.

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The Power of Feeling Uncomfortable About Race

Thinking about racism can bring up uncomfortable feelings. These feelings can be an important and powerful guide to transforming ourselves and overcoming a centuries-old trust deficit with minority communities across this country. **BY SHAWN SINGH SIDHU, M.D.**

*"Our lives begin to end the day we become silent about things that matter."
—Rev. Martin Luther King Jr.*

The entire nation is watching as our nation has undergone a very painful chapter in its history. The seeds of this suffering were planted hundreds of years ago. When a relationship between people begins with forced enslavement and family separation, and personal and intergenerational trauma, it results in a vast and pervasive trust deficit from its very inception. There have been countless opportunities for the citizens of this nation to repair and rebuild this relationship; however, to this day our African American sisters and brothers still do not have equal access to basic rights such as health care, education, protection of the law, and freedom. It has been absolutely heartbreaking to see the impact on those individuals whose lives have been irreversibly changed by recent events, and even more chilling to think of the countless families who have suffered silently without a voice in our nation's past.

Many of us have felt a sense of great heaviness, sadness, frustration, powerlessness, hopelessness, and helplessness as we watched parts of our cities come apart, even if we fully understood the sequence of events that led to such events unfolding. Nonetheless, feeling uncomfortable can be a powerful tool to understanding and ultimately challenging our deeply held beliefs. Sometimes we may be completely unaware of biases that we have until we feel an uncomfortable physical sensation in our bodies, emotional reactivity and defensiveness, a mental block, or avoidance. However, when deeply accepted and understood, feeling uncomfortable can be a blessing in disguise. It can offer a rare glimpse into the windows of our souls, which are usually clouded by day-to-day distractions and never-ending "to-do" lists. The uncomfortable feelings can allow us to redefine ourselves at the deepest levels of our emotional cores and release centuries of harmful beliefs. We may even be able to gain insight into the misguided thinking of our ancestors and shift this such that future generations can view the world in a wholly different way. It is worth noting that our uncomfortable feelings do not represent a drop in the proverbial ocean of suffering that African American communities have experienced over the past centuries.

Can our uncomfortable feelings be



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channeled to propel us toward creating real, meaningful change in our communities? We can no longer afford to be innocent bystanders; otherwise, the events of 2020 will only continue. Many well-meaning psychiatrists, myself

included, have written about health inequities in the African American community. Others have talked about the fact that there were fewer Black men in medical school in 2014 than there were in 1978. Many of us have opined from our academic ivory towers, citing our own research, about solutions to problems affecting the African American community.

In short, we have done a lot of talking, but how many of us have really listened to our African American colleagues? How many of us have really listened to African American community members? How many of us have been to an African American church? How many of us have had African American friends over to our homes? How many of us have asked our African American brothers and sisters what they want, what they need, and how we can help them get it? How many of us have asked African

American community members about what would actually work on the ground in their communities or what would be practical for them? How many of us would consider ourselves part of an African American community? How many of us have sat with African American families as they relate the beautiful richness of their culture or the pain of intergenerational trauma?

Until we actually listen, we will always be seen as authority figures from the outside who may be well meaning but ultimately do not want to take the time to understand another perspective from our own. If we can harness the power of our uncomfortable feelings to gain a sense of empathy with our African American neighbors, we can truly plant the seeds for a new kind of relationship based on trust, listening, mutual respect, love, unity, togetherness, and, hopefully, someday healing. **PN**



PSYCHIATRY & INTEGRATED CARE

Collaborative Care Fits COVID-19 Workflows

BY ANNA RATZLIFF, M.D., PH.D., DIANE POWERS, M.A., M.B.A., AND SARA BARKER, M.P.H.

During the COVID-19 public health emergency, health care organizations are quickly learning to adapt, demonstrating how the five key principles of the Collaborative Care Model (CoCM) can fit their new workflows and facilitate ongoing delivery of behavioral health services to patients served in primary care and other medical settings.

Patient-Centered Team Care

Telehealth, especially via the telephone, has always been a recommended component of CoCM since the original development and testing of the model in the 1990s. Even before recent widespread use of telehealth necessitated by COVID-19, telephone or telehealth contact was often welcomed by patients because it is more convenient and can facilitate more frequent check-ins. Building warm connections is an area where health care organizations are getting creative in response to COVID-19. Some clinics have the behavioral health care manager "sit in" on primary care telehealth appointments where behavioral health is the presenting problem so an immediate connection can be made.

Population-Based Care

One adaptation some clinics are using is to examine electronic health record (EHR) data to identify patients with a recent prescription for a psychotropic medication or a new behavioral

health diagnosis and have the behavioral health care manager reach out to them by phone for a quick follow-up to determine whether they need care management. Some clinics are using EHR data to identify patients with an existing behavioral health diagnosis seen in the past week for follow-up. Another patient identification strategy involves the behavioral health care manager reviewing the primary care provider's (PCP) daily or weekly schedule to identify patients with a behavioral health diagnosis who are not engaged in CoCM. During a virtual huddle or messaging between the PCP and behavioral health care manager, they can discuss a virtual warm connection or follow-up visit for these patients.

Measurement-Based Treatment to Target

An aspect of CoCM that needs little, if any, adaptation for COVID-19 workflows is caseload review between the behavioral health care manager and psychiatric consultant and follow-up treatment recommendations to the PCP. While some clinics use face-to-face caseload consultation when both providers are on-site, many CoCM programs have always had this consultation occur via phone with both providers using a registry they can access in real-time to facilitate identification of patients who are not improving as expected. Psychiatric consultants transmit their treatment



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recommendations to PCPs via the EHR, which does not require adaptation.

Evidence-Based Treatments

Behavioral health care managers help primary care providers optimize pharmacotherapy through the addition of psychotherapeutic interventions like behavioral activation and through proactive follow-up to support medications. When psychotherapy is a component of the treatment plan, use of telehealth is likely the most sig-



Earth Day From 1970 to 2020: The Journey From Petroleum Lover to Climate Activist

BY STEPHEN PETERSON, M.D.

With 2020 being the 50th anniversary of Earth Day (to be formally celebrated in October), Mother Nature has given us a harsh new wake-up call: the coronavirus pandemic. We are reminded of our intimate connections with all life on Earth. Getting too close to other species unfortunately led to this new deadly scourge.

The pandemic is everywhere and immediate. The grim daily statistics of death, reflected in graphs and stark photographs, thrusts us into a new, threatening reality. The pandemic definitely has our attention. Yet,

nificant adaptation in response to COVID-19. While this has always been an option, it was previously not often practiced, in part because of limitations on billing for telehealth delivery. The Centers for Medicare and Medicaid Services (CMS) CoCM billing codes have permitted telehealth delivery of services since the codes were released in 2017. In addition, during the COVID-19 public health emergency, many payers, including CMS, have greatly expanded the ability to bill for psychotherapy delivered via telehealth. This is important because many health care organizations use a combination of psychotherapy and CoCM billing codes to fund their care delivery.

Accountable Care

CoCM leverages scarce behavioral health resources, especially psychiatrists, to inform treatment of a larger population receiving behavioral health care in medical settings than a provider can treat directly. This expands access at a time when more people are expected to need behavioral health services. Research shows the behavioral health care manager does not have to be on-site to provide effective care. CoCM is compatible with telehealth, whether by telephone or videoconferencing, and supports frequent contact with patients.

Clinics wishing to adapt CoCM for COVID-19 requirements should use a quality-improvement approach to making changes, either those outlined here or others. They can test the effectiveness of changes to determine which work best for their organization and make adjustments accordingly. **PN**



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on Climate Change and Mental Health.

there is another even greater and far deadlier threat: the climate crisis and all its implications.

Distant threats seem unworthy of our attention. This is especially true when one lives paycheck to paycheck. However, my journey to gradual understanding of the deeper threat of global warming may help to make that threat more palpable.

I reflect back to my first Earth Day. On that spring day, a group of students at my college in Tennessee were galvanized to action. We organized a clean-up of a winding mountain road that had been severely trashed. We collected 14 truckloads of trash. It was a thrilling start.

In 1970 we were aware of pollution and the ominous dangers that Rachel Carson had predicted in *The Silent Spring*. At that time, our focus was on visible pollution. Our hearts were in the right place, but we did not fully grasp the unseen dangers of greenhouse gases. CO₂ and other greenhouse gas accumulation would create rising heat. Incomplete combustion would disseminate very small particulates with devastating effects on health. As is well known, the rise of global temperatures from 1750 has been 1 C or 2.7 F and CO₂ levels have risen 40%. These changes might seem small, but the effects on climate have been considerable. Think about the drought and heat impacts on Australia this year. According to the World Health Organization, small particles and other airborne pollutants have caused more than 90% of the inhabited world to have air quality that is unhealthy.

Many in the United States and globally have been quite slow to acknowledge the reality and immediacy of climate change. Thinking back, I realized that what made me a latecomer to climate awareness is related to where I grew up. I grew up in Baytown, Texas, in the 1950s, where oil was king, and the world's largest oil refinery was producing gasoline. My father and all his friends worked for the oil industry. The fossil fuel energy, which is actually

stored sunlight, powered everything: airplanes, cars, boats, lawnmowers, and much more. I loved filling my home-made go-cart and lawnmower with sweet-smelling leaded gas. Everyone loved oil in Texas.

In 1894, Svante Arrhenius had predicted that CO₂ levels derived from fossil fuel combustion would increase our temperatures by 3 C to 4 C. He was uncannily accurate. Since 1970 scientists from government, academia, and the private sector studied the phenomena and reconfirmed these predictions. But the fossil fuel industry, driven by profit motives, introduced doubt through confounding propaganda. The industry has spent millions to cloud the truth about climate change.

I previously rationalized that extreme weather was a natural aberration. Yet I developed ominous forebodings after seeing "An Inconvenient Truth" based on the book by Al Gore and learning about the European heatwaves that killed 70,000 in 2003. Two years later, Katrina struck with a storm surge of more than 26 feet, and more than 1,200 died in New Orleans. Since then, a steady cascade of extreme weather has followed.

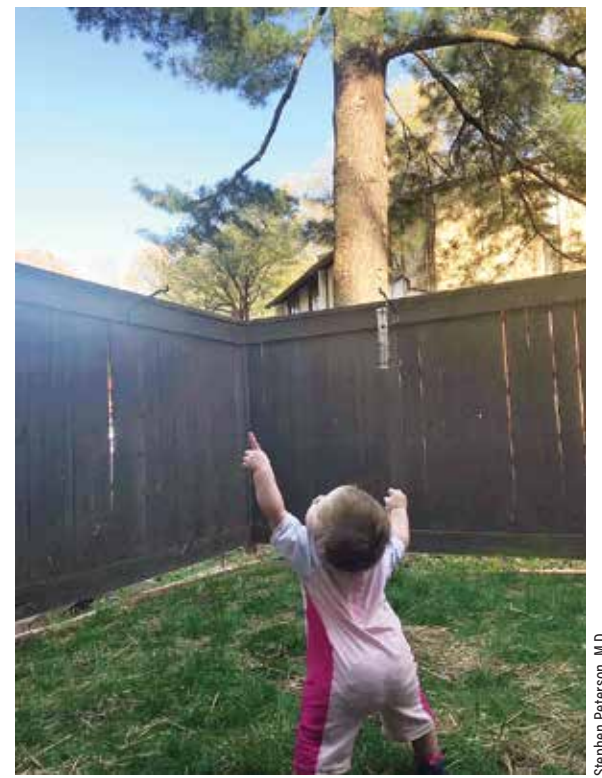
In 2017 everything came together for me in a big climate wakeup call when I read Peter Brannen's *The Ends of the World*. At that time we had joyful news—the birth of our first grandchild. Brannen demonstrated that cycles of increased CO₂ multiple times in Earth's history and the resultant increased global temperatures had rendered the Earth so hot that mass extinctions occurred. Indeed five mass extinctions have happened over the course of Mother Earth's life. Brannen also showed how elevated CO₂ from before the Industrial Revolution created the conditions for the sixth major mass extinction.

