

PSYCHIATRIC NEWS

ISSN 0033-2704



SEE STORY ON PAGE 8

The Sólheimar Ecovillage in Iceland was founded in 1930 for foster children. Today the village is home to more than 100 people, nearly half of whom have a mental illness or intellectual disability. Guiding principles of the village are that everyone lives and works together and contributes to its being self-sustainable. Above is the village's first house.



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Insurers will soon be required to be transparent about pricing.



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Learn more about the candidates in APA's 2021 election.



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COVID-19 creates new challenges for those with eating disorders.

Psychiatrists Discuss Impact of Racism Across Generations

Panelists in APA's third town hall on structural racism discussed how discrimination creates persistent stress throughout life for people of color and people in LGBTQ communities. BY TERRI D'ARRIGO

The adverse effects of structural and interpersonal racism persist across generations, said panelists last month in the third virtual town hall meeting hosted by APA's Presidential Task Force to Address Structural Racism Throughout Psychiatry.

"This is a period of turbulence in our country, and we are all being forced to confront the disparities in the treatment of Black, indigenous, and people of color," said moderator, task force

member, and APA Trustee-at-Large Michele Reid, M.D. She is a clinical assistant professor in the Department of Psychiatry and Behavioral Neurosciences at Wayne State University in Detroit and the chief medical officer of CNS Healthcare. The COVID-19 pandemic has highlighted long-standing inequities associated with race, ethnicity, and income, she said.

Chuan-Mei Lee, M.D., an assistant clinical professor in psychiatry at the

University of California, San Francisco (UCSF), and a child and adolescent psychiatrist at UCSF Benioff Children's Hospital, spoke about the long-term, epigenetic effects of adverse childhood events (ACEs) that may occur as the result of structural and interpersonal racism.

"Experiences of discrimination produce the type of chronic stress that increases allostatic load, sets off cortisol production, shortens telomeres, and methylates DNA," Lee explained.

Lee discussed screening for ACEs using the Pediatric ACEs and Related Life Events Screener (PEARLS). Part 1 of PEARLS screens for ACEs such as abuse, neglect, and household dysfunction. Part 2 screens for social determinants of health and includes questions such as "Has your child experienced discrimination?" and "Has your child ever been separated from their parent or caregiver due to foster care or immigration?"

Lee also noted the Everyday Discrimination Scale, which asks how often a person has been treated with less cour-

tesy or respect than others, receives poorer service than others in restaurants and stores, is called names or insulted, or is threatened or harassed.

"We can screen for racial discrimination and its effects among kids and their parents," Lee said. "This acknowledges and validates the negative health effects of racism. It also brings to our attention individuals who could potentially benefit from treatment."

Ebony Dix, M.D., an assistant professor in the Department of Psychiatry at Yale University School of Medicine and an inpatient geriatric psychiatrist, discussed how structural racism affects Black adults on a daily basis. She cited as an example the ways patients are treated differently in the emergency department because of their race.

"Take an African American male who is 50 years old and a white female who is 50 years old presenting to the same emergency department with the same psychotic symptoms," Dix said. "I've seen time and time again that the

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PERIODICALS: TIME SENSITIVE MATERIALS

PSYCHIATRIC NEWS

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FROM THE PRESIDENT

From a National Election to an APA Election: A Lesson Learned

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

In the U.S. election this year, more Americans voted than in any previous presidential election. CBS News reported that as of November 30, both former Vice President Joe Biden with 80,120,249 votes (51.1% of the total) and President Donald Trump with 73,925,044 votes (47.2%) exceeded Barack Obama's previous record of 69,498,516 votes in the 2008 election. Voter turnout was reported as 66.8% of eligible voters, the highest in 120 years. In 1900, William McKinley won reelection with a 73.7% turnout. The highest voter turnout in U.S. history occurred in 1876, when our 19th president, Rutherford Hayes, was elected to his one term in office with a voter turnout of 82.6%. The comparisons with these last two elections are not fair, however, as the pool of eligible voters consisted basically of White men.

U.S. Voting History

In 1776, voting was controlled by individual state legislatures; only White men who were age 21 and older and owned land could vote. The 14th



Amendment, approved by Congress in 1866 and ratified in 1868, granted citizenship to all people "born or naturalized in the United States," including former enslaved individuals, and guaranteed to any person within its jurisdiction the equal protection of the laws. In 1870, Congress passed the 15th Amendment, which stated that voting rights could not be "denied or abridged by the United States or by any state on account of race, color, or previous condition of servitude." But through such means as literacy tests, poll taxes, fraud, and intimidation, significant numbers of Black people were still effectively precluded from voting for close to another century.

In 1964, the 24th Amendment eliminated poll taxes, and the Voting Rights Act of 1965 prohibited the states from using literacy tests and other methods that would result in excluding Blacks, or anyone else, from voting. This catapulted the percentage of Black people registered to vote from

an estimated 23% to 61% in 1969. As the 2020 election illustrates, however, this hardly eliminated methods to interfere with elections.

Women got the right to vote with passage of the 19th Amendment by Congress in 1919 and ratification by the states in 1920. Achieving this milestone required organized efforts spanning over half a century. Most indigenous people in the United States were not given the right to vote until 1924, with the passage of the Indian Citizens Act.

In 1971 the 25th Amendment lowered the voting age to 18 years old. In 1975, the Voting Rights Act was amended to require bilingual elections in areas with large numbers of citizens with limited English skills, and in 1984, the federal Voting Accessibility for the Elderly and Handicapped Act required polling places to be accessible to people with disabilities.

The turnout in the 2020 presidential election represents a combination of many factors including the respective positions on important issues facing this country, the character and styles of the two candidates, their choice for

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Last month's initial hearing of the Supreme Court included discussion over whether the individual mandate can be severed from the Affordable Care Act.

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vice president, and some unintended consequences of the COVID-19 pandemic. Depending on where they lived, voters had the option of voting early or on election day or by ballots mailed to voters who could return them by mail or put them in drop-off boxes. A significant number of votes were cast before Election Day—more than 100 million—which was far in excess of prior national elections.

Will our country's history and the circumstances surrounding our most recent national election affect the voter turnout in the APA election in January? It's clear how hard we've worked as a nation, and are still working, to encourage Americans to register and vote and ensure their vote is counted. For most of us, voting in the APA election is easy. Every eligible voting member of APA has one vote, and no one needs to register. Do APA members vote?

APA Voting History

The history of APA's elections shows progressively decreasing participation of APA voting members as indicated for the president-elect race and by the total votes cast in the table.

Earlier data indicate that in the 1970s, 50% to 60% of eligible voters voted, declining to about 40% by the 1990s. During this time, ballots were cast by mail.

While making it easier to vote in the 2020 national election appears to have resulted in more voter participation, ease of voting has not had a comparable effect on APA elections. In 2001, eligible voting members began to receive electronic ballots in addition to paper ballots. Beginning with the 2011 election, due to budgetary constraints, eligible voting members no longer received both electronic and paper ballots. All eligible voters with correct email addresses on file with APA receive only electronic ballots. Other voters receive a paper ballot.

Vote Tallies in APA Elections From 2005 to 2020				
Year	President-Elect Voter Turnout (%)	President-Elect Voters (#)	Voter Turnout (%)	Voters (#)
2005	33.87%	10,347	34.12%	10,424
2006	32.09%	9,727	32.39%	9,819
2007	28.38%	9,115	28.79%	9,248
2008	30.83%	9,941	31.18%	10,053
2009	31.03%	9,276	31.56%	9,435
2010	30.62%	9,245	31.05%	9,374
2011	24.81%	7,183	25.44%	7,364
2012	20.15%	5,809	20.42%	5,886
2013	18.48%	5,323	18.90%	5,442
2014	18.84%	5,624	19.08%	5,694
2015	21.07%	6,417	21.35%	6,502
2016	17.29%	5,282	17.94%	5,483
2017	18.62%	5,742	19.54%	6,026
2018	17.51%	5,304	18.25%	5,527
2019	17.51%	5,389	17.95%	5,525
2020	17.03%	5,197	17.48%	5,334

By 2010 half of voters cast their votes electronically, and in 2020 that percentage increased to approximately 95%. During the same period, the percentage of APA voters who cast ballots decreased from 31.05% to 17.48%, the lowest percentage voter turnout in the past 16 years and probably ever.

The 2021 APA Election

Many of my predecessors have wondered in this column why voter turnout is so low in APA elections. None have come up with a satisfactory answer, nor do I have one. But some reasons endorsed by voters are all wrong. Among them: your vote doesn't matter, the candidates' positions don't differ ("they all make roughly the same promises"), and members of the Board of Trustees don't really influence what happens because "the staff make all the decisions."

Here's the truth: The Board holds the fiduciary responsibility for APA and approves the annual budget, focuses on APA's priorities, and approves APA

policy. The APA president, with the support of the other Board members, establishes special projects for the year. The CEO/medical director is hired by the Board and answers to the Board. The APA Assembly is advisory to the Board; the Board decides on the outcome of actions that come to the Board (usually through the Joint Reference Committee). The Board establishes dues. The Board can modify any council or committee. The staff executes much of the work of APA; the Board decides what that work will be.

It should not be hard to see how Board members affect not only APA, but also *you* as an individual member of APA, the field of psychiatry, and even medicine at large. For example, this year it was the Board that focused APA's activities on structural racism (directly

and through a task force), worked on a project to determine a psychiatric-bed need formula (through another task force), decided that the 2021 Annual Meeting would be virtual, and passed a significant number of position statements that impact your practice (see <https://www.psychiatry.org/psychiatrists/search-directories-databases/policy-finder>).

It's not difficult to learn about the candidates, although live opportunities that existed in years past are not available this year. This issue of *Psychiatric News* includes the names, photos, and website addresses of the candidates (see page 6). Each candidate participated in a virtual "Meet the Candidates" session, which is available for viewing at psychiatry.org/MeetTheCandidates.

Electronic ballots will be mailed to eligible voting members with a valid email address on file beginning January 4; reminders to vote will be sent through direct emails and the *Psychiatric News Update* and *Alert*. You can cast your vote anytime between January 4 and February 1. Paper ballots are available on request by sending an email to election@psych.org and must be postmarked by the February 1 deadline. It's not hard to vote and takes only a few minutes.

If every APA member who voted in the national election voted in the APA election, we would surely have a turnout that exceeds any in modern times. I hope this information about our nation's and our Association's voting history will move you to participate in dramatically reversing a trend in APA members' participation in elections. Please join me and vote in the upcoming election—your vote really does matter. The 2020 national election should have certainly driven that point home! **PN**

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Psychiatric News to Move to Monthly Schedule

Beginning with the January 2021 issue, *Psychiatric News* will be published monthly instead of twice a month. This change is being accompanied by increased in-depth reports on clinical and research topics, including articles written by APA member subject experts, while we will continue to publish the information you need to know about the advocacy activities, professional initiatives, and educational services that APA undertakes on your behalf. To keep you up to date in today's fast-paced news environment, you can continue to get breaking news through our digital products: our website (psychnews.org); the *Psychiatric News Alert*, which reports on a major clinical study each day; and the weekly *Psychiatric News Update*, which describes events, programs, and services for APA members. (If you do not receive the *Psychiatric News Alert*, please sign up at <https://alert.psychnews.org/>.)

I welcome your thoughts and feedback about *Psychiatric News* as we continue to serve as the authoritative source of news and information for our profession. Please contact me at jaborenstein@gmail.com.