Ironically, at the time of my granddaughter's birth, increasing heat became a sudden reality to me. Surely, I realized, the increase in global warming would have dramatic impacts on all future generations. I asked myself,

how would my grandchild fare during her lifetime?

I dropped my attachment to fossil fuels. Instead, I now work on activist projects with my colleagues to understand more about climate change and how it will impact us all.

The good news is that we can do much to mitigate global warming and the impacts of the climate crisis, just as we are addressing the COVID-19 pandemic, but we must act immediately and decisively. Personal choices to address our own practices and carbon footprints will help. Just as important as handwashing and physical distancing are to managing COVID-19, indi-



Stephen Peterson, M.D.

Stephen Peterson, M.D.'s granddaughter discovers beautiful blue sky after long days of clouds and rain.

vidual and collective actions to decrease global warming are necessary. Such behaviors include eating plant-based diets, using public transportation and stairs rather than elevators, taking fewer airplane trips, turning off lights at night, recycling, and using clean energy sources.

Most important, our biggest impact will be seen through collective work for political, economic, and societal changes. We need leaders who can help us create and sustain a healthier Earth where our children and grandchildren will thrive. In our relationship with nature, we can, as the Shaker hymn says, "come down to where we ought to be."

Let us all work together to protect ourselves from COVID-19 and the slower but more dire mega-disaster of the climate crisis. Our grandchildren will love us for this, and we owe it to them. **PN**



VIEWPOINTS

COVID-19: Wake-Up Call to Reduce Barriers to MH Care For Intimate Partner Violence, Other Traumas

BY OBIANUJU O. BERRY, M.D., M.P.H.

Under pre-COVID-19 circumstances, intimate partner violence (IPV) was already a public health crisis, with the World Health Organization naming IPV a global health problem of epidemic proportions. In a 2015 national survey, a staggering 12 million men and women, 24 people per minute, were victims of rape, physical violence, or stalking by an intimate partner within the United States.

During a pandemic, we can expect gender-based violence to intensify due to increased tension and economic distress in the household, compounded by limited in-person resources to seek help and an inability to escape abusive partners. In fact, preliminary reports suggest that there has indeed been an exponential rise in IPV-related cases.

In addition to increased rates of IPV, mental health experts are warning of a mental health crisis to follow this initial COVID-19 outbreak that will impact a large segment of the population. Vulnerable populations will be especially affected as socioeconomic and racial inequities underlie multiple mental health conditions. The presence of these inequities prior to COVID-19 now serve as catalysts for heightened mental



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health-related stress during this pandemic: Members of marginalized groups are less likely to work in jobs that can be performed remotely, less likely to have benefits such as paid sick leave and health insurance, less likely to have a financial safety net, and more likely to live in dense neighborhoods and crowded homes, limiting the ability to maintain social distancing safety measures, but also limiting the ability for accessing social support during times of need. IPV and mental health have a bidirectional relationship: IPV increases the risk of mental illness (for example, posttraumatic stress disorder, depression, anxiety, substance use disorders, suicide attempts), which themselves increase the vulnerability to IPV. The added risks during COVID-19 require interventions that are agile for identifying and addressing both IPV and mental illness.

Prior to COVID-19, significant struc-

tural and systemic barriers prevented IPV survivors from accessing high-quality mental health care. Importantly, these obstacles were especially pronounced for minority women, who in the United States are less likely than white women to seek help from various formal and informal sources. In New York City, some of us began addressing this issue in 2014, initiating a tripartite partnership with private, public, and academic collaboration that imbeds skilled mental health clinicians within the Family Justice Center (FJC), a resource center for survivors of IPV and sex trafficking. Since 2017, this new collaboration has been funded by ThriveNYC and provides free, evidence-based treatment, including psychotherapy, skills-based learning, and psychopharmacology in a trauma- and culturally informed capacity by the country's largest public hospital system, NYC Health + Hospitals. This is the nation's first such integrated mental health model. New York City now boasts the largest network of FJCs in the country, operated by the Mayor's Office to End Domestic and Gender-Based Violence.

By bringing experienced mental health clinicians to the community, the program is meeting the survivors where they are and where they feel safest. In a citywide program evaluation I led, our

data demonstrated that not only do the survivors continue to report feeling safe physically, but they also report feeling safe emotionally and improvements in sleep, mood/anxiety, psychological distress, interpersonal relationships, and parenting skills. Additional bonuses of the program are reduced wait times and improved staff morale.

At this time, the continuing challenge is to create and maintain a system that can meet the ever-growing mental health needs of IPV survivors during COVID-19. Although our program has shifted to remote work, technology has allowed for greater cross-collaboration across institutions and immediate access to clients. Increased brief sessions serve as anchors for augmented support during social distancing measures. Privacy, confidentiality, and assessing safety present ongoing challenges that require creative solutions. Furthermore, formal psychological support systems have been created for frontline mental health workers, who are partaking in a shared collective trauma response.

IPV and mental health concerns were here prior to COVID-19, but as with any disaster, cracks in the system have been revealed that should not be overlooked. This is a wake-up call and an opportunity to reduce systemic barriers to ensure families affected by trauma are not only safe physically, but also emotionally. **PN**



TRIBUTE

Tribute to Professor Emeritus Frederick Hickling

BY SAMUEL O. OKPAKU, M.D., PH.D.

May 8 was a very sad day for Jamaica for she lost an illustrious son. It was equally sad for those of us who had come to know Professor Emeritus Frederick Hickling through our professional wanderings and also for those patients, students, and other friends whose lives had been touched by him.

I have always debated whether great men are created or they achieve greatness. Dr. Hickling probably met the criteria for both categories. Much has been written about him, but much more remains to be said. The full extent of his contributions to psychiatry has yet to be fully appreciated.

Dr. Hickling had many facets: He was a poet, a musician, a debater, and, above all, a sensitive, caring individual who was sometimes misunderstood because of his deeply held philosophical and political views. He had the rare



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gift of being a great debater who was capable of vehemence but never harbored any rancor.

He was a towering figure, not only physically but also in terms of his genius. He had a beard that looked like the mane of a lion, and like a lion, he would stealthily walk down a hallway with steady and regal steps, much like a lion prowling through the forest. Deep down, however, he was a lamb who cared very much for the welfare of others.



Professor Emeritus Frederick Hickling

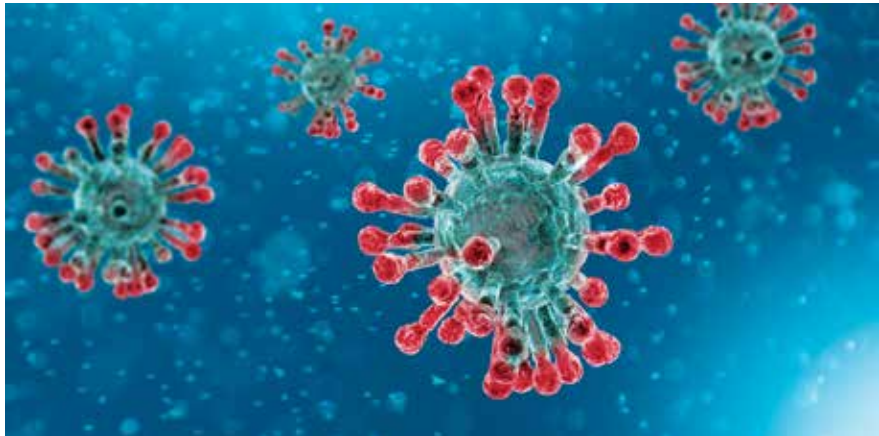
Dr. Hickling distinguished himself early in high school. He had an incisive intellect and a piercing sense of humor. Long before becoming a physician, he studied at the University of the West Indies and then at St.

Thomas Hospital in London and Edinburgh University in Scotland. While in the United Kingdom, he witnessed how the West Indian and other immigrants were treated and was aggrieved by the lack of social justice. He encountered discrimination himself when some of his early original research papers were rejected for publication. Nevertheless, he was not deterred by these kinds of experiences, which fueled his determination to address the wounds of slavery.

After his psychiatric training and practice in the United Kingdom, he returned to his native Jamaica to continue his work. His thoughts and creativity flourished against setbacks. He was moved by the early history of the West Indies, including the trauma of slavery and colonization. His interest in this area was very broad and buttressed by his wide reading and experience. He was not only an expert in African history and culture, but he was also very knowledgeable about classical

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Psychological Stress May Not Be Only Route Of COVID-19's Psychiatric Burden



iStock/Naehlys

Current and historical evidence shows that viruses such as COVID-19 can induce numerous biological changes that can adversely impact brain functioning. **BY NICK ZAGORSKI**

While much of the focus of treating the most severe of COVID-19 cases has been on how to mitigate the acute effects of the virus on the lungs, many experts are warning about the rise of long-term psychological problems due to this pandemic.

"The global spread of this virus has created a universal, shared trauma," said Suzi Hong, Ph.D., an associate professor of family medicine and public health and psychiatry at the University of California, San Diego (UCSD). "Everyone's mental health is, in a sense, vulnerable."

This vulnerability is amplified in the millions of people who have been infected with the virus and survived, she said. Though it's still too early to know about the long-lasting psychological effects of COVID-19, a study from Hong Kong looking at mental health outcomes among survivors of the 2003-2004 SARS (severe acute respiratory syndrome) outbreak offers a clue about what may be to come. A survey of 369 SARS survivors found that 40% had a diagnosed psychiatric illness four years after the outbreak.

As psychiatrists prepare for a possible surge in the numbers of people

with psychiatric illness, experts such as Hong believe it's important to understand how much of the psychiatric burden in COVID-19 survivors may be due to the infection itself.

Neuropsychiatric Impact of Viruses

Researchers have long suspected and debated the neuropsychiatric impact of respiratory viruses. During World War I, Austrian psychiatrist and neurologist Constantin von Economo characterized a novel neurologic problem among wounded soldiers, which he called *encephalitis lethargica* (sleepiness was a common symptom). Many of these soldiers and others diagnosed with this disorder later developed mood problems, such as depression and mania.

Von Economo theorized this disorder was caused by a bacteria or virus—like the influenza virus that was spreading across the globe at the time. Other scientists, such as the prominent American psychiatrist Smith Ely Jelliffe, countered that these mood symptoms were psychosomatic, brought on by the stress of being sick.

Jelliffe's position became the more popular belief in the short term, but data gathered from subsequent outbreaks—including preliminary data from COVID-19—has affirmed that respiratory viruses can infiltrate the brain, potentially leading to acute and chronic neuropsychiatric consequences. One early report of hospitalized patients with COVID-19 in Wuhan identified neurologic problems such as impaired consciousness or strokes in 45% of those with a severe infection.