—Jeffrey Borenstein, M.D.
Psychiatric News Editor in Chief



AMA House Calls for Continued Flexibility Of Telehealth Regulations Beyond the Pandemic

APA leaders testified during the virtual meeting of the House of Delegates in support of making permanent the flexibilities that have been adopted around telehealth during the pandemic. **BY MARK MORAN**

At its virtual meeting last month, the AMA House of Delegates approved policy advocating for widespread adoption of telehealth services by physicians and physician-led teams beyond the COVID-19 pandemic.

The resolution was one of dozens of new policies on public health, physician practice and payment, and medical education adopted by the House. Among those was a resolution outlining principles for protecting residents when the institution where they are training closes (see box).

The resolution on telehealth calls for the Centers for Medicare and Medicaid Services (CMS), other federal and state agencies, and the health insurance industry to provide equitable coverage that allows patients to access telehealth services whether at home or elsewhere.

Testifying on the telehealth resolution, Theresa Miskimen, M.D., an APA delegate to the Section Council on Psychiatry, cited a recent APA poll showing that 62% of Americans are experiencing more anxiety now compared with this time last year (see *Psychiatric News*, <https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2020.11b17>).

“We know that we need mental health and substance use treatment more than ever,” she said. “APA supports permanently maintaining a number of the telehealth flexibilities that have been implemented. We also sup-

port Congressional action to remove the geographic restrictions.”



“APA supports permanently maintaining a number of the telehealth flexibilities that have been implemented.” —Theresa Miskimen, M.D.

port Congressional action to remove the geographic restrictions.”

Maintaining telehealth flexibilities beyond the pandemic will “ensure a smooth transition to in-person care and increase telehealth access.” Such access, she said, “is especially important for mental health and substance use treatment, where the ability to establish and maintain a strong, uninterrupted therapeutic alliance with patients is critical to ensure effective interventions for all payors.”

Delegates also approved a report by the AMA’s Council on Science and Public Health calling cannabis “a dangerous drug and ... a serious public health concern” that should not be legalized. The report says that states that have already legalized cannabis (for medical or adult use or both) should be required to take steps to regulate the product effectively to protect public health and safety.

“There is no current scientific evi-

by the federal government,” Pender said. “The adverse effects of cannabis, including, but not limited to, the likelihood of addiction, must be simultaneously studied.”

The possibility of enactment of a “public option” in the next administration was the source of vigorous debate. Delegates adopted a report of the Council on Medical Service stating that the “primary goals of establishing a public option are to maximize patient choice of health plan and maximize health plan marketplace competition.”

The report delineates these other AMA priorities for any public health option:

- Eligibility for premium tax credit and cost-sharing assistance to purchase the public option should be restricted to individuals without access to affordable employer-sponsored coverage.
- Physician payments under the public option should be established through meaningful negotiations and contracts and not be tied to Medicare and/or Medicaid rates.
- Physicians should have the freedom to choose whether to participate in the public option.
- There should not be subsidies for public option that give it an advantage over other health plans.

Six months after the killing of George Floyd at the hands of Minneapolis police, Delegates debated several resolutions around racial bias and adopted new policy calling racism “a threat to public health.” The policy requests the AMA to identify a set of best practices for health care institutions, physician practices, and academic medical centers to address and mitigate the effects of racism on patients, international medical graduates, and other health care professionals.

Dionne Hart, M.D., an alternate APA delegate to the House of Delegates, spoke to the House about the effect of police brutality on public health. “According to a 2019 report from the U.S. Department of Justice Bureau of Justice Statistics, Black residents are more likely to experience both street and traffic stops,” said Hart. “The presumption of threats by officers increases levels of chronic stress among minority populations who are impacted by these volatile police interactions. Black Americans are three times more likely than

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AMA Seeks to Protect Residents Whose Training Institutions Close

The AMA House of Delegates last month approved a resolution outlining the AMA’s principles for protecting residents when their training institution closes. The resolution was a response to last year’s abrupt closing of Hahnemann University Hospital in Philadelphia, resulting in more than 500 residents having to relocate to other institutions. Hahnemann was the primary academic partner for Drexel University College of Medicine.

The new policy calls for the Centers for Medicare and Medicaid Services to stipulate in its regulations that residency slots are not assets that belong to the teaching institution. It also encourages the Association of American Medical Colleges (AAMC), American Association of Colleges of Osteopathic Medicine, and the National Resident Matching Program to develop a process similar to the Supplemental Offer and Acceptance Program that could be used when a teaching institution or program is suddenly closed.

Under the new policy, the AMA will also take the following steps:

- Encourage the Accreditation Council on Graduate Medical Education (ACGME) to specify that sponsoring institutions are to provide residents and residency applicants information regarding the financial health of the institution, such as its credit rating, or if it has recently been part of an acquisition or merger.
- Work with the AAMC, ACGME, and relevant state and specialty societies to collaborate on the communica-

tion with sponsoring institutions, residency programs, and resident physicians in the event of a sudden institution or program closure.

- Encourage the ACGME to revise its Institutional Requirements to state that sponsoring institutions must maintain a fund to ensure professional liability coverage for residents in the event of an institution or program closure.
- Continue to work with the ACGME to monitor issues related to training programs run by corporate entities and the effects on medical education.

Ken Certa, M.D., APA’s senior delegate to the Section Council on Psychiatry and former psychiatry residency training director at Thomas Jefferson University in Philadelphia, was familiar with the tumultuous events surrounding Hahnemann’s closing.

“Graduate medical education funding for teaching hospitals will continue to be an issue, as many hospitals are bleeding money because of the pandemic, and it is likely that more hospitals will be in a precarious position,” he told *Psychiatric News*. “The AMA has now outlined some guideposts for making sure people in training will not be left in the lurch as they were when Hahnemann went under.”

Certa said that the AMA was active in advocating for trainees at the time of Hahnemann’s closing. “The only ones looking out for residents were the AMA and the medical specialty societies.”

Government Releases Final Rule On Transparency in Health Care Costs



iStock/Oleg Elkov

The final rule will require health insurers to share out-of-pocket estimates and negotiated rates with patients and the general public. **BY KATIE O'CONNOR**

In an effort to encourage comparison shopping in health care, the federal government finalized a rule in late October requiring insurers to provide patients with cost estimates before receiving health care services.

Long a priority for the Trump administration, the Transparency in Coverage rule was released by the departments of Health and Human Services, Labor, and

Treasury. According to a Centers for Medicare and Medicaid Services (CMS) news release, the rule will allow 200 million Americans to gain access to real-time information on health care costs.

Under the rule, most health insurers must create an online tool through which patients can access personalized out-of-pocket cost estimates and the underlying negotiated rates for all cov-

ered services, including prescription drugs. The plans must make a list of 500 shoppable services available through the online tool by January 1, 2023. The costs for the remaining health services must be available by 2024.

By January 1, 2022, insurers must make detailed pricing information available to the public, including negotiated rates for all covered services between the plan and in-network providers, historical payments to out-of-network providers (with a minimum of 20 entries to protect patient privacy), and the in-network negotiated rates and historical prices for all covered prescription drugs. The data, which must be updated monthly, “will provide opportunities for detailed research studies [and] data analysis and offer third party developers and innovators the ability to create private sector solutions to help drive additional price comparison and consumerism in the health care market,” a CMS fact sheet states.

In her blog for *Health Affairs*, Katie Keith, J.D., M.P.H., noted that the new rule relies on legal authority granted to the federal government under the Affordable Care Act, the constitutionality of which is now before the Supreme Court (see page 7).

Insurers have strongly objected to the rule. In a statement, Matt Eyles, president and CEO of America's Health Insurance Plans, claimed the rule will reduce competition and increase health care prices. “[D]isclosing privately negotiated rates will reduce incentives to offer lower rates, creating a floor—not a ceiling—for the prices that drug makers, providers, and device makers would be willing to accept,” he said.

In the final rule, the government acknowledged this objection but claimed that “consumers must have meaningful information in order to create the market forces necessary to achieve lower health care costs.” Further, the government argued that transparency in cost reduces the potential for surprise billing. “While price transparency alone is not a complete solution to this problem, the disclosure of pricing directly to consumers could help mitigate some unexpected health care costs.” **PN**

2 The CMS news release is posted at [cms.gov/newsroom/press-releases/cms-completes-historic-price-transparency-initiative](https://www.cms.gov/newsroom/press-releases/cms-completes-historic-price-transparency-initiative). The CMS fact sheet is posted at <https://www.cms.gov/newsroom/fact-sheets/transparency-coverage-final-rule-fact-sheet-cms-9915-f>.

Racism

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full... work-up will be given to the white woman, but for the Black man, the first thing at the top of the differential is substance abuse or schizophrenia.”

Dix also discussed the importance of recognizing diversity within the Black population, particularly as it relates to immigrants.

“We have Black immigrants from the Caribbean, from Africa, from all over the world. We have to make sure that we are not overgeneralizing and [instead] recognize that people who emigrate from other countries have very specific challenges that people who are born in America don’t neces-

sarily encounter,” Dix said.

Peter Ureste, M.D., an assistant clinical professor in the Department of Psychiatry and Behavioral Sciences at UCSF, discussed how structural racism affects Latinx populations. He described how schools were segregated before two landmark cases: *Mendez v. Westminster*, in which it was ruled that forced segregation of Mexican-American students into separate “Mexican schools” was unconstitutional, and *Brown v. Board of Education*, in which it was ruled that state laws establishing racial segregation in public schools were unconstitutional.

Ureste explained that the quality of education in “Mexican schools” was below that of White schools, a disparity

that still has implications today.

“This is just one of many reasons there are a lot of essential workers within the LatinX community, and ... this came into play during the COVID-19 pandemic when a lot of essential workers don’t have the luxury of working at home. They work in the restaurant, food, agricultural, and transportation industries,” he said. “That is one of the reasons there is a higher proportion of people of color who are diagnosed with COVID-19.”

Ureste also discussed how structural inequities disproportionately affect transgender men and women.

“Transgender and gender-nonconforming individuals face extraordinarily high rates of social and health inequalities, including poverty and discrimination by employers. They are [more likely to be] victims of violence, and they face higher rates of family rejection and homelessness than their cisgender peers. I would say this is even more so for transgender people of color,” Ureste said.

At the end of the discussions, Reid gave an update on the task force’s work. Highlights included the following:

- A website resource, [psychiatry.org/TaskForce](https://www.psychiatry.org/TaskForce), offers a recommended

reading list, educational content, and a glossary of terms approved by the APA Board of Trustees.

- Three mini-surveys have been conducted to guide the task force’s work and engage APA’s membership. The results are posted at [psychiatry.org/taskforce](https://www.psychiatry.org/taskforce).

- The task force’s Assembly work group outlined eight actions to improve diversity and inclusion and reduce structural racism in the Assembly, actions that have since been approved by the Board of Trustees.

- Feedback sessions have been held with APA councils and committees.

- Presentations have been made at the Kentucky, Missouri, North Dakota, Ohio, Utah, and Virginia district branches. **PN**

2 “The Trauma of Structural Racism and Its Transmission Across Generations” is posted at <https://www.psychiatry.org/psychiatrists/meetings/addressing-structural-racism-town-hall>. The next town hall will be held Monday, February 8, 2021, from 8 p.m. to 9:30 p.m. ET.

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White Americans to be killed by police and account for over 40% of victims of police killings nationwide. In this past year alone, 1,020 Black people have been shot and killed by police. Black men are especially likely to be imprisoned. Black Americans have lived with these risks that were largely ignored while community leaders with the power to make a change, including members of law

enforcement, have dismissed or ignored these real concerns.”