The mechanisms behind COVID-19's brain effects are still being teased out but are likely multifaceted, noted Hong and colleague Emily Troyer, M.D., a child and adolescent psychiatrist and post-doctoral research fellow at UCSD. Together they penned a recent review discussing the biological effects of COVID-19.

As the pair described in the review, preclinical studies in mice have shown that the virus can directly invade and kill brain cells. There have also been reports that the virus can trigger excess blood clotting, which can cause strokes. Additionally, the virus elicits a strong response from the immune system, which can cause neuropsychiatric problems from inadvertent damage to neurons done by various immune molecules as they fight off the invaders.

Side Effects From Medications Used to Mitigate COVID-19

In addition to the psychiatric effects that may be caused by the

COVID-19 virus, pharmacological agents being used to try to help patients with severe infections come with their own neuropsychiatric risks. Side effects are a risk with any medication, but COVID-19 poses additional challenges since hospitals are using novel agents whose effects are unclear. Even drugs that are regularly used can be risky, as data emerging from the off-label use of the antimalarials hydroxychloroquine and other chloroquine compounds show.

These antimalarials were much touted by President Donald Trump early in the pandemic, after a few small studies suggested the medication could be used to treat or prevent the spread of COVID-19. In May—before larger clinical trials involving patients with COVID-19 were complete—the Food and Drug Administration (FDA) granted "emergency use authorization" to these medications. This distinction made it easier for health care providers to use these medications to treat suspected or laboratory-confirmed COVID-19 in adults and children hospitalized with severe disease. Subsequent evidence gathered from the trials since completed suggests these drugs are not particularly effective, and the FDA recently revoked the emergency authorization.

Though antimalarials are more commonly associated with potential cardiac risks, there is evidence antimalarials can trigger symptoms of insomnia, abnormal dreams, anxiety, mild paranoia, and/or acute memory problems.

These symptoms may signal the onset of quinine toxicity, which could lead to chronic neurological damage, noted Remington Nevin, M.D., M.P.H., Dr.P.H., executive director of the Quinism Foundation, which seeks to raise awareness of this disorder. Nevin pointed out that many of these early toxicity symptoms mirror delirium; however, patients with chloroquine toxicity do not flicker in and out of consciousness, which physicians can use as a diagnostic indicator.

Steroid therapy, which is given to combat the hyperinflammation that manifests in many COVID-19 patients, is also known to induce psychiatric symptoms including psychosis, mania, and insomnia, according to a review by researchers at Mount Sinai School of Medicine. Early evidence, however, suggests the psychiatric effects of steroids are transient, the authors noted.

Could COVID-19 Lead to New Psychiatric Treatments?

Understanding how COVID-19 or medications being used to treat symptoms of the disease contribute to psychiatric problems is important from an intervention standpoint since such information may help to predict the

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history. In his understanding of slavery and racism, he was like James Baldwin. Like Bob Marley, he believed that the struggle is on and the fight not over and that we cannot forget the "400 years." He is reputed to have said that 70% of Jamaicans have mental illness—a theme he developed into his mantra "own your madness." In an awards speech in Germany, he used the initials "TRMS," meaning "this madness must stop"—that is, colonial oppression and exploitation. When he said 70% of Jamaicans were mad, I do not believe anyone else could have made that statement with impunity or without an outcry.

In wanting to give back to his people, Dr. Hickling was engaged in a variety of mental health care projects in Jamaica. He shared with me an interest in training African mental health workers. I do not know if he succeeded, but as everyone knows, "Ars longa, vita brevis" ("Art is long, but time is fleeting").

Dr. Hickling had too many accom-

plishments to list here. He was the recipient of several national and international awards. Other major achievements included his efforts at deinstitutionalization and advocacy for access to mental health services in Jamaica. In a recent award lecture in Berlin, he emphasized his frequent exhortation to his students: "If you don't write it, you haven't done it." He is perhaps one of the few legitimate critics of Western classificatory systems of classifications.

I believe we will learn that his most important contribution was in the field of educational pedagogy rather than mental health. He firmly believed in the value of education as a means to emancipation and achieving self-esteem. He is the newest hall of famer to the Pantheon that already houses the likes of Bob Marley, James Baldwin, and Frantz Fanon. What an event it would have been to see Dr. Hickling and Bob Marley sipping rum and Coke on a Kingston beach by a fire burning until midnight. He was amazing. May his soul rest in peace. **PN**

Clozapine During COVID-19: How Best to Ensure Patient Safety



During the COVID-19 public health emergency, physicians can prescribe clozapine without an up-to-date blood test. **BY NICK ZAGORSKI**

Clozapine is the best option for patients with treatment-resistant schizophrenia, but due to the risk of a rare but serious condition known as neutropenia (an abnormal loss of important immune system cells known as neutrophils)

people taking clozapine need to have regular blood checks. In the era of COVID-19, however, getting regular tests can be problematic.

“Travel restrictions and shutdowns across the globe are limiting access to sites that can conduct blood tests,”

noted Dan Siskind, M.D., Ph.D., an associate professor of medicine at the University of Queensland who specializes in treatment-resistant schizophrenia. To stop the spread of COVID-19, many pathology labs have also reduced staff or working hours, while others have focused their available resources on COVID-19 tests, he noted.

Fortunately, the Food and Drug Administration (FDA) recognizes the difficulties facing patients taking clozapine or other drugs that require certain risk-management protocols. In March, the agency announced it would not take action against health care professionals for failing to adhere to certain Risk Evaluation and Mitigation Strategy (REMS) requirements involving laboratory tests and medical imaging tests for the duration of the COVID-19 public health emergency.

Under the FDA's Clozapine REMS Program, it is recommended that patients prescribed clozapine have blood tests weekly for the first six months while taking the medication, biweekly for the next six months, and monthly after one year. Though these

rules remain in effect, the FDA will not actively enforce the REMS during the pandemic. This means physicians can prescribe, and pharmacists can dispense, clozapine without an up-to-date blood test.

While the FDA did not provide specific new blood testing requirements for clozapine during the pandemic, Siskind and several other schizophrenia experts who are members of the international Treatment Response and Resistance in Psychosis (TRRIP) work group created a guideline they believe might help manage patient risk. Their guidelines were published in the *Journal of Psychiatry and Neuroscience*.

“We used the best available evidence to strike a balance between the significant risks of neutropenia, especially during an infectious pandemic, versus the risks of patients ceasing their medication and becoming unwell,” Siskind noted. Available clinical data suggest neutropenia risks drop off sharply after the first year of clozapine use, he said.

The TRRIP work group recommended that patients who have been taking clozapine continuously for at least one year can reduce their testing to once every three months provided they have never had their neutrophil levels fall below 2,000/ μ L (or 1,500/ μ L if they have benign ethnic neutropenia,

see *Clozapine* on page 22



RESIDENTS' FORUM

A Canadian's Reflections on American Psychiatry

BY DAVID MANCINI, M.D.

In the wake of an approaching general election and further partisan divide over hot-button issues, health care has reemerged as a subject of great debate. Americans are increasingly faced with skyrocketing prescription drug costs, copays, premiums, and deductibles with few signs of relief, resulting in a culture of resentment and anger toward medicine. As a senior psychiatry resident and Canadian from a border city, my recent time spent in a mental health policy elective led me to reflect on the mental health disparities in this country. It felt significant for me to reflect on being a Canadian working in the United States. Throughout my training, I have found myself comparing one system with another and becoming disillusioned with both systems. Now, as I quickly approach the end of residency and the decision of where to work, I have noticed a pervasive sense of ambivalence over where to practice.

As a psychiatry resident in an urban setting, I have witnessed the impact of the U.S. medical system on the delivery of mental health care. Given a patient's insurance, I have heard discussions



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about potential discharges due to a lack of reimbursement for a hospital stay, even in cases in which a patient might benefit from further treatment. Clinicians often sought to petition hospital administration to subsidize hospital stays for poorly and uninsured individuals, ultimately creating a fraught dynamic between administrators, clinicians, and patients.

As I transitioned to my outpatient year, many patients at the residents' outpatient clinic at Sheppard Pratt—a fee-for-service clinic providing psychotherapy and medication management at significantly reduced rates—stated that the affordability and ability to obtain quality services were otherwise unavailable to them due to lack of financial means and/or insurance. We have also spent countless hours on the phone with insurance reviewers in the

hopes of obtaining necessary services for patients who we knew were in such desperate need of treatment. Oftentimes we were left demoralized, as if we needed to beg and plead for services from individuals who were more focused on their bottom line than patients' well-being.

There is, however, tremendous good that comes from the American medical system. I have found it striking how there seems to be a richer “menu of options” even in the most basic centers as compared with Canadian counterparts. The Sheppard Pratt Retreat (a self-pay residential inpatient treatment unit) is one such example—it allows psychiatrists the freedom and flexibility to provide individualized care to both patients and their families to support longstanding recovery out in the community. In the United States, it seems as though these types of programs are more likely to thrive as there is already a cultural understanding around private pay for medical services that does not exist in Canada.

Both systems seem to struggle with providing adequate and quality services for the countless patients that require medical assistance, along with an overall

insufficient number of mental health professionals. However, whereas the Canadian system falters at being able to deliver quality, well-rounded subspecialty mental health services in a timely and consistent manner, the American system struggles with providing the same quality of care and breadth of services to similar individuals by virtue of their insurance coverage and financial background. For me, the American approach seems to emphasize an already prevalent divide within social classes and becomes problematic for our patients, specifically those with severe mental illness.

Though the Canadian system provides its own unique challenges, there is solace in knowing that every Canadian (citizen or immigrant) has the ability to seek out medical services without fear of financial ruin or social ostracism. In contrast, the American health care system has many sophisticated and advanced treatment options and services that are not as readily accessible in Canada.

Despite the opportunity to reflect on these personal experiences, I remain unsure about where the next chapter lies in my career. Despite my upbringing in the Canadian system, the Canadian health care system seems like a foreign place altogether to practice as a physician. However, to stay in the

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Antipsychotics Increasingly Prescribed for Bipolar Disorder

More than half of outpatients with bipolar disorder received a second-generation antipsychotic in 2016, up from 12% just 20 years ago. **BY NICK ZAGORSKI**

Over the past 20 years, a growing number of patients with bipolar disorder have been prescribed antipsychotics, as the number of prescriptions for the mood stabilizer lithium—considered a gold-standard treatment—have dropped. This uptick in antipsychotic prescribing is not surprising given that the Food and Drug Administration (FDA) has approved multiple antipsychotics for bipolar disorder during the last two decades. An analysis reported in *AJP in Advance* now quantifies this national paradigm shift.

Investigators at Yale University School of Medicine and colleagues examined data from the 1997-2016 National Ambulatory Medical Care Surveys, an annual questionnaire completed by a nationally representative sample of office-based physicians.

The sample included 4,419 outpatient visits to a psychiatrist by a patient diagnosed with bipolar disorder; this represents over 4 million visits nation-

ally over the 20-year period, according to the authors. The total number of visits per year rose over time, with about 467,000 visits occurring between 1997 and 2000 and 1.06 million visits occurring between 2013 and 2016.