Hart is a member of the APA Council on Government Relations and AMA representative to the National Commission on Correctional Healthcare. **PN**

2 Resolutions and reports approved by the AMA House of Delegates are posted at <https://www.ama-assn.org/house-delegates/special-meeting/business-november-2020-special-meeting-ama-house-delegates>.



Meet the Candidates In APA's 2021 Election

Voting begins on Monday, January 4, 2021, and ends on Monday, February 1, 2021.

There are 19 candidates vying for national and Area office in APA's 2021 election. Here are their photos and, for those who would like more information about the candidates directly from them, the addresses of their personal websites.

To help APA members select the candidates they believe are best qualified for office, candidates' biographical and position statements are posted on the APA election website at psychiatry.org/election. Also, members can view videos of the candidates answering questions posed by the Elections Committee or making brief statements posted at psychiatry.org/MeetTheCandidates.

If you have specific questions for candidates, you are encouraged to contact them by using the contact information posted at http://apapsy.ch/contact_information.

Beginning January 4, ballots will be emailed to all eligible voting members with a valid address on file with APA; they may also go to psychiatry.org/election and use their member login information to access their electronic ballot. Those who do not have a valid email address on file will be mailed a paper ballot. Also, any member may request a paper ballot or a replacement ballot by sending an email request to election@psych.org. The deadline for such requests is Friday, January 15.

The deadline for online voting is Monday, February 4, at 11:59 p.m. EST. Also, paper ballots must be postmarked by that deadline.

APA members wishing to campaign on behalf of a candidate are encouraged to review the APA Election Guidelines, which can also be accessed at psychiatry.org/election. Those with comments or questions about the election should email them to election@psych.org. **PN**

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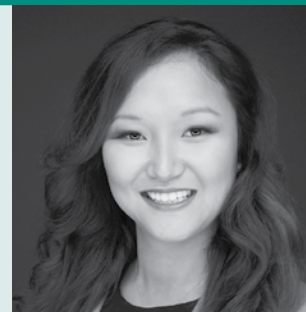
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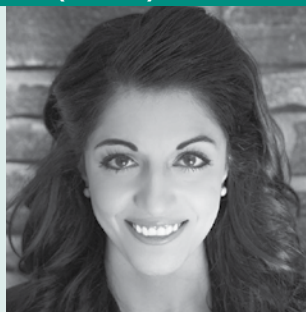
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Supreme Court Justices Seem Wary Of Striking Down Affordable Care Act

In testimony in the Supreme Court case over the future of the Affordable Care Act, a majority of justices seemed reluctant to overturn the 10-year-old law that has granted coverage to millions of uninsured Americans. A final ruling on the case isn't likely until spring. BY LINDA M. RICHMOND

The Supreme Court has just begun deliberating the constitutionality of the Affordable Care Act (ACA), but so far justices appear to be in favor of keeping intact much of the far-reaching health care law.

The ongoing litigation challenges the ACA's minimum essential coverage provision (known as the individual mandate) and raises questions about the entire law's survival.

The ACA's individual mandate required all Americans to obtain health insurance. In 2012 the Supreme Court upheld the mandate and its tax penalty for those who failed to obtain insurance, saying the provision was authorized by Congress's power to levy taxes. Then Congress passed the Tax Cuts and Jobs Act, setting the tax penalty for failing to obtain health insurance at zero as of January 2019. Without the tax penalty, the constitutionality of the mandate is once again in question.

In March, the Supreme Court accepted an appeal by 21 states led by California, in *California v. Texas* (formerly *Texas v. United States*), to rule on the constitutionality of the ACA. The court also accepted a cross-appeal by Texas and other states asking for the invalidation of the entire law.

The Trump administration opposes the law. "It is unusual for the federal government not to defend the constitutionality of a federal law," said Mary-Beth Musumeci, associate director at the Kaiser Family Foundation's Program on Medicaid and the Uninsured.

A trial court ruled that the 10-year old, 1,000-page ACA in its entirety should be invalidated. APA and four

other medical organizations filed an amicus brief in that case, asking for a reversal to avoid "a devastating impact on patients and the American health care system." A divided Fifth Circuit Court of Appeals set aside the trial court's ruling but agreed that the ACA's individual mandate is unconstitutional.

The Supreme Court justices spent much of last month's hearing weighing whether there is even legal "standing" for the lawsuit. Chief Justice John G. Roberts Jr. and Justice Brett Kavanaugh, both conservatives, questioned whether the ACA's individual mandate could have caused the required legal injury for the case to proceed now that the Congress zeroed out the tax penalty.

"The individual mandate now has no enforcement mechanism, so it's really hard to determine what the threat of an action is against you," Roberts said.

If standing is demonstrated, the nine justices must then decide whether the mandate is constitutional and, if not, whether the mandate can be "severed" from the law and leave the remaining ACA provisions to stand or if the entire law should be struck down.

Michael J. Mongan, the attorney representing California and the 21 states, argued in favor of excising the mandate if needed. The insurance marketplaces established by the ACA have continued to function well even without the tax penalty because of the incentives the ACA gives individuals for buying health coverage, he said.

Both Roberts and Kavanaugh discussed severing the mandate and seemed reluctant to strike down the entire law. "I think it's hard for you to argue that

Congress intended the entire act to fall if the mandate were struck down when the same Congress that lowered the penalty to zero did not even try to repeal the rest of the act," Roberts said. "I think frankly that they wanted the court to do that. But that's not our job."

Kavanaugh said, "I tend to agree with you [that] this is a very straight-

forward case for severability under our precedents, meaning that we would excise the mandate and leave the rest of the act in place. ..."

If Roberts and Kavanaugh are in agreement with the three liberal justices on the court, there could be potentially five votes in favor of tossing out the case or potentially removing the mandate—and doing as little damage to the rest of the law as possible, said KFF's Musumeci. However, she emphasized, "Any reading of the oral arguments is highly speculative at this point. Nothing is certain about the outcome until the court issues its written opinion." The court tends to issue its higher profile decisions closer to the end of the term in June.

ACA Critical for Many Americans

In the 10 years since its passage, the ACA has reshaped the health insurance landscape. Millions rely on coverage through the ACA's individual marketplaces and the state Medicaid expansions it created, and millions more benefit from its myriad patient protections. Overturning the law would cause massive upheaval across the entire health system during a global pandemic, triggering far-reaching implications for most Americans, whether their health care is individual, employer-based, or

see **Supreme Court** on page 13

Advertisement



Photos: Courtesy of Sólheimar

Left: The entrance to the Sólheimar Ecovillage at sunset. **Right:** Residents practice yoga in Sólheimar.

Icelandic Community for People With Disabilities Built on Reverse Integration, Sustainability

The 90-year-old ecovillage offers support to residents with disabilities while encouraging independence and creative expression. **BY KATIE O'CONNOR**

In September, the northern lights unfurled over the skies of Sólheimar Ecovillage in Iceland. It was rather early in the season for the phenomenon, said Hallbjörn Rúnarsson, social educator at Sólheimar, yet for the sustainable community that emphasizes the connection between humans and nature, the northern lights are a fitting addition to the sweeping Icelandic landscape.

The community is known for its artistic and ecological endeavors, but at its heart, Sólheimar is home to more than 100 people, nearly half of whom have a mental illness or intellectual disability. The residents all live and work together, and their ages range from under a year to more than 80. Some have lived in the community their entire lives.

"At the core of everything we're doing,

we're supporting people so they can live independently," said Rúnarsson.

Sólheimar is an example of "reverse integration," meaning the community developed based on the needs of its residents with disabilities, and those without disabilities adapted to their needs. "In my mind, this is simply a community of people," Rúnarsson said. "It just so happens that there are many people here who need special attendance."

Iceland's first community for children with disabilities, Sólheimar was founded in 1930 by Sesselja Sigmunds-

dóttir, who had studied pedagogy, childcare, and the operation of orphanages in Denmark, Switzerland, and Germany. At only 28 years old, she founded the community in southeast Iceland, about 85 kilometers outside Reykjavik. It is situated in a valley fed by hot springs, allowing the community to access its own hot water.

Sigmundsdóttir began the community with five foster children, and over time, children with disabilities arrived in Sólheimar. "In those days, sometimes people just didn't want their children if they were born with a disability," Rúnarsson said. "They wanted the system to take care of them."

Eventually, the government stepped in and told Sigmundsdóttir that she would have to build a separate house for the children with disabilities. She strongly disagreed, Rúnarsson said. She believed that people should be together regardless of whether they have disabilities. "That's how these strong roots started here," he said.

Today the community accepts people of all ages. When individuals apply to live in Sólheimar, the community coordinates with the person's municipality of residence and evaluates the applicant using the American Association on Intellectual and Development Disabilities' Supports Intensity Scale (SIS) to determine what level of support he or she needs in such areas as personal, work-related, and social activities. Sólheimar then sets up a service contract with the municipality to provide that individual with the needed services.

continued on facing page



Left: The Sólheimar theater group presents its annual production. The theater group will celebrate the community's 90th anniversary in 2021. **Right:** Two residents pose for a photo at the community's organic market.

continued from facing page

For the residents, Sólheimar's mission is to emphasize the importance of autonomy and personal choice. "The first thing that we ask an applicant is: Is it your will? Do you want to live here or is there someone telling you that you want to live here?" Rúnarsson said. "We always want to be certain that people are making this decision themselves."

The community's goal is to build a society in which all people, no matter their disabilities, are welcome while also ensuring that the community is as sustainable as possible. It relies on some external sources, such as government funding for social services, and it exchanges hot water for cold water with a nearby farm. But as much as possible, Sólheimar tries to create a cohesive relationship with the environment, using renewable energy, such as geothermal energy from the hot springs, and feeding its residents with food grown in the organic garden.

There are plenty of opportunities for employment in the community, too, including working in forestry, the greenhouse, the post office, the café, and the secondhand market. The community recently started working with a large laboratory company that was throwing away plastic trays used to hold test tubes after one use. The company now pays Sólheimar's residents to clean the trays and return them for further use. "We are always trying to reach out to other communities to show them how we would like to help them," Rúnarsson said.

Sólheimar is also well known for its thriving cultural life and encourages residents to express themselves creatively. There are five arts workshops from which they can choose to participate: art, ceramics, weaving, wood working, and candle making. There are also a music workshop and theater group, which presents a play every year on the first day of summer. This year, the residents in the theater group wrote a play about Sigmundsdóttir's life, adding a touch of fantasy by including classic creatures of Icelandic folklore, such as trolls and elves.

Every summer Sólheimar has an art exhibition during which residents can sell what they have made. The proceeds support the overall community, but residents can keep a portion for themselves.

"I wanted to be here because I think we can make a perfect example of a community in which we can all live together cohesively no matter our abilities," said Rúnarsson, who also lives in Sólheimar with his family. "That's what we're doing with this sustainable piece, as well. This small community can show the rest of the world: This is how it can be." **PN**



The new John Porter Neuroscience Center at the National Institutes of Health was one of many mental health-related research centers that had to temporarily close in response to the pandemic.

As 2020 Closes, Researchers Reflect On Uncertainty and Opportunity

Investigators and funders have had to be nimble to shift projects online if possible and find ways to integrate COVID-19-related research into existing studies. **BY NICK ZAGORSKI**

After years of working out technical details, consulting with focus groups, and conducting promising pilot studies, Duke University Assistant Professor Roger Vilardaga, Ph.D., was ready to test his mobile app Learn to Quit—a smoking cessation tool designed specifically for people with serious mental illness. In early March, he received welcome news: The National Institute on Drug Abuse (NIDA) would fund his proposed multisite clinical trial of the app.

A few days later, in response to the emerging COVID-19 outbreak, North Carolina declared a state of emergency, the Duke campus shut down, and Vilardaga's study came to a screeching halt. As he told *Psychiatric News*, that week proved to be an emotional roller coaster.

Vilardaga's experience was echoed thousands of times over across the country, as investigators in mental health and other disciplines were forced to postpone or even abandon their research projects in the wake of a novel coronavirus and the dramatic early measures to slow its transmission.

"The past several months has been challenging for everyone in research,"

said Susan Weiss, Ph.D., director of the Division of Extramural Research at NIDA. On the funding side, NIDA and its fellow institutes have been allocating their limited resources between providing extensions or amendments for existing projects impacted by the pandemic and supporting important new initiatives exploring COVID-19's impact on mental health.

"We don't have enough money to make every impacted researcher whole again," she said. "We try to ensure that the most vulnerable grantees, especially new investigators, receive support. But some investigators' projects just had to stop."

With challenges come opportunities, and mental health researchers are finding ways to adapt to and solidify on in these uncertain times.

"This past year has been tough on research, but I have also seen tremendous resilience among our research community," noted George Koob, Ph.D., Director of the National Institute of Alcoholism and Alcohol Abuse. "Like everyone, I'm hopeful the situation will soon resolve, but this pandemic has made us all a little more efficient and creative."

Researchers Adapt to Remote Research

Studies requiring psychological or cognitive evaluation of patients with mental illness may be able to adapt to physical distancing restrictions now in place, but researchers have faced hurdle after hurdle in the nine months since the pandemic emerged in the United States.

"Our group was in a better situation than [others] since we were already working with digital health and remote monitoring," noted Zev Schuman-Olivier, M.D., the director of the Center for Mindfulness and Compassion and medical director for Addiction Services at Cambridge Health Alliance (CHA), a Harvard-affiliated safety-net health system in the greater Boston area.

In addition, Philip Wang, M.D., Dr.Ph., CHA's chief of psychiatry, had conducted studies on how Hurricane Katrina had impacted mental health care. "Katrina, as well as the 2016 Baton Rouge flood, were localized events, but they both highlighted how a disaster both exacerbates the need for mental health services while disrupting the paths to receive these services," Schuman-Olivier said.

As a result, in the earliest days of COVID-19, CHA was aggressive in expanding its telemental health capacity.

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COVID-19 Lockdowns Bring Challenges For Patients With Eating Disorders

Changes in living arrangements and everyday tasks such as grocery shopping and conference calls may promote anxiety and increase eating disorder symptoms.

BY TERRI D'ARRIGO

The COVID-19 pandemic and its associated lockdowns have brought with them a spate of challenges for patients who have eating disorders by disrupting routines, increasing social isolation, putting diet and weight front and center in the news and social media, and introducing stressors such as videoconferencing, according to researchers in the field.

"Soon after the pandemic started, we started seeing an increase in calls to our intake line. Within a few weeks the numbers were up 30%," said Cynthia M. Bulik, Ph.D., the founding director of the University of North Carolina Center (UNC) Center of Excellence for Eating Disorders. She is also the Distinguished Professor of Eating Disorders in the Department of Psychiatry at the UNC School of Medicine.

Alarmed by the trend, Bulik and her colleagues developed an online survey to study the concerns and challenges that people with eating disorders face with regard to their disorders and their general mental health during the pandemic. Their study, which included



Recovering from an eating disorder requires structured meal plans, says Cynthia M. Bulik, Ph.D.

more than 1,000 people with eating disorders in the United States and the Netherlands, was published in the *International Journal of Eating Disorders*. Among survey respondents, 79% of those in the United States and 66% of those in the Netherlands reported being concerned about their eating disorders worsening because of a lack of structure in their days.

"Recovery from an eating disorder often requires clear structuring of meals and snacks—in anorexia to ensure adequate intake and in bulimia

and binge-eating disorder to re-establish a healthy regular eating pattern," Bulik told *Psychiatric News*. "With none of the typical time markers that we have during the day, such as getting up, getting dressed, and commuting to work—all of which we build our recovery eating plans around—suddenly the daily scaffolding has disappeared, and the kitchen is always right there."

Changes in access to food also presented a challenge to the respondents, particularly in the beginning of the pandemic. Those with anorexia

reported increased restriction in their eating and fears about being able to find appropriate foods.

"[They] were incredibly anxious that they would not be able to get 'safe' foods or foods consistent with their meal plans. They were not able to spend a lot of time in grocery stores looking at labels, and they were very concerned about shopping online," Bulik said.

Those with bulimia and binge-eating disorder reported increases in their binge-eating episodes and urges to binge.

"A common strategy to control binge eating is to keep high-risk foods out of the house. Yet we were being told by the authorities to keep supplies on hand. Many reported binge eating on stockpiled foods and then feeling extremely guilty because they could have compromised the health and well-being of their roommates or family members," Bulik said.

Changes in living arrangements can also present a challenge to patients who have eating disorders. In a study of 129 people with eating disorders in the United Kingdom published in the *Journal of Eating Disorders*, more than 20% reported a change in their normal living situation because of the pandemic. Among those, 85% said that the change had worsened their symptoms. They reported multiple reasons for this, including increased interpersonal stress, increased scrutiny and/or pressure from others to eat more, and a loss of control over what they ate (such as when other people in their households cooked meals, and the respondents

see **Lockdowns** on page 16



VIEWPOINTS

Coming From the Outside: Why Much Feels the Same in 2020 From a Diversity Standpoint

BY ERIC WAGNER

Feeling "different" from the people around me is not something new to my lived experience. As a person of color in the white spaces I frequently navigate, it has, at times, become my sole identity and a conversation starter. My story of resilience and being an "underrepresented minority" for the past few years for the most part has been met with praise and kindness, a stark contrast from the previous life I had before entering medical school. In the past, my skin complexion came with assumptions of criminality, illegal immigration status, and preconceived notions of my own personal interest and culture. Now it comes with the confusion of being "exotic or special."

In medical school, a world full of indulgence and privilege, I often



Eric Wagner is a third-year medical student at the University of Colorado and will be interviewing for a psychiatry residency in fall 2021.

thought less of my race and the challenges that I faced. It wasn't until an all-too-cliché rainy evening that my race and cultural identity surfaced while attending my state's annual psychiatry conference.

Before entering medicine, I always had a serious interest in mental health, specifically substance use and addiction. In the community where I grew up, which was predominantly Black and Latino, I witnessed how American drug policy destroyed my community

and how unaddressed trauma reared its ugly head in a place too proud to admit its suffering. Reflecting on my experience of how the people I loved lacked the literacy, financial means, and support to address their suffering fueled my passion for chasing, what was in my adolescence, a hysterical fantasy: becoming a physician.

This experience came back full circle on an interesting, but oddly devastating, night, because what so long had been a positive aspect of my journey became a harsh reminder of the battle that psychiatry, and all of medicine, is facing. As I entered the hotel conference room, I felt uneasy. Glancing around the room, I couldn't help but notice that there was only one other person of color in the room—a young Asian woman, one of the few psychiatrists whom I knew in the room. Being in a white

space was nothing unique to me, but I also felt uneasy as the only person who had not gone through the rigors of residency and earned an M.D.

Upon entering circles of conversation, I fumbled through my sentences, caught a couple eye rolls, and even had folks walk away from me abruptly. Observing the behavior of others, I felt I was in the stereotypic high school class where the clique of popular kids gather to engage in the latest gossip. In what was supposed to be a night of making valuable connections to my network, I found myself flustered, uncharacteristically labile, and desperate for human connection.

As dinner was being served, the Asian woman kindly let me sit by her for the presentation. As it went on, I was dead silent and a shell of myself.

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Eating Disorders, OCD Common Comorbidities



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Understanding what the two conditions have in common is the starting point for developing effective treatments for patients who have both. **BY TERRI D'ARRIGO**

Roughly 15% of patients who have an eating disorder also have a current diagnosis of obsessive-compulsive disorder (OCD), and 18% of those with an eating disorder will be diagnosed with OCD at some point in their lifetimes (lifetime comorbidity), a meta-analysis published in the *Journal of Affective Disorders* has found.

Anna-Rita Atti, M.D., Ph.D., M.A., an associate professor in the Department of Biomedical and Neuromotor Sciences at the University of Bologna in Italy, and colleagues pooled data from 32 studies that reported current comor-

bidity, lifetime comorbidity, or both current and lifetime comorbidity with eating disorders and OCD. Twenty-seven of the studies were cross-sectional and five were prospective. The prospective studies had follow-up periods ranging from several months to several years.

Data from the cross-sectional studies revealed that 14% of patients with anorexia and 9% of patients with bulimia had current comorbidity, and 19% of those with anorexia and 13% of those with bulimia had lifetime comorbidity. Data from the prospective studies suggested much higher

prevalence of lifetime comorbidity: 44% of patients with anorexia and 19% of patients with bulimia.

The researchers noted that cross-sectional studies about eating disorders tend to include adolescents and young adults and that patients in prospective studies may be older. Therefore, the data from the prospective studies suggest that the occurrence of OCD in people with a history of eating disorders may be greater than the cross-sectional studies would suggest.

Although the analysis was not designed to tease out the relationship between eating disorders and OCD, the two conditions may share a common, underlying pathology, Atti told *Psychiatric News*.

"Patients who have both OCD and eating disorders, especially those who have anorexia, share a lack of cognitive flexibility that would enable them to adapt effectively to changes in the environment or to changing demands," Atti explained. "This could be the common starting point of a combined intervention for both disorders."

Walter H. Kaye, M.D., Distinguished Professor of Psychiatry in the Department of Psychiatry at the University of California, San Diego (UCSD), agreed that there is an overlap in traits among patients with eating disorders and those with OCD. He is the founder and executive director of the UCSD Eating Disorder Research and Treatment Program.

"If you look at people with both [disorders], you'll see there is an emphasis on symmetry, exactness, and order. They don't like to make mistakes," said Kaye, who was not involved in the research.

Last year Kaye and his colleagues published research in the *European Eating Disorders Review* that explored the psychological and personality factors shared by people with anorexia and OCD. They examined data from 732 women who either currently had anorexia or who had recovered from anorexia and found that a concern over mistakes was common to core dimensions of both anorexia and OCD, such as obsessions, compulsions, body dissatisfaction, and a drive for thinness. However, they did not determine whether concern over mistakes is a risk factor for these core dimensions or a consequence of experience with the symptoms that define the disorders.

Kaye said that patients who have one condition should be screened for the other because of the overlapping concern for mistakes and because of an overlap in symptoms. Yet, there is a dearth of treatments for patients who have both conditions, he added.

"Those patients with anorexia and OCD tend to not respond as well to medication or therapies that are useful



Patients who have eating disorders and OCD lack the cognitive flexibility to adapt effectively to changes in the environment, says Anna-Rita Atti, M.D., Ph.D., M.A.



University of California, San Diego

Patients who have an eating disorder should be screened for OCD and vice versa, says Walter H. Kaye, M.D.

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My attention fixated on the fact that only a third person of color was now in the room—a Black man who had been flown from Baltimore to give the keynote. For a moment, I felt I could breathe. Listening to his work on marijuana and hearing the stimulating conversation diverted my attention to why I was so excited to be there in the first place. Yet, the overwhelming emotion carried over my head like a haze.

When I finally got to meet this man after his excellent presentation, I blurted out, "I'm so thankful that you're here because you're the only other person of color I've seen." After a somewhat awkward pause and a gesture of acknowledgement, I quickly got his information and ran out of there as fast as I could to cry in my car.

I learned a tough lesson from that night.