As the number of visits for bipolar disorder rose, so did the use of second-generation antipsychotics; 12.4% of all outpatient visits in 1997 included second-generation antipsychotic prescriptions, compared with 51.4% of all visits by 2016. Visits for bipolar disorder that included prescriptions for lithium dropped from 30.4% to 17.6% during this same period, while prescriptions for any mood stabilizer (which includes carbamazepine, lamotrigine, and valproate) decreased from 62.3% to 26.4%.

The analysis revealed that the largest surge in antipsychotic use occurred between 2000 and 2008—a time in which five antipsychotics received FDA approval for bipolar disorder (aripiprazole, olanzapine, quetiapine, risperidone, and ziprasidone). Overall prescribing rates have remained stable since then.

“This study highlights how targeted marketing can make a loud splash in an area where there is not a lot of data,” said Michael Ostacher, M.D., a professor of psychiatry and behavioral sciences at Stanford University, who was not involved with the study.

He noted that for decades bipolar patients were limited primarily to lithium as a treatment option. This medication is effective at controlling manic episodes, but it can take a while to reduce symptoms, and it comes with some medical risks. These include toxicity when lithium levels become too high and/or thyroid and kidney damage from long-term use. (Patients on lithium are required to have regular blood tests to monitor lithium levels.)

“Lithium also has some common ‘nuisance’ side effects such as acne and hair thinning,” added Benjamin Goldstein, M.D., Ph.D., a professor of psychiatry at the University of Toronto and director of the University’s Centre for Youth Bipolar Disorder. Goldstein was not involved with the study. Such side effects may be particularly off-putting for teens and young adults—the age group in which bipolar symptoms typically manifest, he said.

In addition, there was a belief among some in the psychiatric community that lithium was not well suited for some patients, such as those who experience mixed bipolar episodes (depression and mania at the same time), Ostacher said.

Pharmaceutical companies marketed antipsychotics to doctors as possessing numerous benefits over lithium

and other mood stabilizers; these drugs could offer rapid relief of manic symptoms with less stringent blood test requirements. “On top of that, the United States has the phenomenon of permitting direct-to-consumer advertising of prescription products,” added Taeho Greg Rhee, Ph.D., M.S.W., an assistant professor of medicine and public health at Yale and lead author on the study. That amplified the message being sent to physicians and enabled antipsychotic use to take off.

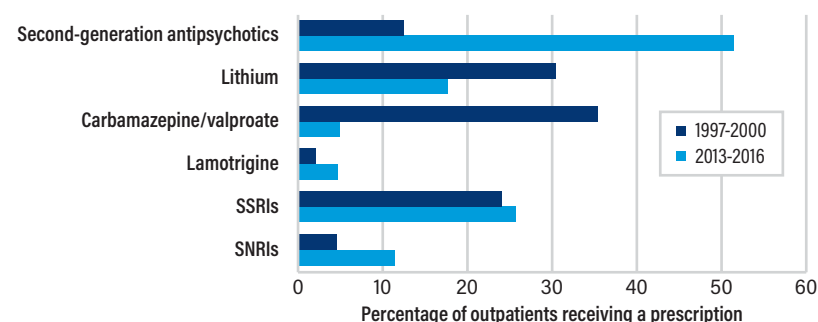
Since lithium and bipolar disorder have been so closely linked for decades, many patients might con-

head-to-head research is needed to see how lithium, antipsychotics, and other bipolar medications stack up, especially in relation to long-term effectiveness and safety outcomes, including suicide risk.

In addition to studies, Ostacher—who admits to being a big fan of lithium—suggests this medication needs more champions in the field to highlight the medication’s benefits and dispel some of the myths that it doesn’t work in certain patients. Goldstein added that training programs should ensure that psychiatry residents are effectively trained about lithium and its potential

Medications to Treat Bipolar Disorder Changed Over 20 Years

The past two decades have seen a surge in antipsychotic prescriptions for bipolar disorder at the expense of lithium and some other mood stabilizers.



Source: Taeho Greg Rhee, Ph.D., M.S.W., et al, *AJP in Advance*, April 21, 2020

flate the medication with the negative stereotypes about bipolar disorder, noted Goldstein. “A young person might remember a grandparent with bipolar who had to be hospitalized because of severe mania and be wary of lithium.” These new medications did not have such historical baggage and were appealing to many patients, he said.

Ostacher added that the role of marketing was not limited to antipsychotics. The mood stabilizer valproate also experienced an uptick in use for a few years after it was approved by the FDA in 1995, but valproate prescriptions have since declined, likely due to studies showing that this drug may pose health risks during pregnancy, he said. “[S]econd-generation antipsychotics also have several health warnings clearly printed on their labels yet remain widely prescribed for bipolar despite no demonstrated evidence that they are superior.”

Ostacher highlighted the risk of antipsychotic-induced weight gain as especially concerning in light of the ongoing COVID-19 pandemic. “Hospital data show that people with obesity and diabetes are at higher risk of severe COVID symptoms, so psychiatrists should consider that when prescribing antipsychotics.”

Rhee noted that more rigorous

risks, so they can feel comfortable prescribing it early in their careers.

In a study that was heavily focused on medication data, one of the most disconcerting findings to Goldstein, however, was the marked reduction of patients on medication who also received psychotherapy; rates dropped from 50.9% of patients in 1997 to 35.7% in 2016.

“Psychotherapy not only helps with bipolar symptoms but also encourages better nutrition, exercise, sleep, and medication adherence,” he said. “We can debate the relative benefits of mood stabilizers and antipsychotics, but no medication will keep a patient organized and motivated; we need psychotherapy for that.”

This study was supported by multiple grants from the National Institutes of Health with additional support from the Dauten Family Center for Bipolar Treatment Innovation, Agency for Healthcare Research and Quality, Brain and Behavior Research Foundation, Robert E. Leet and Clara Guthrie Patterson Trust, and the American Foundation for Suicide Prevention. **PN**

“20-Year Trends in the Pharmacologic Treatment of Bipolar Disorder by Psychiatrists in Outpatient Care Settings” is posted at <https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.2020.19091000>.

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current American health system means having to continue to confront these longstanding inequities and struggle with insurance companies and institutional bureaucracy.

I am not sure what the future holds for me; however, what seems clear is there will need to be a shift in public social consciousness before any meaningful change can occur in our American system, including shifting from individualist thinking toward valuing equality. Part of the burden will ultimately fall on physicians to assume a greater sense of advocacy in health policy to begin changing the conversation at all levels—from individual patients to the top levels of government. **PN**

I would like to extend my sincerest thanks to Dr. Steven Sharfstein, whose invaluable mentorship and guidance throughout my three-month mental health policy elective helped shape this paper. I would also like to extend my thanks to Dr. Christopher Miller, who assisted with multiple revisions of this paper and helped to achieve this final product.

The full version of this article is posted at <https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2020.7a12>.

Early Childhood Behavior Predicts Adult Temperament, 26-Year Study Finds

A tendency to react negatively to new experiences as an infant may signal an increased risk for anxiety and depression in adulthood. **BY KATIE O'CONNOR**

At 14 months, children may already be exhibiting temperaments that offer a glimpse of their future personalities.

According to a longitudinal study published in *Proceedings of the National Academy of Sciences*, behavioral inhibition at 14 months predicts a more reserved, introverted personality at age 26. Behavioral inhibition—characterized as aversion to anything new or unfamiliar and timid behaviors—was also a risk factor for internalizing psychopathologies, such as anxiety and depression, in adulthood.

“This finding shows that temperament and its underlying biology plays an important role in terms of how we think about the development and expression of personality over the lifespan,” said Nathan Fox, Ph.D., a distinguished professor in the University of Maryland Department of Human Development and Quantitative Methodology.

Fox and his colleagues began examining the influence of infant temperament on socioemotional development almost 30 years ago. They recruited 165 infants between 1989 and 1993 and observed the children's behavioral inhibition at 14 months in the laboratory, exposing them to three episodes during which mothers were present: a free-play session in an unfamiliar playroom, with an adult stranger, and with a novel toy robot. The researchers observed and coded the children's responses to create a measure of behavioral inhibition, including how quickly they touched new toys, vocalized during free play, approached the stranger, and other reactions.

Then, 115 of the participants returned to the laboratory at age 15 so researchers could assess error-related negativity, the degree to which individuals are sensitive to errors. Sets of five letters, such as SSHS or HHSH, were flashed on a screen and participants were asked to identify the middle letter as quickly as possible. Simultaneously, researchers collected electroencephalography (EEG) data. Error-related negativity was shown as a negative dip in activity in the mediofrontal cortex within milliseconds of making an incorrect response.

Finally, 109 of the participants completed a series of questionnaires when they were 26 years old. The question-



“We had remarkable retention of the sample in this study. Most of the families were quite interested in our work and kept coming back over and over again for assessments,” says Nathan Fox, Ph.D.

naires assessed the participants' psychopathology, personality, social functioning with friends and family, history of romantic relationships, highest level of education, and employment status.

The authors found that higher levels of behavioral inhibition early in life predicted a more reserved personality and lower social functioning with friends and family at age 26. Higher

behavioral inhibition was also associated with fewer romantic relationships in the past 10 years, though it was not related to whether the participants were in a current relationship at age 26. Behavioral inhibition did not predict education or career attainment.

Behavioral inhibition at 14 months also predicted internalizing psychopathology at age 26, but only among those who showed greater levels of error-related negativity at age 15. Increased error monitoring “might reflect a rigid and ‘over-controlled’ response pattern that hinders social interactions across development among temperamentally inhibited individuals,” the authors wrote.

The authors noted some limitations to the study, including the small sample size and that the participants were primarily Caucasian who grew up in middle- to upper-middle-class families.

“It's remarkable and powerful that this temperament, which we assessed in infancy, has such a powerful effect on personality over such a long period of time,” Fox said. He emphasized how-



PSYCHIATRY & PSYCHOTHERAPY

Seven Tips for Maintaining the Frame in Online Therapy

BY CLIFFORD ARNOLD, M.D., AND THOMAS FRANKLIN, M.D.

While we are in the midst of a pandemic, teleconferencing technology can be a source of both stability and insecurity in the therapeutic relationship; on the one hand, it confers the near-miraculous ability to remain connected at a safe distance, while on the other hand it upends the basic conditions under which therapy takes place, like simply being in the same room together.

When striving for continuity in the transition from in-person to online therapy, a possible pitfall is to conserve the verbal elements of therapy and ignore the rest. This is counterproductive since the nonverbal aspects of therapy have an arguably greater impact on patients, and without them words can be ineffectual. The set of nonverbal conditions that engender trust, confidence, and security in patients and allow the words of therapy to be effective is called the therapeutic frame. The following tips are meant to help maintain the therapeutic frame during this precarious time, specifically in the transition from the office to the screen.

1. Create some distance: One way to



Clifford Arnold, M.D., is a fellow in child and adolescent psychiatry at the University of Kansas School of Medicine and a fellow in the Psychotherapy Committee of the Group for the Advancement of Psychiatry. Thomas Franklin, M.D., is the president of Mind-Work Group LLC in Baltimore, where he practices psychiatry,



psychoanalysis, and organizational consulting. This column is coordinated by APA's Caucus on Psychotherapy and the Psychotherapy Committee of the Group for the Advancement of Psychiatry.

preserve a familiar and comfortable frame is to observe personal space online as one would in the office. It would feel awkward, intrusive, and exhausting to sit four feet away from a patient and stare directly into her face for an hour straight in the office, yet we do that regularly online. Perhaps we are

compensating for feeling distant in other ways or perhaps we simply can't see or hear very well. It's ok to back up, and some technological modifications can help (see tip #3). The extra space might allow both parties to feel less self-conscious and more at ease, less focused on maintaining a perfect affect and more on the therapy.