Despite the hope I hold for the profession of psychiatry, the lack of diversity and elitist feel of this encounter

burned me. The differences in the complexion of my skin, the credentials that I still lacked behind my name, and my far different lived experience mattered more than I think anyone who attended that evening would like to admit. Although the room was filled with incredible minds, innovators, and some of the finest the profession has to offer, I know that with time, change must come. What motivates me to continue pursuing a career in psychiatry is knowing that we can improve. Marginalized communities and the growing minority populations of this country depend on there being culturally competent health care professionals and health care professionals who look like them. Without that connection, we will continue to fail those who need us the most. Now, not later, psychiatry needs to bring in new faces and perspectives—and it starts with addressing that elephant in the room of race and a flawed culture that has kept progress far too slow for the likes of the year 2020. **PN**

in those with only OCD," Kaye said. "We are behind in understanding the neurobiology of these illnesses, and until we do, it will be hard to come up with treatment approaches."

Atti and colleagues did not receive outside funding for their research. Kaye and colleagues received support for their work from the National Institutes of Health, the Swedish Research Council, and the Franklin Mint Endowed Chair in Eating Disorders. **PN**

2 "Rates of Comorbid Obsessive-Compulsive Disorder in Eating Disorders: A Meta-analysis of the Literature" is posted at <https://www.sciencedirect.com/science/article/pii/S0165032720326975>. "Associations Between Dimensions of Anorexia Nervosa and Obsessive-Compulsive Disorder: An Examination of Personality and Psychological Factors in Patients With Anorexia Nervosa" is posted at <https://onlinelibrary.wiley.com/doi/abs/10.1002/erv.2635>.



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Faith Communities Are Potent Resource For Creating Connection and ‘Mattering’

The Black church is one of the most important resources in the community for counteracting risk factors for mental illness and suicide and bolstering protective factors among Black youth at risk for suicide. **BY MARK MORAN**

Communities of faith can promote resilience and the experience of belonging and being celebrated within a community, crucial to buffering against the risk of suicide, said Sherry Davis Molock, Ph.D., M.Div., a professor in the Department of Psychological Brain Sciences at George Washington University.

During the virtual 2020 fall conference “Suicide: Culture & Community,” sponsored by the Erikson Institute for Education and Research at the Austen Riggs Center, Molock urged clinicians to leverage resources in the community for their patients, especially faith communities.

“When thinking about upstream interventions for prevention of suicide, communities of faith are a rich opportunity,” she told conference attendees. “Faith leaders and faith communities are often first responders on the front line of mental health crises. Faith communities care for the whole person and their families and provide a venue for interaction with people in diverse settings.”

Moreover, Molock said, “mental health crises are often also crises of faith, when people are struggling with a sense of abandonment by a deity.”

She also said she believes some of the attitudes and beliefs within the Black church that have traditionally served as barriers to seeking mental health care—such as the belief that



“Clinicians can connect patients to community resources, including faith communities, grassroots advocacy groups, and youth groups such as scouting and boys and girls clubs,” says Sherry Davis Molock, Ph.D., M.Div.

depression or suicidality is a failure of faith—are changing. Within her own church in the District of Columbia (where she is co-pastor with her husband), Molock said she has led Bible study courses emphasizing that prominent figures in the Bible have experienced deep periods of darkness, mimicking the symptoms of depression.

“The silence is being broken, and clergy see their role as partners with

other mental health professionals,” Molock said.

At the virtual conference, Molock and other clinicians and suicide researchers explored the psychosocial, cultural, and political factors that drive suicide in a range of different communities. An overriding message was that rising rates of suicide are driven not only by individual loss, shame, and guilt but also by family, community and cultural factors, and economic and political conditions.

Katie Lewis, Ph.D., research psychologist at Austen Riggs, who served as a discussant for Molock’s address, has focused her work on the momentary and day-to-day situational experiences that can influence suicide risk.

“The most important message I have taken away from this work is that contextual and relational networks matter,” Lewis said. “The day-to-day experiences and exchanges with those in our networks and communities carry a cumulative impact on our well-being and sense of fortitude in withstanding life challenges.

“We are not isolated creatures, but our lives and well-being are intertwined with those around us. Understanding this, we cannot ignore the vital importance of conceptualizing suicide prevention at the individual, family, and community levels.”

Calling for ‘Upstream Approach’

Molock especially focused her comments on youth suicide in the African American community, citing a 2019 report in *Pediatrics* showing that suicide attempts rose by 73% between 1991

and 2017 for Black adolescents, while injury by attempt rose by 122% for adolescent Black boys during the same period (see *Psychiatric News*, <https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2019.11b17>).

She was a member of an expert work group of the Emergency Task Force on Black Youth Suicide of the Congressional Black Caucus, which emphasized the need for an “upstream approach” focusing on risks and protective factors in the community. (Also participating as expert members were past APA President Altha Stewart, M.D., psychiatrist and APA member William Lawson, M.D., and former APA Deputy Medical Director Annette Primm, M.D. See *Psychiatric News*, <https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2020.9b12>.)

Risk factors include substance use, exposure to suicidal behavior of others, being a member of a sexual minority, exposure to discrimination and trauma, and lack of residential stability. Protective factors include strong familial support/relationships; religious and spiritual engagement; community/social support; and stable family housing, income, and employment.

“What many of these protective factors have in common is promotion of a sense of connectedness and ‘mattering’—being acknowledged by others and having a sense that others are concerned about your well-being,” she said.

Molock said the Black church is one of the most potent resources in the community for counteracting risk factors for mental illness and suicide and bolstering protective factors.

“The Black church is an excellent venue for promoting positive mental health and one of the most influential institutions in the Black community,” she said. Though church membership is declining overall, across denominations, a 2009 Pew Foundation survey found the trend is not true in the African American community: 87% of African Americans are affiliated with a religious organization, and 79% of African Americans say religion is very important in their lives.

“You might feel like you don’t matter anywhere else, but you can matter in your church,” she said. “You might be a janitor in a school system and feel yourself to be disrespected, but you can be a deacon in your church, and when you are absent, people will miss you.” **PN**

“Mental Health: A Guide for Faith Leaders” by the APA Foundation and the Mental Health and Faith Community Partnership is posted at <https://apafdn.org/impact/community/faith-based-guide>. Information about the Mental Health and Faith Community Partnership is posted at <https://www.psychiatry.org/psychiatrists/cultural-competency/engagement-opportunities/mental-health-and-faith-community-partnership>.

The Lonely Society: Medical Anthropologist Examines Loneliness and Suicide

In her examination of suicide websites, Chikako Ozawa-de Silva, Ph.D., saw the expression of a society whose very structures promote a sense of loneliness rather than one of belonging and connection.

BY MARK MORAN

Loneliness has emerged in recent years as a topic among public health experts, especially as it relates to the increasing rates of suicide. The term usually conjures up an individual who is isolated, cut off from social contact, alone.

But is it possible for an entire society to be lonely? Is there such a thing as a “lonely society”? Can a society itself breed loneliness?

Chikako Ozawa-de Silva, Ph.D., a medical anthropologist who began studying suicide in Japan when that country first began to experience a spike in suicides in the late 1990s, believes so. She discussed the phenomenon at the 2020 virtual fall conference “Suicide, Culture and Community,” sponsored by the Erikson Institute for Education and Research at the Austen Riggs Center.

“Based on my long-term ethnographic studies, I came to a realization that what I have been witnessing was not just the loneliness of a single person, or a few people, but the loneliness of a society,” Ozawa-de Silva said. “That is—a type of society that makes people feel uncared for, unseen, and unimportant: *the lonely society*.”

This phrase is intentionally paradoxical, she said. “Society means people being together and living together, engaging socially. To be in society means to not be alone. But it does not mean that one does not *feel* alone. There are forms of society that make people feel cared for and connected, that instill in people a sense of belonging, and there are forms of society that do the opposite. Every society is somewhere along the scale, but as societies continue to develop, it is increasingly concerning that they seem to be moving in the direction of the lonely society.”

Ozawa-de Silva, an associate professor of anthropology at Emory University, described her research on a troubling and macabre phenomenon: “suicide websites” that began to attract young Japanese men and women seeking to participate in group suicide. She was led to study the websites following several group suicides that captured the nation’s attention and by the fact that the prevailing explanation for Japan’s sharp rise in suicides—the country’s deep economic downturn in the 1990s—did not seem to



Medical anthropologist Chikako Ozawa-de Silva, Ph.D., says the factors in Japanese culture that have produced a lonely society are evident in the U.S. and other societies, as well as in developing countries.

fully account for epidemiological facts.

“The spike in suicide was seen as being a problem primarily impacting men in their 40s to 60s, who faced economic uncertainty and unemployment due to the burst of the bubble economy in the early 1990s,” she said. “This picture was imperfect from the beginning. For one thing, the spike in suicides happened not only among working-aged Japanese men, but across multiple age

categories, including adolescents, who experienced an increase in suicide of 50% in a single year. Secondly, the narrative of ‘economic stagnation leading to suicide’ did not fit the subjective reports of those who were attempting or dying by suicide; nor did it easily account for entirely new forms of suicide, such as internet group suicide.”

At suicide websites described by Ozawa-de Silva, strangers came together online and then sometimes agreed to meet in person to die by suicide together. “It did not take me long to discover that the problems expressed by suicide website visitors were rarely about unemployment or work conditions; neither were they about depression,” she said. “Rather, the most common themes that emerged were loneliness, a lack of meaning in life, and a lack of feeling needed by others.”

(Ozawa-de Silva has been studying the websites devoted to suicide since the early 2000s, when the phenomenon of internet suicide began to gain national attention. In 2006, many of the suicide websites began regulating the behavior and deleting visitors’ personal information.)

The case of a young woman in her 20s who died with a man she had just met over the internet was illustrative. She stated in her will: “It’s sad to die alone. It could have been anyone.” Another website visitor stated: “I no longer wish to suffer. But I am too afraid to die alone. Is there anyone who wishes to die with me?”

Ozawa-de Silva said the distinctive types of mental pain and existential angst expressed by visitors on suicide websites included the following:

- Severe loneliness to the point of feeling too lonely to die alone and wanting others with whom to die.
- An absence of *ikiru imi* (“meaning in life”).
- A feeling of not being needed.
- An absence of social connections and sense of belonging.

“Since the cause of much of the pain expressed by suicide website visitors is loneliness and a lack of social connection, there is a wish not only to escape the pain of this life, but also to escape the pain of loneliness and disconnection,” Ozawa-de Silva said. “Dying with another person serves both purposes.”

She added, “A lonely society is not just one where a very high number of people within it feel lonely—it is also one where the people do not feel taken care of and cared for by society as a whole and where the structures of society promote a sense of loneliness rather than one of belonging and connection.

“But Japan is not the only country in this situation. The epidemic of loneliness and the social conditions that promote it are widespread. ... The same trends can now be seen in the U.S., Europe, and elsewhere. As developing countries struggle to catch up with developed ones, the same worrying social trends are emerging.” **PN**

Supreme Court

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government sponsored. Overturning the ACA would increase the number of uninsured by at least 65%, causing more than 20 million Americans to lose coverage, according to the Washington, D.C.-based think tank Urban Institute. About 15 million Americans would lose Medicaid and CHIP eligibility granted by ACA’s Medicaid expansion.

“If the court overturns or dramatically alters the Affordable Care Act in the middle of a pandemic and the growing mental health crisis created by the outbreak, people most in need will not have access to care,” said APA CEO and Medical Director Saul Levin, M.D., M.P.A., in a press statement last month. “APA is extremely concerned about the lives of those with mental health and substance use disorders who are covered under the ACA. Now more than ever access to health care is essential, and we should be doing everything possible to make it available.”

Overturning the law would also trigger major changes in employer-spon-

sored coverage. “The ACA has been in place for so long now that a lot of people aren’t aware of all that it encompasses,” said Tara Straw, senior policy analyst at the Center on Budget and Policy Priorities, a nonpartisan research and policy organization.

The ACA requires plans to cover new employees’ preexisting health conditions on their first day of coverage; prior to the ACA, plans would decline to cover these employees for previously treated conditions, including mental illness, for up to 12 months, Straw pointed out. The law also requires all health plans to cover preventive health care with no cost sharing, allowing a crucial point of contact for patients to be screened for possible mental illness, among other ailments.

Also, the ACA extends coverage to dependents up to age 26 under their parents’ employer plans, giving coverage to 2.3 million young adults at an age when mental illness is often first diagnosed. Prior to the ACA, most employer plans terminated dependent coverage at age 18, Straw explained.

Without the ACA, insurers in the individual market could revert to their

former practice of charging higher premiums—or denying coverage altogether—to individuals with mental illness or other preexisting conditions. Individuals who failed to disclose their conditions and later found themselves in need of care for them could find their policy canceled.

Health plans would also no longer be required to cover the ACA’s 10 “essential health benefits,” which include mental and substance use disorder services, including psychotherapy, prescription drugs, hospitalization, emergency services, and lab work. It also applies parity to coverage. Straw explained that prior to the ACA, most individual health plans didn’t cover mental or substance use disorders or at best offered expensive riders priced for those who expected to need those benefits. **PN**

2 The transcript for the Supreme Court hearing is posted at https://www.supremecourt.gov/oral_arguments/argument_transcripts/2020/19-840_1a72.pdf. “APA Joins Amicus Brief in Argument Against Texas Ruling Invalidating ACA” is posted at <https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2019.5a19>.

FDA Clears Smartwatch App That Detects, Interrupts Nightmares



iStock/Tero Vesalainen

With the marketing clearance, NightWare becomes the first prescription therapeutic for nightmare disorder or nightmares associated with posttraumatic stress disorder.

BY NICK ZAGORSKI



In November, the Food and Drug Administration (FDA) cleared NightWare—a smartwatch-utilizing program that can reduce the occurrence of wake-inducing nightmares—to be marketed in the United States as a prescription digital therapeutic. The new system is indicated to treat nightmare disorder or severe nightmares related to posttraumatic stress disorder (PTSD) in adults aged 22 and over.

The clearance of this prescription wearable marks another milestone for the field of digital mental health, while also bringing to market the first treatment for disordered nightmares. NightWare is not a standalone therapy; it should be used as part of a multicomponent treatment plan.

Studies suggest that about 4% of Americans may suffer from clinically significant nightmares, which contribute to sleep deprivation, fatigue, alcohol/substance use, and even suicidal ideation. Such nightmares are especially prevalent in people who experience trauma, and it is estimated that about 70% to 80% of people with PTSD have co-occurring nightmares. Common treatments for people with nightmares often include psychotherapy and/or off-label use of antipsychotics or sedatives.

NightWare uses software installed on an Apple Watch to monitor a person's heart rate and body movement while sleeping. The software can learn a person's regular sleep biometrics and can detect when a nightmare is occurring. When the app detects the onset of a nightmare, the watch vibrates just enough to shift the wearer from the dream state (REM sleep) into a non-dream state of sleep.

Patients who are prescribed NightWare receive both the Apple Watch and a linked iPhone with the software preloaded; the phone is locked such



By monitoring a person's heart rate and movement via smartwatch sensors, the NightWare software can identify the onset of nightmares and interrupt them with precise vibrations.

that the user cannot add any additional apps.

"We didn't want to make the software downloadable on someone's personal

device because many people are in the habit of using their phones during the day and then charging them at night," said Grady Hannah, CEO of NightWare. "The goal is to treat this kit as its own medical device that people get in the habit of putting on every evening."

NightWare received a breakthrough device designation from the FDA in May 2019 following promising results from an open-label study involving 20 veterans with PTSD. Breakthrough status allows drugs and devices to go through an expedited FDA review process; it is given to products that may treat severe conditions that have no approved remedies.

Last month's clearance was based on data from 70 patients receiving care at the Minneapolis Veterans Affairs Health Care System. In this randomized, controlled trial, all the participants received the NightWare kit but only the portion in the active arm received vibrations when nightmares were detected.

After 30 days, participants in the active arm reported improvements in their overall sleep quality of 3.2 points, as measured with the Pittsburgh Sleep Quality Index (PSQI), compared with 2.2 points among patients in the sham

see **Smartwatch** on page 18

Polysubstance Use Common in Buprenorphine Deaths

Sedatives often noted in toxicology reports highlight the need to monitor patients on buprenorphine for other substances. BY TERRI D'ARRIGO

Deaths among people who use buprenorphine often also involve benzodiazepines, gabapentinoids, alcohol, and illicit substances, a study in *Drug and Alcohol Dependence* suggests. The findings signal a need to both screen for polysubstance use in people with substance use disorder and monitor carefully those patients who receive buprenorphine to treat opioid use disorder (OUD) who are also prescribed medications that can interact with the drug and raise the risk of accidental death.

"The importance of sedatives [in the deaths] was far greater than we could have imagined," senior author Ilkka Ojanperä, Ph.D., a professor of forensic toxicology in the Department of Forensic Medicine at the University of Helsinki, told *Psychiatric News*. "It was clearly shown that buprenorphine alone does not cause deaths."

Ojanperä and colleagues analyzed the autopsy records of 792 people aged 15 to 64 years who died in Finland between 2016 and 2019 wherein buprenorphine or norbuprenorphine was found in the decedents' blood, urine, vitreous humor, liver, or muscle. In more than a third of these cases,

buprenorphine was implicated in a fatal poisoning without other opioids. Among those, benzodiazepines were found in 94%, illicit drugs in 63%, gabapentinoids in 50%, and alcohol in 41%. Clonazepam was the most common benzodiazepine found in this group, present in 53%, while pregabalin was the most common gabapentinoid, present in 41%.

That buprenorphine was the sole opioid in so many of the fatal poisonings may seem unusual to Americans when opioid deaths in the United States largely involve synthetic opioids such as fentanyl and fentanyl analogs, prescription opioids such as oxycodone or hydrocodone, or heroin. Although the study was not designed to determine the source of the buprenorphine found in the autopsies, the researchers noted



Prior research suggests that most of the buprenorphine-related deaths involved illicit medications, says Ilkka Ojanperä, Ph.D.

that more than 80% of people in Finland who use opioids illicitly use buprenorphine as their main substance. Furthermore, only 1% of those

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who receive medication treatment with buprenorphine in Finland take buprenorphine-only medications such as Subutex, yet 85% to 95% of the buprenorphine administered illicitly by injection originates from buprenorphine-only drugs, Ojanperä explained.

"Buprenorphine is used in opioid agonist treatment in our country mainly as a buprenorphine-naloxone combination [such as] Suboxone, but the poisoning deaths involving buprenorphine are mainly due to Subutex tablets smuggled from France," Ojanperä said.

Buprenorphine was implicated along with other opioids in roughly 13% of the 792 deaths. Among those, benzodiazepines were found in 94%, gabapentinoids in 65%, and alcohol in 32%.

"The study found that the differences in substance findings between user groups were quite small," Ojanperä said. "It is important to recognize the unsafe patterns of drug use and drug combinations and inform the patient."

"Many patients with OUD also use other substances besides opioids. Ideally, it makes sense to monitor patients on buprenorphine for use of other substances either through clinical observation or toxicology testing or both," said Andrew J. Saxon, M.D., a professor in the Department of Psychiatry and Behavioral Sciences at the University of Washington and director of the Center of Excellence in Substance Addiction Treatment and Education at the VA Puget Sound Health Care System. Saxon, who was not involved in the research, is a member of APA's Council on Addiction Psychiatry.

"When other substance use is occurring, address it using the best evidence-based interventions," Saxon said. "However, do not discontinue treatment for OUD with buprenorphine even if other substance use is occurring. Overall, staying on buprenorphine is more protective against overdose than discontinuing it."

Ojanperä and colleagues noted that medications that may enhance the respiratory depressant effects of opioids and increase the risk of overdose death are often prescribed to patients with OUD, even though guidelines advise against it. Indeed, earlier this year, a study in *Addiction* revealed that 24% of adults who received buprenorphine treatment for OUD in Massachusetts between 2012 and 2015 filled at least one benzodiazepine prescription during buprenorphine treatment. During that time, 183 patients in the study died of opioid overdose, and nearly a third of those deaths occurred when patients received benzodiazepines during buprenorphine treatment.


Saxon said that prescribing benzodiazepines for patients on buprenorphine should be rare.

"In general, except for treating acute alcohol withdrawal, benzodiazepines are best avoided in most patients. We generally have better and safer treatments for anxiety disorders and insomnia disorders than benzodiazepines, primarily cognitive-behavioral therapy, but also medications such as a

variety of antidepressants and buspirone for anxiety," said Saxon. "In rare cases patients do not respond to any other intervention, and then, as a last resort, benzodiazepines could be prescribed with very careful monitoring

at low or modest doses for patients on buprenorphine for OUD."

Ojanperä's study was supported in part by a personal grant to one of the researchers from the Häme Students Foundation in Helsinki, Finland. **PN**

 "Concomitant Drugs With Buprenorphine User Deaths" is posted at <https://www.sciencedirect.com/science/article/pii/S037687162030510X#bib0165>. "Associations Between Prescribed Benzodiazepines, Overdose Death, and Buprenorphine Discontinuation Among People Receiving Buprenorphine" is posted at <https://onlinelibrary.wiley.com/doi/abs/10.1111/add.14886>.

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Lockdowns

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could not be sure of the ingredients in the food).
In the same survey, more than 86% of respondents reported feeling more social isolation during the pandemic, and more than 81% reported spending more time online. Yet spending more time online increased their exposure

to triggering messages, such as social media posts that referred to diet, weight, and exercise.
“The internet has played a positive role for many individuals during the pandemic, including providing a valuable source of social support and connectedness. However, it can be detrimental if individuals find themselves exposed to online content that they find triggering of their eating disorders,” study co-author Dawn Branley-Bell, Ph.D. (C.Psychol.), told *Psychiatric News*. She is a health and cyber psychologist at Northumbria University in Newcastle upon Tyne, England.
“Some of our respondents reflected on the constant public dialogue on social media about ‘daily exercise’ and weight gain during the COVID-19 pandemic and associated lockdown,” Branley-Bell added. “This suggests that men-

tal health professionals might wish to investigate strategies that patients could use to monitor and potentially regulate their internet usage if it is proving problematic and if providing this regulation does not impact upon positive aspects of internet use such as access to social support.”
Technology presents another challenge to patients with eating disorders, including the technology used for tele-

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health appointments.

“The individuals in our study raised concerns around the suitability of videoconferencing software, which often meant they were faced with seeing themselves on the monitor during the call. Our participants explained how this could exacerbate their self-awareness and self-criticism, which could worsen their eating disorder symptoms or have a negative impact on their

recovery progress,” Branley-Bell said.

“Health professionals may wish to use technology that does not have self-view enabled as the default option, or alternatively provide guidance on how their patients can disable self-view on their devices. If patients are uncomfortable with video calls, they may wish to investigate whether there are other options available for remote treatment, such as audio calls,” she added.

Bulik and other mental health professionals at UNC have made turning off self-view an option for their patients.