2. Body language matters: Here's another reason to back off the camera a bit: Expanding the field of vision to include not just facial expressions but also upper-body language (for example, hand gestures, posture, distance modulation) has been shown to increase empathy measures, according to David T. Nguyen and John Canny in the article “More Than Face-to-Face: Empathy Effects of Video Framing.” Experiment with this. Sit back, expand the visual frame, move, and gesture as you would in person—find what feels connective and go with it. In addition to camera distance, the angle matters too; if the lens is positioned at a height lower than your eyes it may appear to your patients that you are looking down on them. Stack

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ever, that not all children who exhibit behavioral inhibition go on to develop an anxiety disorder or depression. “The environment plays a powerful role in terms of either moderating or exacerbating temperament,” he said.

But further understanding of how behavioral inhibition predicts internalizing psychopathology in adulthood could have implications for intervention, noted Alva Tang, Ph.D., the study's lead author and postdoctoral fellow in the University of Maryland's Child Development Lab, of which Fox is the director.

Parents and clinicians often begin thinking of a child's long-term physical health during infancy, explained co-author Daniel S. Pine, M.D., chief of the section on development and affective neuroscience in the National Institute of Mental Health (NIMH) Intramural Research Program. “This work shows that people should really start thinking about mental health right at the beginning of a child's life, as well,” he said.

This research was supported by funding by NIMH and a postdoctoral fellowship from the Social Sciences and Humanities Research Council of Canada. **PN**

➤ **“Infant Behavioral Inhibition Predicts Personality and Social Outcomes Three Decades Later” is posted at <https://www.pnas.org/content/117/18/9800/tab-article-info>.**

Paid Maternity Leave Improves Health, Mental Health for Both Mothers and Infants

For greatest benefit, paid maternity leave should last at least 12 weeks. BY TERRI D'ARRIGO

Paid maternity leave benefits the mental and physical health of both mothers and children, a review in the *Harvard Review of Psychiatry* has found. The benefits include a decrease in postpartum depression and mother and infant rehospitalizations and improved infant attachment.

“Given the substantial mental and physical health benefits associated with paid leave, as well as favorable results from studies on its economic impact, the United States is facing a clear, evidence-based mandate to create a national paid maternity leave policy,” said lead author Maureen Sayres Van Niel, M.D., a reproductive psychiatrist in Cambridge, Mass. She is the APA Assembly's representative to the Caucus of Women Psychiatrists and chair of the Assembly Committee of Representatives of Minority/Underrepresented Groups. Van Niel and colleagues reviewed 26



The United States is facing an evidence-based mandate to create a national paid maternity leave policy, says Maureen Sayres Van Niel, M.D.

studies about the relationship between maternity leave and health outcomes in mothers and their children. Key findings among the studies in the review include the following:

- Significantly higher scores for maternal depression and increased diagnoses of major depressive disorder among women who took fewer than 12 weeks of paid leave.
- An increased risk of postpartum depression among women who took less than six months of maternity leave in general (paid or unpaid).
- A 58% lower chance of reporting physical and psychological intimate partner violence in the year following birth for women who took paid maternity leave compared with those who were not working or were not eligible for paid leave.
- A 51% lower chance of being rehospitalized in the year after birth among women who took paid leave of any duration.
- A 46% reduced likelihood of infant rehospitalization in the first year among infants born to mothers who took paid leave compared with those whose mothers took no leave or unpaid leave.

“The United States is one of [very few] developed countries to lack a national policy on paid family leave,” said review coauthor Nicholas Riano,



Christina Mangurian, M.D., M.A.S., encourages psychiatrists to advocate for paid maternity leave to promote bonding between infants and their mothers.

M.A.S., an assistant clinical research coordinator in the Department of Psychiatry at the University of California, San Francisco (UCSF). “This review substantially adds to the literature. It is important for policymakers to consider the benefits of paid maternity leave and

see *Maternity* on page 28

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some books under your monitor to avoid the impression of being overbearing or aloof.

3. Mind your tech: Some minor technological improvements might be required to see and hear clearly at a less awkward and more full-bodied distance from your camera. Headphones with a built-in microphone preserve volume and fidelity at any range. A high-definition camera and a large monitor enable clearer images especially from farther away. If you use a laptop, you may need to plug in a keyboard and mouse to operate it from a convenient distance. Poor internet connections are an immutable fact of life for many these days, but for others, paying a bit more per month can buy a much smoother experience.

4. Minimize gaze error: The somewhat disconcerting deviation from direct eye contact that occurs in all videoconferencing is called “gaze error,” and it results from the distance between the image of the person on your screen and the camera above it. Naturally, then, you can minimize gaze error by moving your patient's image as close as possible

to the top of your screen.

5. Keep it formal: Panning out from the technological, we consider the physical frame shift from the professional office to the home. The office setting conveys a therapeutic formality that can be lost online. An appropriate amount of formality can signal and maintain professional boundaries, which in turn establish a frame of stable and secure expectations and ultimately engender trust. Your patients (or you) might want to wear pajamas and stay in bed, but you would be within your professional mandate to demur. Dress up. Sit up. Mind the backdrop. Lock the kids out. Stick to the clock. Encourage your patients to do the same.

6. Adapt your authority: Another function of the professional setting is to clarify the leadership role; the office frame is your turf and your prerogative. Not so online. How does the dynamic shift when patients feel right at home? Perhaps they experience less paternalism and a more level playing field. Good. In contrast, they may feel less confidence in your authority, unsupported as you are by the professional edifice. The tip here is more diagnostic than

curative; if you feel more challenged and exhausted in your sessions, consider whether a shifted authority dynamic is part of the altered therapeutic frame, and discern how much therapeutic authority would be beneficial to recover.

7. Own the frame: The many factors that influence the online therapeutic frame (for example, technological, social, regulatory) are in constant flux, especially in a time of crisis; some of these tips will likely be irrelevant in a few months and antiquated in a few years. To adapt, stay tuned to the collective wisdom, but also adopt your own frame-oriented approach to future circumstances. Clarify for yourself what elements seem foundational for therapy (for example, trust, confidence, security), discern what frame conditions engender them (for example, easy communication, formal cues, therapeutic authority), attend closely to the ways that the new online environment creates barriers to these conditions, devise ingenious ways to overcome them, and share your wisdom freely. **PN**

➤ **“More Than Face-to-Face: Empathy Effects of Video Framing” is posted at <https://dl.acm.org/doi/abs/10.1145/1518701.1518770>.**

Racism

continued from page 1

males make up 7% of the American population, they account for 37% of people who are incarcerated.

Wilson discussed how the image of Black men has been crafted in the United States, beginning with their arrival in North America in shackles, moving on to depictions of them as animalistic and hypersexualized in early 20th century novels and movies such as *Birth of a Nation*, and continuing today with their portrayal in the news as thugs and criminals.

Wilson spoke about the slogan “All Lives Matter” as a response to the Black Lives Matter movement. He described an analogy he had seen online.

“If you distill American society into one neighborhood, and each house represents a different racial or ethnic group, oftentimes African Americans end up

that racism is something white people must actively address.

“This is not an issue for Black people, but rather an issue for our white brothers and sisters to reckon with,” she said. “Truly, if it were up to Black people, indigenous people, Latinx people, and

School of Medicine, discussed disparities in health care and how they are rooted in disparities in other areas of life.

“Perpetual cycles of hospital admissions, ER visits, and poor health outcomes persist because they are just downstream consequences of root



Acknowledging that students and trainees experience racism is the first step in addressing racism in medical and psychiatric education.

—Danielle Hairston, M.D.

other people of color, racism would have already been eradicated. So today I am speaking to my white brothers and sisters: You have to step up and do the work,

causes upstream like lack of income, unstable housing, and lack of access to healthy, affordable foods,” she said.

Geller announced that he had established the APA Presidential Task Force to Address Structural Racism Throughout Psychiatry. “The goal of this group is to create actions, not position statements, not white papers, but actions,” Geller said.

The task force consists of the following APA members, the first five of whom are members of the Board of Trustees:

- Cheryl D. Wills, M.D., Area 4 trustee (chair)
- Eric Plakun, M.D., Area 1 trustee
- Michele Reid, trustee-at-large
- Richard Summers, M.D., APA treasurer



Racist images of Black males in the U.S. date back to when they first arrived in North America as slaves in shackles and persist today in

popular media. —Walter E. Wilson, M.D., M.H.A.

asking for help throughout the community for emergencies associated with their house, and others respond with, ‘Well, all houses matter,’” he explained. “The problem with that is that the African American house is on fire. It has been on fire for 400 years. We were forced to live in a house that was smaller than the other houses, we were forced to be firefighters, and then we were blamed for the fire.”

Ayana Jordan, M.D., Ph.D., ECP trustee-at-large on the APA Board of Trustees and an assistant professor of psychiatry at Yale University School of Medicine, began her talk with a moment of silence for Black people who were killed by racially motivated acts of violence and police brutality. She expressed her grief over their deaths and described her distress over being unable to comfort her

and boy do you have a lot of work to do.

“I am asking that we as a member-led organization enter into a liberated space together. No, it’s not safe. Yes, you may



Open dialogue about racism may be uncomfortable for some white psychiatrists, but in conflict lies the opportunity for growth.

—Ayana Jordan, M.D., Ph.D.

get your feelings hurt,” she continued. “But as psychiatrists we understand that in conflict, often therein lies the work which can indeed yield growth. ... At

- Sanya Virani, M.D., M.P.H., resident-fellow member trustee
- Renée Binder, M.D., former APA president and forensic psychiatrist
- Frank Clark, M.D., member of the APA Council on Minority Mental Health and Health Disparities
- Danielle Hairston, M.D., president of the APA Caucus of Black Psychiatrists
- Hunter McQuiston, M.D., member of the *Psychiatric Services* Editorial Board and a community psychiatrist
- Steven Starks, M.D., the representative to the Assembly for the APA Caucus of Black Psychiatrists **PN**



Poor health outcomes and repeated hospital admissions among Black patients are linked to socioeconomic disparities. —Thea James, M.D.

10-year-old nephew, who, she said, is “experiencing extreme duress secondary to the belief that one day his mother—my older sister—or his father—my brother-in-law—might be the next victim of police murder.”

Directing her comments toward white psychiatrists, she emphasized

some point, you must wrestle with the truth that is deeply embedded in the foundation and roots of this organization and inherent in the practice of psychiatry: that of anti-Black racism.”

Thea James, M.D., an associate professor of emergency medicine at Boston Medical Center/Boston University

Clozapine

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a condition observed in some African and Middle Eastern populations).

The work group recommended that physicians evaluate patients who have been taking clozapine for six to 12 months and shown stable neutrophil counts on a case-by-case basis. For patients recently initiated on clozapine, physicians should maintain existing monitoring guidelines in their country.

Even if blood monitoring is reduced in some patients prescribed clozapine, all patients should continue to be evaluated through regular check-ups, Siskind said. In addition to blood risks, clozapine is known to increase risk of cardiometabolic side effects, such as weight gain, which may put patients at higher risk of poor outcomes if they contract COVID-19, he said. Another known clozapine side effect is excess drooling, which can be problematic in people with an infection, as virus-containing saliva may accidentally end up going down the windpipe and increasing the risk of pneumonia in the lungs.