“One of the things that we’re doing for group meals and for monitoring meals is that patients can turn off cameras so they don’t have to see themselves, but the therapist can see what they’re eating,” she said. “It’s important to see what the patient looks like, as there are visual cues that we use to fuel

treatment and psychotherapy.”

However, patients with eating disorders should not be forced to enable video at other times, such as for work or with friends, and psychiatrists should be prepared to support their patients in this matter, Bulik said. “A doctor’s note for not turning on video is completely appropriate.”

Respondents in Branley-Bell’s study

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expressed two main concerns about the future. First, they were worried about adjusting to a “new normal” once the pandemic ends, such as re-adapting to social and public situations, including dining out and grocery shopping. Second, they had concerns about recovering from eating disorder behaviors that became worse

during lockdown.

“Health care services need to ensure that adequate, accessible support is readily available during and after the pandemic, including plans to help indi-

viduals during the transition out of lockdown,” she said.

Neither Bulik nor Branley-Bell reported outside funding for their studies. **PN**

■ “Early Impact of COVID-19 on Individuals With Self-Reported Eating Disorders: A Survey of ~1,000 Individuals in the United States and the Netherlands” is posted at <https://onlinelibrary.wiley.com/doi/10.1002/eat.23353>. “Exploring the Impact of the COVID-19 Pandemic and UK Lockdown on Individuals With Experience of Eating Disorders” is posted at <https://jeatdisord.biomedcentral.com/articles/10.1186/s40337-020-00319-y>.

Smartwatch

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treatment arm (a three-point improvement in the PSQI is considered a clinically relevant change in symptoms). The participants in the active arm also reported improvements on the PSQI-A (an addendum to the PSQI that looks specifically at PTSD-related nocturnal symptoms such as hot flashes or memories of bad dreams) by 3.3 points compared with 1.4 points in the sham arm. The devices also passed safety measures, as they did not reduce sleep quality or trigger any suicidal ideation.

The 70 patients were the first wave of a planned enrollment of 240 patients. “One of the expedited processes for breakthrough devices is you can submit preliminary data for clearance so long as you promise to complete the trial,” Hannah said. “I thought our data looked promising, and we made our case.”

Peter Colvonen, Ph.D., an assistant clinical professor of psychiatry at the University of California, San Diego, and a clinical psychologist at the San Diego VA said the clearance of NightWare shows the continued progress of digital mental health technologies. But he noted that the app’s goal of interrupting REM sleep may not be right for everyone.

“While there are no approved nightmare medications, we do have behavioral treatments that are incredibly effective,” he said. “The goal of behavioral therapy is not to interrupt nightmares, but to enable patients to process their nightmares and get over the trauma causing them.”

Colvonen noted that REM sleep is tied to emotion processing, which explains why people who have poor sleep become more irritated and emotionally reactive. Interrupted sleep also leads to REM rebound, in which people enter REM sleep sooner and stay in that state longer once they are able to sleep. Thus, a person who forgets to put on the watch after several days of use might be at risk of intense dreams.

“If someone is waking up three or four times a night dripping in sweat because of terrible nightmares, then this device could certainly be part of a therapeutic regimen,” he said. “For less severe cases, it may not be necessary.”

Since the existing trial of NightWare is being conducted at a VA center, Hannah and his team are working to ensure the device is available through the VA. The company is also exploring the possibility of submitting NightWare for Medicare Coverage of Innovative Technology, a new initiative in which cleared breakthrough devices are covered by Medicare for four years. **PN**

■ More information on NightWare is posted at <https://nightware.com/>.

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Patients With Refractory Bipolar Depression May Benefit From ECT

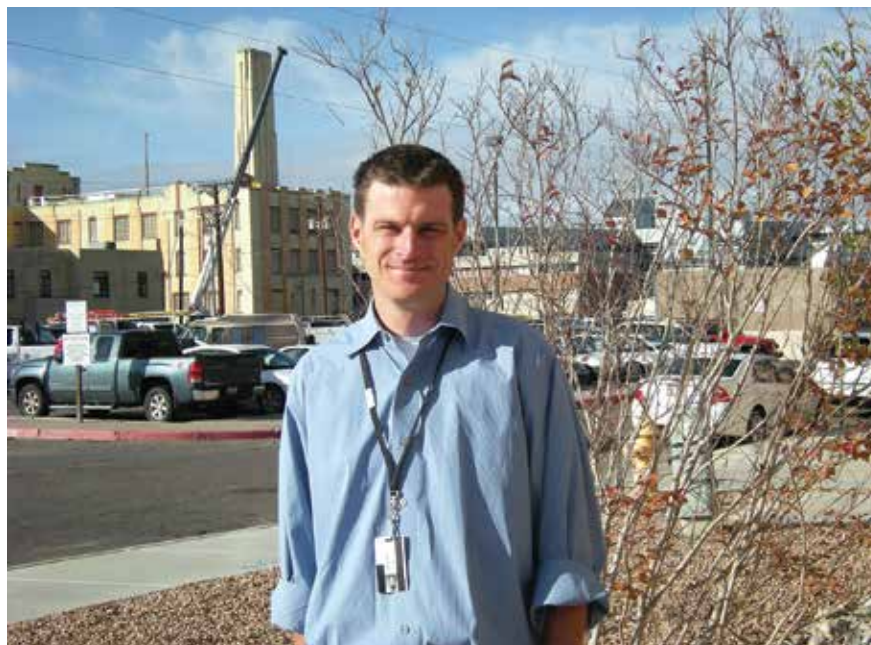
Electroconvulsive therapy (ECT) is equally effective for bipolar depression and unipolar major depression, experts say.

BY NICK ZAGORSKI

Nearly two decades ago, APA published clinical practice guidelines on bipolar disorder, noting that there was substantial evidence to support the use of electroconvulsive therapy (ECT) for patients with severe, treatment-resistant bipolar depression. Since then, the clinical evidence in support of ECT for bipolar disorder has continued to grow.

“Yet to this day, many people still dismiss ECT when discussing bipolar disorder treatment options, despite the many studies showing its effectiveness,” said Charles Kellner, M.D., an adjunct professor of psychiatry at the Medical University of South Carolina and a leading expert on the use of ECT for treating mood disorders. “In fact, patients with bipolar depression on average respond with fewer treatment sessions [than those with unipolar depression].”

Kellner noted that multiple recent journal review articles have failed to mention ECT when describing evidence-based treatment options for patients with bipolar disorder. He praised a comprehensive review published this year in the *New England Journal of Medicine* for referencing the effectiveness of ECT for treating acute and long-term symptoms of bipolar disorder, but even in this case, the dis-



Though ECT poses legitimate risks like delirium and cognitive problems, Christopher Abbott, M.D., says that post-ECT mania in depressed bipolar patients is rare and likely not directly caused by the electrical stimulation.

cussion of ECT was relegated to a few short sentences.

Why aren't more people talking about the potential benefits of ECT for patients with bipolar disorder? Kellner thinks that some psychiatrists see major depressive disorder and bipolar disorder as so distinctly different that they assume the procedures or criteria for ECT must be different if a patient has bipolar depression rather than unipolar depression.

“But polarity of the mood disorder makes no difference in determining who is a good candidate for ECT,” he

continued. Better clues for determining patients most likely to benefit from the therapy include those with very severe depression, delusions, suicidal behaviors, or catatonic symptoms, he noted.

Psychiatrists should consider ECT for patients experiencing particularly serious symptoms, said Christopher Abbott, M.D., an associate professor of psychiatry at the University of New Mexico who studies ECT in bipolar patients. “If you see a patient with severe bipolar depression who is not eating and losing weight, then ECT should come up in the conversation sooner than later.”

Managing ECT Side Effects

Treating bipolar patients with ECT may require tapering some medications prior to the therapy and closely tracking the patients for emerging symptoms of mania after ECT, Abbott explained.

ECT works by applying electricity to the brain to stimulate brief seizures. Because anticonvulsants (commonly prescribed to patients with bipolar disorder) can make it harder to induce these seizures, safely tapering the medications prior to the procedure is recommended. This helps ensure the minimum effective electrical charge is used, minimizing cognitive side effects from ECT, Abbott said. He added that lithium—though not an anticonvulsant—should also be discontinued prior to an ECT procedure since there is evidence that patients receiving ECT while taking lithium have an increased risk of delirium and transient cognitive impairment.

“There is clear evidence that bipolar patients in remission are more likely to have lingering cognitive impairments compared with remitted unipolar patients, so it is a researchable question as to whether ECT would affect cognition differentially in these two disorders,” Peter Rosenquist, M.D., a professor and the Leon Henri Charbonnier Endowed Chair of Psychiatry at the Medical College of Georgia, told *Psychiatric News*. The current data, however, suggest there are no differences in the risk of short-term cognitive issues between unipolar or bipolar patients following ECT.

Case reports have also shown that some patients with bipolar depression experienced emergent mania following an ECT procedure, but there is no strong evidence to infer that ECT causes the mania, Abbott continued.

“As a field, mood disorder researchers need to address the stigma surrounding [ECT, including] cognitive side effects like delirium and brief memory loss,” Abbott said. These are legitimate concerns that doctors should address with patients, but their impact remains exaggerated in the public eye.

ECT Research Continues

In addition to improving awareness about the effectiveness of ECT for patients with bipolar disorder, continued research is needed to make ECT a more precise treatment, Abbott continued. He is currently using brain imaging techniques to pinpoint activity changes in brain circuit networks following ECT, which he said may one day reveal the optimal places to place ECT electrodes and focus the stimulation.

Another area of research interest is developing better ways to predict the patients with bipolar disorder who are most likely to benefit from ECT. Giulio Perugi, M.D., and his colleagues at the University of Pisa in Italy have been following a cohort of several hundred patients with bipolar depression who received ECT for years to assess their recovery and what factors might be predictors of that recovery.

In an analysis published this year, Perugi and colleagues identified several traits in patients with bipolar depression that appeared to signal a better response to ECT. Perugi's team found that patients with delusions of guilt were much more likely to respond to ECT than those with other types of delusions, such as paranoia. They also found that patients with strong mixed features (symptoms of depression and mania) were more likely to benefit from ECT than those with pure depression or minor mania symptoms.

Kellner lauded this important work at characterizing bipolar response to ECT, but also emphasized that 72% of the bipolar patients in the study showed

see ECT on page 21

AJP Review Examines Evidence Supporting ECT for Mania

While there is less clinical evidence supporting the use of ECT for mania compared with bipolar depression, studies over the past three decades suggest ECT can also lead to symptom improvements in patients with mania and related syndromes. ECT expert Harold Sackiem, Ph.D., of Columbia University along with Alby Elias, M.D., and Naveen Thomas, M.D., of the University of Melbourne presented key takeaways from these trials in a recent review in *AJP in Advance*.

“ECT is one of the few interventions in psychiatry with established efficacy in treating both depressive and manic syndromes,” Sackiem and colleagues wrote. Still, the authors acknowledged many questions remain, including how frequently ECT should be administered to patients with mania, the best placement of electrodes, and whether patients should continue taking anticonvulsant medications and/or lithium during an ECT course. There are also ethical challenges that may arise when considering ECT for patients with mania, who the authors noted are more likely than those with depression to experience “severe impairment of judgment and insight, and catatonic or delirious presentation.”

They added, “Stigma, logistics, and ethical factors constrain ECT administration in this condition and lead to its underutilization. However, the past three decades have produced promising research regarding the use of ECT in mania.”

“Electroconvulsive Therapy in Mania: A Review of 80 Years of Clinical Experience” is posted at <https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.2020.20030238>.