The TRRIP work group recommended that patients on clozapine who develop signs of an infection should have their clozapine dose reduced until at least three days after a fever has subsided. At that point, the physician can slowly titrate the dosage back to the pre-infection levels. As Siskind explained, clozapine is metabolized more slowly during an infection, so standard doses might lead to a toxic buildup in the blood.

“I believe this is an important guideline, irrespective of COVID,” noted Robert Cotes, M.D., an assistant professor of psychiatry and behavioral Sciences at Emory University School of Medicine. “Clinicians need to recognize that any systemic infection can cause clozapine levels to increase.”

Cotes added that obtaining blood clozapine levels as soon as a patient with symptoms of infection presents for medical attention is critical. Since getting COVID-19 blood tests results can take several days in some health systems, physicians should not be afraid to start reducing the clozapine dose before the levels are known and then adjust once the results are in.

Siskind told *Psychiatric News* that the TRRIP work group is continuing to monitor COVID-19 developments as they relate to schizophrenia and will put forth additional recommendations if needed. **PN**

➤ The TRRIP consensus statement on the use of clozapine during the COVID-19 pandemic is posted at <http://jpn.ca/45-3-222/>. The FDA’s REMS policy during the COVID-19 pandemic is posted at <https://www.clozapinerems.com/CpmgClozapineUI/home.u>.

➤ An archived recording of the town hall can be accessed at <https://www.psychiatry.org/psychiatrists/meetings/addressing-structural-racism-town-hall>.



PSYCHIATRIC NEWS *Special Report*

Hispanic Community and COVID-19: Addressing Health Inequalities Can No Longer Be Delayed

The Hispanic community in this country, which has long been underserved with regard to health and mental health care, is experiencing additional barriers to maintaining their health and mental health and getting the care they need during the pandemic. BY HECTOR COLON-RIVERA, M.D.

The values of a community are reflected in individuals' willingness to secure well-being and vitality for all. I envision a day when preventable death, disabilities, and health disparities are eliminated. This transformation will occur only by examining the causes of health inequities and social determinants of health and directing more interventions to collaborate in health promotion and disease prevention.

The socioeconomic status of Hispanics in the United States is considerably lower than that of

non-Hispanic whites due to several specific characteristics of the Hispanic population, including their lower family income, more limited educational attainment, and lower-paying occupations.

Hispanics are more likely to work in agriculture, construction, domestic and food services, and other low-wage occupations with inadequate health insurance coverage. Limited formal education may impair people's ability to navigate the complex health care delivery system. Additionally, Hispanics are more likely to live in impoverished communities, in close living conditions, and cities with



Hector Colon-Rivera, M.D., is medical director for APM Inc., a nonprofit that serves the communities of North Philadelphia with behavioral health, housing, foster home, and education services. He is also a faculty member at the University of Pittsburgh Medical Center and the

Einstein Medical Center, the president of APA's Caucus of Hispanic Psychiatrists, and the Area 3 representative to the APA Assembly.

less-developed trash and sewer infrastructures. Most foreign-born Hispanics and Puerto Ricans primarily speak Spanish, and most of the health-related instructions and materials are in English, so non-English speakers don't have access to them.

Despite the disparities in employment, educa-

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tion, and income, Hispanics have lower age-adjusted mortality rates than African Americans and, in many cases, lower rates than non-Hispanic whites. One possible explanation is the social support and traditional values of the families and community as they tend to stay together.

This action makes it hard for communities with extended families who highly value family contact to get through difficult situations when asked to stay away from each other because of the pandemic. A loss of cultural values in family members who are U.S. born or assimilated to the culture can lead to intergenerational stress that undermines family relationships and lowers expectations about academic performance, mental health, and well-being.

These socioeconomic differences of Hispanic communities continue to be valid during the COVID-19 pandemic. Of course, all human beings have a right to know when and how to seek care. But data continue to show that African Americans and Hispanic people are dying from COVID-19 at higher rates than whites, even though they make up a smaller percentage of the population.

Unfortunately, it was not until the pandemic affected both white and non-white communities that we saw a loosening of the rules. That loosening increased access to resources that could have been the salvation, for so long, of socioeconomic revitalization, connectivity, and technology infrastructure development to address health equity for underserved communities. The same effect was seen when the life expectancy of the U.S. white population declined mainly due to the opioid epidemic. Specific treatment options were marketed primarily to suburban communities, whose residents can pay for treatment.

The spread of telehealth services during the pandemic and increased medication access for assisted treatment during the opioid epidemic have a lot in common. They illustrate how racially different health policies and health care practices make those vulnerable even more vulnerable in the face of inadequate attention to public health.

Case Examples of Impact of Pandemic on Hispanic Community

Let's take the experiences of some of my patients. I am using pseudonyms for both of the cases dis-

in-person meetings, remaining sober is difficult for some individuals, and it is difficult for our communities to call for help.

Unfortunately, there are countless stories of patients struggling with similar situations. Having clinics provide their services over the phone presupposes that there are physicians who are healthy and certified to prescribe every medication and that the pharmacies and doctors' offices are functioning. Additionally, rehabilitation facilities have limited new admissions, canceled programs, or even shuttered their doors for fear of spreading the virus.

Another patient was Marla, an undocumented Guatemalan woman who worked in a pizzeria "under the table." She never stopped reporting to her job, even after she began coughing and feeling ill. Her condition quickly deteriorated. She was admitted for treatment and discharged two weeks later. However, her mother became sick while Marla was in the hospital. After her mother began gasping for air, Marla's husband rushed her to the hospital. Marla and her mother could not see each other due to COVID restrictions, and her mother died from COVID-19. Marla feels guilty about what happened, saying that finding support and accepting the loss

"Healthy social conditions can ensure that the most vulnerable members of society benefit from the same fundamental rights and opportunities as more affluent citizens."



This situation is similar to the Spanish flu in 1918, cholera pandemic of 1961 to 1975, and the H1N1 swine flu outbreak in 2009. People with limited ability to communicate because of language differences and limited social and economic options do not receive adequate health information and services, which ultimately exacerbates health disparities. We must learn from our past mistakes.

Closing places of trust for our communities like churches, barbershops, and community parks has left a gap in communication channels in minority neighborhoods across the country. Without culturally relevant communication strategies, many cities were lost.

The Centers for Medicare and Medicaid Services and other federal and state regulatory bodies waived specific requirements for telecommunications, which has allowed many Americans to continue to get health care services. While based on my colleagues' and my experiences during the pandemic, telehealth is not the optimal solution for every patient, these changes are important to not only ensure but also increase access to care. In addition to physicians and nurses, other health care professionals, including psychologists and social workers, can provide telehealth services. I have been practicing telemedicine for more than four years, and this is the first time I have seen such policy changes. Telehealth has been promoted as an innovative approach to bridging the health care delivery gap by increasing access to services for medically underserved communities for decades.

cussed to protect the patients' identities.

Gilberto was doing well; his diabetes and opioid use disorder were well controlled. He was working and taking care of his family. After the pandemic hit, the restaurant where he was working was forced to close. He did not have health benefits or accumulated days off, so his boss let him go. He started eating junk food, which affected his sugar control. Poor glycemic control is a risk factor for severe infections, and adverse outcomes of infection with COVID-19 and other diseases, including bacterial pneumonia, are more likely without reasonable glycemic control.

Gilberto was admitted to the hospital for glycemic control and discharged home to quarantine after testing positive for COVID-19 because he was asymptomatic. His wife called my office after he relapsed on heroin after three years of sobriety on buprenorphine. Gilberto then told me that he was ashamed of calling me as he had "failed."

Stigma and shame associated with mental illness and lack of information reduce the utilization of services. But we know that a fact in recovery culture is that a substance use disorder is a disease of isolation, and, in every possible way, what we are asking people to do during the pandemic is to isolate.

For people struggling with a substance use disorder and chronic illness, virtually all of the services and treatments available to them have been disrupted by the COVID-19 epidemic. People are told to stay home, which directly contradicts the need to go to clinics to obtain services. Without

of her mother have been hard without seeing her psychotherapist and me, her psychiatrist, in person.

We need to make extra efforts to maintain social bonds during this time of enormous stress and social isolation. Healthy social conditions can ensure that the most vulnerable members of society benefit from the same fundamental rights and opportunities as more affluent citizens. We need to ensure that all residents have equal access to quality health care and essential community services that preserve and protect health.

How to Strive to Understand the Social Determinants of Health

For providers, the complexity of social health determinants paired with the medical field's challenges and organizational priorities make it hard to know where to start focusing, but determining the "who," "how," "where," and "what" of the underlying factors impacting minority communities is critical. Food security, jobs, education, and quality of housing are four determinants of a secure link to health and are common areas of focus for health care organizations.

Understanding market-specific population issues should lead our health systems and private practices to focus on increased access to behavioral health services and virtual telehealth offerings as part of overall growth strategies. Shifting individuals' and organizations' mindset around can better inform the way we create services aligned to health equity and the communities' preferences and needs.

Social Determinants of Health Go Beyond Racism and Colorism

The coronavirus is not a racist disease. It has no eyes, and its only goal in life is to replicate inside the living cells of an organism. There are no biological reasons why Black and Hispanic people should be getting sick with and dying of coronavirus more than white people. Skin color continues to serve as the most apparent criterion in determining how a person will be assessed and treated in our country. The racial categories in the United States for our phenotypically ambiguous population are limited. According to the U.S. Census, you are white, Black, American Indian/Alaska Native, Asian, Native Hawaiian/other Pacific islander, or multiracial. The privileging of light skin over dark affects where you live, what you eat, where you work, and other environmental factors.

What Can We Do?

- **Improve education and leadership programs in the workforce:** Without a doubt, the future workforce will have an increasingly Hispanic identity. We need to improve the access of Hispanics to education and eradicate

- **Partner with communities, nonprofits, and community leaders:** Community leaders are trusted messengers and influencers to their communities. They know their community's needs. They often have diverse partnerships and collaborations with schools, local businesses, law enforcement, and medical personnel. Mental health professionals are critical for outreach, engagement, and linking Blacks and Latinos with mental and substance use disorders to treatment. As medical professionals, we should promote and educate patients about lifestyle factors associated with disparities, including preventive care; dietary behavior; physical activity; use of tobacco, alcohol, and other substances; and sexual practices. Screening and treatment are particularly crucial for the control and prevention of many conditions. Knowing where to find treatment facilities with cultural competence and resources for Hispanics is essential to obtain preventive care and treatment and avoid the progression of disease and worse outcomes, including death.

- **Collect and release data to improve resources to improve health disparities:** All states and municipalities need to collect and

and targeting disparities in population health. An increased focus on chronic disease prevention and control programs that engage Latino communities in addressing environmental, policy, and behavioral changes is needed.

- **Supporting our international medical graduates (IMGs) colleagues:** Join advocacy efforts and groups supporting non-U.S. citizen international medical graduates (IMGs) who are practicing or otherwise lawfully present in the country. Given workforce demands during and probably after the pandemic, there is an urgent need to take these opportunities for fast-tracking immigrant and bilingual people into the health care force, especially in areas of the country with higher rates of poverty and chronic disease such as minority communities.

The trends in health disparities are demographic and based on socioeconomic inequalities that create high-risk conditions for Hispanic communities. We can reduce health disparities by addressing inequalities, but we need to deliberately change our focus from thinking only of white-type patterns

"The privileging of light skin over dark affects where you live, what you eat, where you work, and other environmental factors."



the root causes for the shortage of Hispanics' advancement into leadership. Less than 5% of corporate leaders and physicians are Hispanics. For one, there is still outright prejudice and bias in the workplace. A fair and equitable work environment creates a competitive system. Those who do well get promoted, and issues of race, ethnicity, and gender do not matter because merit is all about performance. For the most part, Hispanic individuals have been closed out of the health professions, and supporting them would create a pool of potential health care workers in the United States.

- **Create flexible and culturally competent policies and payments:** Culturally specific guidelines for mental and substance use disorder treatment programs must be created so that Black and Hispanic people can access treatment and get high-quality care.

- **Tailor communication channels:** Public health information changes rapidly, and timely guidance to minority communities is critical. Public health concepts are not readily understandable across cultures. Concepts such as social distancing, flattening the curve, self-quarantining, wearing face masks, and washing hands should be explained in a culturally appropriate manner. The dissemination of news and information through mainstream and social media should also be done in a culturally appropriate manner.

release the demographic data on who is being affected with coronavirus in both the Hispanic and Black communities. The more we understand about the virus, the better equipped we will be to determine the resources and funding needed in these communities. The COVID-19 pandemic has common ground with the Black Lives Matter movement. These bring opportunities for our country to make investments that will help revive our national potential for productivity by promoting the health of minority communities

Resources

APA offers a number of resources on working with Latino/a and Hispanic patients on its website:

1. "Guide on Best Practice Highlights Latino/as and Hispanics": <https://www.psychiatry.org/File%20Library/Psychiatrists/Cultural-Competency/Treating-Diverse-Populations/Best-Practices-Latinos-Patients.pdf>
2. A video presentation titled "Working with Latino/a and Hispanic Patients" with Lisa Fortuna, M.D.: <https://player.vimeo.com/video/152625229>
3. "Mental Health Facts for Hispanics and Latinos/as": <https://www.psychiatry.org/File%20Library/Psychiatrists/Cultural-Competency/Mental-Health-Disparities/Mental-Health-Facts-for-Hispanic-Latino.pdf>
4. "Stress & Trauma Toolkit for Treating Hispanics in a Changing Political and Social Environment": <https://www.psychiatry.org/psychiatrists/cultural-competency/education/stress-and-trauma/hispanics>
5. A course titled "Engagement Interview Protocol" that helps psychiatrists work with patients from different cultural backgrounds and understand the meaning of symptoms based on patients' cultures and traditions: <http://apapsy.ch/EngagementProtocol>
6. A *Psychiatric Services* article titled "Psychosis Literacy Among Latinos With First-Episode Psychosis and Their Caregivers": <https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201700400>

APA members interested in joining the Caucus of Hispanic Psychiatrists should go to <https://www.psychiatry.org/psychiatrists/cultural-competency/mur-caucuses> and click on "Join" on the right side of the webpage.



JOURNAL DIGEST

BY NICK ZAGORSKI



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IPSRT Found to Improve Functioning in Patients With Bipolar Disorder

Although interpersonal and social rhythm therapy (IPSRT) can improve functioning in patients with bipolar disorder, the therapy may not reduce the risk of mood relapse. This finding comes from a clinical study by investigators at the University of Otago in Christchurch, New Zealand, that was published in the *American Journal of Psychotherapy*.

IPSRT seeks to balance biological and social rhythms through the practice of regular daily routines, including sleep and other techniques to reduce stress.

The study included 88 patients with bipolar disorder who had recently been discharged from a mental health center. The patients were randomly assigned to IPSRT or usual treatment from their primary care physician for

18 months, with assessments performed every six months. The IPSRT participants also received a brief monthly medication management session from a psychiatrist.

At the end of 18 months, about 40% of patients in each group experienced at least one recurrent mood episode (depression or mania). Both groups also had similar scores on the Longitudinal Interval Follow-up Evaluation (which calculates the average severity of depression and mania symptoms over the previous six months) at each assessment.

The patients who received IPSRT reported statistically lower scores on the Social Adjustment Scale (which rates functioning across a range of family, work, and leisure domains) compared with those patients who received usual treatment. In addition, fewer patients receiving IPSRT required readmission to a mental health center compared with those who received usual care (14% versus 40%).

"Similar to self-management programs for chronic physical conditions, [IPSRT] was focused on promoting self-management and teaching the participants to live well in the presence of symptoms," the investigators wrote. This focus may have been associated with the low readmission rate and improved functioning despite similar relapse events.

■ Crowe M, Porter R, Inder M, et al. Clinical Effectiveness Trial of Adjunctive Interpersonal

and Social Rhythm Therapy for Patients With Bipolar Disorder. *Am J Psychother.* April 20, 2020. [Online ahead of print] <https://psychotherapy.psychiatryonline.org/doi/10.1176/appi.psychotherapy.20190035>



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Internet-Based CBT Effective for Health Anxiety

Hypochondriasis, anxiety about one's health, is a common and potentially debilitating condition. In-person cognitive-behavioral therapy (CBT) is considered the best treatment for hypochondriasis, but a study appearing in *JAMA Psychiatry* reports that an internet-based CBT program for health anxiety may be as effective as face-to-face treatment.

Researchers at Sweden's Karolinska Institute and colleagues randomly assigned 204 adults with health anxiety to either online CBT or 12 weekly in-person CBT sessions. The online program included 12 self-help modules, and the participants were encouraged to complete one a week. Online participants

could also freely communicate with a therapist via email.

After 12 weeks, participants in both treatment groups showed similar reductions in health anxiety, as assessed with the 18-item Health Anxiety Inventory (scores in both groups dropped 11.3 points). The groups showed similar improvements in general anxiety and functional impairment as well.

The researchers calculated that online CBT would produce a lower net societal cost (which considers therapies, medications, nonmedical services, and indirect costs like unemployment) of about \$3,800 per patient over the 12-week period. This was primarily due to lower therapist costs; therapists spent about 10 minutes communicating with each patient per week in the online treatment compared with 45 minutes face-to-face each week.

"Given the low societal costs of ICBT [internet CBT] for health anxiety, our findings highlight the potential benefits of implementing this treatment on a wider scale," the authors concluded.

■ Axelsson E, Andersson E, Ljótsson B, et al. Effect of Internet vs Face-to-Face Cognitive Behavior Therapy for Health Anxiety: A Randomized Noninferiority Clinical Trial. *JAMA Psychiatry.* May 13, 2020. [Online ahead of print] <https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2765960>

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LETTERS TO THE EDITOR

A Case of Stolen Identity at the Pharmacy

I recently received an anxious phone call from one of my outpatients. He said that his prescription for the benzodiazepine I had prescribed needed to be rewritten. Of course, I asked why. The story he told me surprised me as it was the first time in my 25-year career that I had heard it. He said his pharmacy told him that someone else had claimed to be him and picked up the prescription. After I asked for more information, he said he suspected that a certain family member with a history of substance use picked it up. The pharmacy told him to call me to see whether I would prescribe the medication again.

To verify the story, I called the pharmacy. The pharmacist confirmed that someone claiming to be the patient came through the pharmacy drive-through and picked up the refill. I was still surprised that such a thing could happen so easily. The pharmacist said there was no policy for checking a photo ID for benzodiazepines; only the patient's full name and date of birth were requested. The pharmacy did check IDs for opiates and the like.

The pharmacy had camera surveillance, but it would take time to review the video. Also, because of the lighting and the difficulty of seeing people's full face as they use the drive-through, the

pharmacist could not give a useful description of the person who had picked up the medication.

I pondered the situation and contemplated what next steps would be medically and ethically appropriate. I considered the patient's clinical history, diagnosis, medication list, and the pattern of benzodiazepine use. I thought of giving the patient only written prescriptions, but my clinic had completely transitioned to electronic prescriptions. Consequently, I could not ultimately guarantee that the medication would get to the right person, and the pharmacy could not guarantee that either.

After more thought, I decided to replace the benzodiazepine with an alternative as-needed medication and further encourage alternative methods of controlling anxiety. During a difficult conversation with the patient, I explained that I could not continue to prescribe a potentially abusable and habit-forming prescription medication when it was so easily and intentionally being interdicted. I apologized to the patient for this decision and vowed to

assist him in transitioning to an alternative treatment approach.

I have always strongly considered safety and clinical appropriateness regarding such prescriptions. I am aware that any patient could choose to give or sell his or her medication to someone else. I try to maintain an awareness of abuse potential and street values of various prescription medications. Being a naturally trusting person, I have thought less about other ill intentions and the possibility of an associate of the patient interdicting prescriptions from the pharmacy without the patient's consent. This particular experience caused me to further lower my bar for discontinuing medications of higher risk (be they FDA scheduled or not) and to rethink other scenarios by which prescription medications can end up in the wrong hands.

No matter how convenient (or "safe"), a drive-through may not be a wise way to dispense prescription medications, even during the COVID-19 pandemic. **PN**

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Letters to the Editor

Readers are invited to submit letters of not more than 350 words for possible publication. *Psychiatric News* reserves the right to edit letters and publish them in any of its formats—print, electronic, or other media. Receipt of letters is not acknowledged. Letters should be emailed to cbrown@psych.org. Clinical opinions are not peer reviewed and thus should be independently verified.

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Autism Severity May Change In Early Childhood

While early research suggested that symptoms of autism spectrum disorder (ASD) remain stable over the lifetime, a study in the *Journal of Autism and Developmental Disorders* now suggests ASD symptoms in children may change over time.

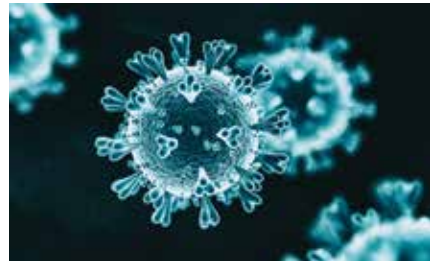
Researchers at the University of California, Davis MIND Institute analyzed data from 125 children (89 boys and 36 girls) with ASD, who at the age of 3 and 6 years underwent symptom severity and IQ assessments. Symptom severity was assessed with the 10-point Autism Diagnostic Observation Schedule Calibrated Severity Scores scale; a change of 2 points or more in either direction was considered significant.

About half of the children (54.4%) displayed stable symptom scores between the ages 3 and 6, while 16.8% exhibited increased severity and 28.8% exhibited decreased severity. The overall symptom severity at age 3 did not affect how symptoms changed over time; however, children with higher IQ scores at age 3 were more likely to experience a decrease in the severity of symptoms at age 6. Symptom severity was more likely to decrease and less likely to increase in girls than boys.

"These findings are somewhat at odds with the common notion that girls with autism are generally more impaired than boys," the researchers wrote. "Yet,

our results are consistent with many recent studies that suggest that girls might actually demonstrate better developmental outcomes than boys in the areas of cognition, sociability, and pragmatic communication skills."

Waizbard-Bartov E, Ferrer E, Young GS, et al. Trajectories of Autism Symptom Severity Change During Early Childhood. *J Autism Dev Disord.* May 14, 2020. [Online ahead of print] <https://link.springer.com/article/10.1007/s2Fs10803-020-04526-z>



istock/koto_1eja

Young People With IDD More Likely to Die From COVID-19

An analysis conducted by researchers at Syracuse University and colleagues suggests that individuals with intellectual and developmental disabilities (IDD), such as cerebral palsy or Down's syndrome, are more likely to die from COVID-19 than those without IDD. This report was published in the *Disability and Health Journal*.

The researchers evaluated information contained in the TriNetX COVID-19 Research Network, a shared collection of electronic health record data from 42 health care organizations from around the world designed to facilitate COVID-19 research. The study included 474 COVID-19 patients with IDD and 29,808 patients without IDD.

The overall death rate for IDD and non-IDD COVID-19 patients was similar (5.1% and 5.4%, respectively). Significant differences emerged when

looking at different age groups, however. Among patients aged 18 to 74, the death rate was 4.5% in patients with IDD and 2.7% in patients without IDD, while in patients aged 17 and younger, the death rate was 1.6% among patients with IDD and <0.1% among patients without IDD. Fatality rates were similar in patients aged 75 and older with and without IDD.

The researchers found that individuals with IDD in all age groups had a higher prevalence of comorbid circulatory, respiratory, and metabolic disorders. This may partly explain the increased risk of death in younger IDD patients who contract COVID-19. Another possible reason is that individuals with IDD are more likely to live in congregate settings like nursing homes, which are associated with worse COVID-19 outcomes.

Turk MA, Landes SD, Formica MK, Gossa KD. Intellectual and Developmental Disability and COVID-19 Case-Fatality Trends: TriNetX Analysis. *Disabil Health J.* May 24, 2020. [Online ahead of print] <https://www.sciencedirect.com/science/article/pii/S1936657420300674>



istock/KPS

Survey Finds Problem Drinking Among Pacific Islander Youth

Pacific Islanders remain heavily understudied in mental health research, which hinders clinical knowledge of this population's psychiatric risk and treatment needs. A new study appearing in the *American Journal of Orthopsychiatry* reports on the rates

of hazardous drinking and alcohol use disorder among this population.

The findings come from a survey of 156 Pacific Islander young adults (aged 18 to 30) across two communities: Los Angeles County and Northwest Arkansas. The survey was conducted by a team at the University of California, Riverside

Participants were asked about alcohol, cigarette, and marijuana use, as well as their perceived need for mental health and/or substance use disorder services. Alcohol use was reported with the three-question Alcohol Use Disorders Identification Test-Concise (AUDIT-C).

In total, 78% of the respondents reported a history of alcohol use, and 56% screened positive for hazardous drinking (defined as an AUDIT-C score of 4 or higher for men and 3 or higher for women). In addition to the high rate of alcohol use, 53% and 54% of the respondents reported a history of cigarette and marijuana use, respectively; 30% of participants reported using all three substances.

Despite the prevalence of alcohol and substance use, only 25% of the survey respondents felt that they needed treatment for substance use disorder. Young adults who had experienced a drinking-related hazard (such as health or financial problems) were more likely to report needing treatment.

"Now that we've demonstrated that a major problem exists, we are starting to design culturally tailored interventions that could help these communities suffering excessive alcohol use and alcohol-related harms," said lead investigator Andrew Subica, Ph.D., in a press release. **PN**

Subica AM, Guerrero E, Aitaoto N, et al. Hazardous Drinking, Alcohol Use Disorders, and Need for Treatment Among Pacific Islander Young Adults. *J Orthopsychiatry.* April 30, 2020. [Online ahead of print] <https://psycnet.apa.org/doiLanding?doi=10.1037%2F0000456>

Stress

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numbers of patients likely to experience psychiatric effects, Troyer said. For instance, if the infiltration of COVID-19 on the brain plays a major role in psychiatric effects, then even infected people who display no respiratory symptoms might be at risk. If excess inflammation is the primary contributor, then those with milder cases might not develop problems in the future.

"Even if someone who is infected with SARS-CoV2 shows no overt symptoms, however, the immune system is still working behind the scenes," Hong cautioned. "We don't know enough to rule out any exposed individual."

Researchers hope that as more is learned about the psychiatric effects of COVID-19, new understandings about medications may also be revealed. Troyer noted that Washington University in St. Louis recently launched a clinical study testing whether the antidepressant fluvoxamine might prevent severe symptoms in people who have been exposed to COVID-19 but who have not been hospitalized; fluvoxamine is one of several antidepressants known to have anti-inflammatory properties.

"We know that there are subtypes of depression and other psychiatric disorders that respond well to different treatments," said Charles Marmar, M.D., the Lucius N. Littauer Professor of Psychiatry at New York

University Grossman School of Medicine. "It might be the case that patients whose depression has a viral connection are more likely to improve with a biological treatment." He encouraged psychiatrists to ask patients about their COVID-19-related experiences in the months ahead to guide treatment.

Marmar stressed to not forget the psychological toll of this pandemic. "Testing has suggested that maybe 20% of New Yorkers have been exposed to the virus, which is high; but 100% have been exposed to the structural damage to the city's economy. We need to stay connected and maintain social support, get adequate rest and exercise, and keep believing that things will get better. Little measures like that will

build resilience against mental illness in everyone." **PN**

"Are We Facing a Crashing Wave of Neuropsychiatric Sequelae of COVID-19? Neuropsychiatric Symptoms and Potential Immunologic Mechanisms" is posted at <https://www.sciencedirect.com/science/article/pii/S088915912030489X?via%3Dihub>. "Mental Morbidities and Chronic Fatigue in Severe Acute Respiratory Syndrome Survivors: Long-term Follow-up" is posted at <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/415378>. "Neurologic Manifestations of Hospitalized Patients With Coronavirus Disease 2019 in Wuhan, China" is posted at <https://jamanetwork.com/journals/jamaneurology/fullarticle/2764549>. "Psychopharmacology of COVID-19" is posted at <https://www.sciencedirect.com/science/article/pii/S0033318220301444>.

Harris

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to the pandemic. We are proud that a psychiatrist was able to lead the AMA during this time of great anxiety.”

Ken Certa, M.D., APA’s Area 3 Trustee and the senior APA delegate to the AMA, added, “Patrice was the perfect spokesperson for the AMA, especially during this time of COVID-19. The AMA was a voice of reason when conflicting messages were coming out of Washington.”

During her virtual address, Harris recalled bringing her family to her inaugural celebration at the AMA House of Delegates Annual Meeting in June last year and showed a photograph of the family members she introduced then.

“Our AMA gave them a warm welcome, ... so much so that at the end of the evening, my cousin exclaimed ‘I love the AMA,’” Harris recalled. “But unfortunately, as we have seen, outside of the walls of the Hyatt Regency [where the inaugural was held in Chicago], these same family members are not safe to jog, or bird watch, or drive, or even breathe.

“I do have hope, however, ... but that hope is up to us. It is up to us, America’s physicians and the AMA, to demonstrate how to understand more, and to fear less ... to be the voices our country can trust in this time of trial and to lead on action to move us forward in this difficult, perilous time.”


Harris outlined several key organizational activities and achievements

that AMA pursued during her presidential year. These include the following:

- Urgently lobbying Congress and the Trump administration to accelerate the production of PPE, test kits, and ventilators.
- Advocating for regulatory changes to facilitate remote patient visits.
- Supporting inclusion of financial support for small and independent practices in economic relief bills approved by Congress.
- Consistently calling on politicians, media outlets, and government officials to focus on science and

evidence in all decision-making.

At a time of enormous national unrest, Harris vowed to be a hopeful supporter and leader of positive change. “My promise to you is that I will be guided by the direction of Dr. Martin Luther King Jr. in his final Sunday sermon—‘to remain awake through a great revolution.’ And so, as I speak to you for the last time as president of the American Medical Association, ... please know that this ‘psychiatrist is in.’” **PN**

 A video of Harris’s address is posted at <https://www.ama-assn.org/press-center/press-videos/2020-special-meeting-house-delegates-immediate-past-president-patrice>.

Consultation Codes

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when at least 50% of the time devoted to consultative discussion with the requesting primary care professional is carried out in verbal or online discussion, in which the psychiatrist provides both a written and a verbal report to the requesting physician. (The consult with discussion codes do not include any time spent communicating with the patient and/or family.)

The 99451 “Consult Without Discussion” code is used when five minutes or more are spent using an electronic health record system, internet, or fax to consult with a physician. Only a written report to the treating/requesting physician is required.

Each of the codes is associated with

an increment of time spent in consultation. The time increments and approximate payments for each code are as follows:

Consult With Discussion

- 99446: 5-10 minutes (\$18)
- 99447: 11-20 minutes (\$37)
- 99448: 21-30 minutes (\$56)
- 99449: 31+ minutes (\$74)

Consult Without Discussion

- 99451: At least 5 minutes (\$38)


The one-page patient information pamphlet is written in a Q and A format, answering five questions: What is an interprofessional consult? Do you see a psychiatric consultant during this type of consult? Why not see a psychiatric consultant in person? Are these

types of consults common in other medical specialties? Will I receive a bill for this type of consult?

Both guides are posted on the APA website and are being disseminated through the Committee on Integrated Care’s listserv. Psychiatrists are urged to share the patient guide with primary care physicians, who can provide it to their patients.

“E-consults and curbside consults help primary care providers to better care for their patients and take a frac-

tion of the time of a formal psychiatric intake,” Kinnan told *Psychiatric News*. “We hope the guides make the codes for these services easier to use and help promote this kind of collaboration among physicians.” **PN**

 The clinician guide to interprofessional consultation codes and the patient information pamphlet are posted at <https://www.psychiatry.org/psychiatrists/practice/practice-management/coding-reimbursement-medicare-and-medicaid/coding-and-reimbursement>.

Maternity

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what policies should be enacted.”

In conducting their review, the authors also found disparities among women of differing socioeconomic backgrounds: Women with higher incomes were more likely to take eight to 12 weeks of leave, including unpaid leave, whereas women with lower incomes were more likely to return to work as early as 10 days after giving birth.


“The United States has a two-tiered system of paid maternity leave. Women with moderate-to-high family incomes can more often afford to stay home with their infants for 12 or more weeks, whereas women with low family incomes cannot afford to do so. They must go to work in order to pay their bills,” Van Niel explained. “Yet it’s very important for all women and their babies to have time together to create a more secure attachment.”

Although psychiatrists do not typically interact with women during the postpartum period unless the women

were established patients before their pregnancies or are grappling with postpartum depression, there is still an opportunity to help, said senior author Christina Mangurian, M.D., M.A.S., former chair of APA’s Council on Minority Mental Health and Health Disparities and professor and vice chair of diversity and health equity at the UCSF Department of Psychiatry.

“My wish is that we [psychiatrists] advocate for paid maternity leave as a profession because of the mental health benefits,” Mangurian said. “We know how important bonding is early in an infant’s life. It’s important for us to use our scientific and clinical expertise to advocate for paid leave to promote this bonding and mental health wellbeing.”

The authors reported no outside funding for their review. **PN**

 “The Impact of Paid Maternity Leave on the Mental and Physical Health of Mothers and Children: A Review of the Literature and Policy Implications” is posted at https://journals.lww.com/hrpjournal/fulltext/2020/03000/the_impact_of_paid_maternity_leave_on_the_mental.5.aspx.

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