'Invisibles' May Provide Needed Data On Compromised Patients

Passive collection of vital signs, including heart rate and respiration, can benefit people with dementia and other cognitive problems, who may not be able to respond to traditional health assessments.

BY NICK ZAGORSKI



Over the past decade, many psychiatrists have realized the value of collecting objective health information from their patients in between scheduled visits. Devices such as smartphones,

smartwatches, or other wearable sensors can capture everything from users' biometric data to their responses to brief surveys on mood.

Even as "wearables" become more popular, some researchers are looking

ahead to the next tech frontier: the "invisibles." These are the tools that can passively monitor vital signs with minimal or no input from the users.

Geriatric psychiatrist Ipsit Vahia, M.D., the director of the Technology and Aging Laboratory at Boston's McClean Hospital, sees passive monitoring as critical to the patient population he serves.

"Current monitoring tools typically require some engagement from a person, even if it entails only putting a phone right next to the bed each night," he said. For people with dementia, Parkinson's disease, or other cognitive disorders, ensuring this regular engagement is problematic. "We need to find ways to collect important data from those patients who cannot provide the data to us."

Vahia noted that vitals that can be readily collected with a passive sensor like heart rate, respiration, or movement are useful in psychiatry since they are biomarkers of anxiety and stress.

Vahia has been testing the feasibility of a device known as Emerald to aid in the monitoring of patients with dementia. Emerald is a small box that continually emits radio signals into the surrounding space much like a wireless router. Whenever the waves hit an object (like a person), they become distorted. By analyzing how wave patterns in a room change over time, Emerald can identify such movements as a person walking or chest movements while a person sleeps.

The device includes machine-learning software that can identify expected wave patterns over a typical day. Abnormal changes in movement due to excess pacing or disturbed sleep—which could signal that an individual is experiencing a medical problem—can be quickly identified. This information can then be transmitted remotely to relevant personnel, including nursing home staff or the patient's physician.

Vahia has teamed up with Emerald designer Dina Katabi, Ph.D., the Andrew & Erna Viterbi Professor of Electrical Engineering and Computer Science at the Massachusetts Institute of Technology, to assess the movement patterns of nursing home patients with dementia. The group's pilot studies have shown that a person's average walking speed and daily spatial patterns can serve as biomarkers for neuropsychiatric symptoms such as apathy, insomnia, or cognitive difficulties.

Vahia said that a device like Emerald could be attractive to many patients

and health care professionals since it can collect vital health data without the need for a camera. The Emerald device is also more practical than video monitoring, as waves from the device can pass through solid objects, which allows it to monitor larger spaces (like a multiroom house).

David Maman, the co-founder and CEO of Israeli tech company Binah.ai, said he believes cameras also have an important role in passive monitoring.

"An average person might spend up to 50% of his or her waking time looking at a camera, even when not actively using it," Maman said, referring to the time people spend on their phones, tablets, or computers.

With just a 60-second scan of a person's face, the Binah.ai software can assess subtle changes in light reflection on the skin and acquire data including heart rate, respiratory function, and mental stress (derived from heart rate variability, or the differences in time from beat to beat)—even while working in the background.

The program can be seamlessly integrated into other platforms, so physicians can have the Binah.ai software running on their computer while conducting a telemedicine session and view real-time changes in their patients' vitals.

Binah.ai is seeking FDA approval to market their software as a medical device in the United States.

"The field of virtual health care has exploded in the past few months" due to COVID-19, Vahia said. "Any tools that can provide patient data without requiring staff contact are becoming invaluable."

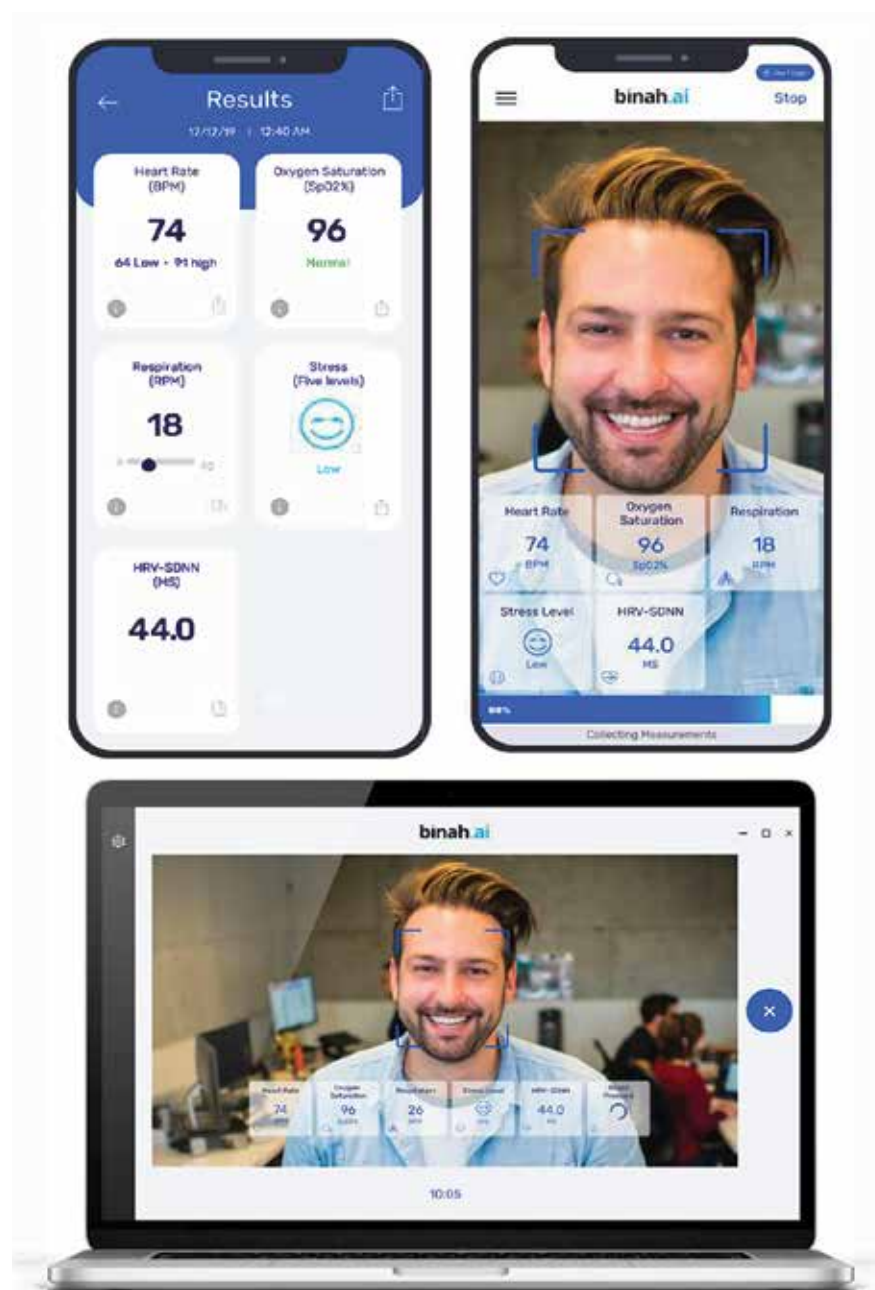
Vahia noted the importance of monitoring stress and anxiety in patients with COVID-19, as these symptoms can impair the immune system and worsen the infection. "To optimally manage a COVID-19 infection, we need to monitor patient physiology and behavior at the same time," he said.

The applications of the invisibles will likely continue well beyond COVID-19. "Like many other psychiatrists, I have switched to full-time telemedicine during this pandemic," Vahia said. "And like many colleagues, I think telemental health care will remain a standard of care after the pandemic ends."

"To make telehealth care even better, we need to supplement it with what we may call digital collateral information," he said. That includes specialty devices such as Emerald but also phone- or tablet-embedded programs, as phones are available almost everywhere and to almost everyone.

"With the help of these collateral tools, psychiatrists can practice personalized, data-based care with their patients in a way that was previously not conceivable." **PN**

"We need to find ways to collect important data from those patients who cannot provide it to us."
—Ipsit Vahia, M.D.



While working in the background of any camera-equipped device, Binah.ai's software can assess subtle changes in light reflection on the skin and acquire a range of data including heart rate, respiratory function, and stress levels.



BY NICK ZAGORSKI



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Autism Diagnosis Rates May Be Rising In Minority Children

Rates of autism diagnosis in the United States have historically been higher among Whites and those of higher socioeconomic status. A study in *PNAS* now suggests this trend may have shifted in recent years, with more children who are minorities and members of families of lower socioeconomic status receiving autism diagnoses than children from other groups.

Investigators at Columbia University and colleagues analyzed California birth data from 1992 to 2016 and autism caseload data from 1998 to 2019 using state records to assess trends across different populations. Overall autism diagnosis rates rose over 600% in California between 1998 and 2018, from 0.49 cases per 1,000 children aged 3 to 6 years in 1998 to 3.49 per 1,000 children

aged 3 to 6 years in 2018.

Autism diagnoses did not rise equally across demographic groups. In 1998, White, Black, and Asian children had similar rates of autism, while Hispanic children had lower rates. Starting in 2009, autism diagnoses slowed in White children, and by 2014, this group had the lowest autism incidence rates of the racial/ethnic groups examined. In contrast, autism incidence among Black and Hispanic children rose significantly.

The investigators also observed interesting trends in relation to income. Among Black and Hispanic children, the yearly rates of diagnosis were similar regardless of whether the children were enrolled in California's Medicaid program (Medi-Cal). For White and Asian children, diagnosis became more frequent in children enrolled in Medi-Cal relative to other children after 2008.

The investigators suggested their observed trends might be due in part to the release of American Academy of Pediatrics guidelines in 2006 that recommended universal screening for autism during well-child visits coupled with state advocacy efforts in 2009 to reduce linguistic and cultural barriers for services provided by California's Department of Developmental Services.

The findings "point to the fundamental role that access to knowledge

and resources plays in driving increased autism prevalence and shifting patterns of autism cases over the past quarter century," the authors noted.

Winter AS, Fountain C, Cheslack-Postava K, Bearman PS. The Social Patterning of Autism Diagnoses Reversed in California Between 1992 and 2018. *Proc Natl Acad Sci U S A*. November 16, 2020. [Online ahead of print] <https://www.pnas.org/content/early/2020/11/10/2015762117.long>



iStock/cagkarsayin

Cognitive Bias Modification Reduces Risk Of Alcohol Use Relapse

Providing cognitive bias training to people receiving inpatient treatment for alcohol withdrawal may reduce the risk of relapse in the first two weeks following discharge, according to a study in *JAMA Psychiatry*. Cognitive bias modification (CBM) is a visually based computer program that trains people to subconsciously avoid alcohol-related cues.

To evaluate the effectiveness of CBM in reducing relapse in patients in treatment for alcohol withdrawal, researchers at Monash University in Melbourne, Australia, and colleagues recruited 300 adults with moderate or severe alcohol use disorder for their trial. Half the participants received up to four 15-minute sessions of CBM along with regular inpatient care, while the other half received a sham treatment (patients also looked at pictures on a computer screen, but the approach was not structured to promote alcohol avoidance). All participants were then contacted two weeks after discharge to assess their alcohol abstinence.

The two-week abstinence rates were 54.4% among participants in the CBM group and 42.5% among those in the sham group. Among participants who completed all four sessions of CBM or sham, the abstinence rates were 63.8% for the CBM group and 46.8% for the sham group. Though the CBM procedure entails viewing many alcohol-related images, the researchers found no evidence that this training increased alcohol cravings in the patients.

"CBM is a promising adjunctive intervention that directly targets key cognitive mechanisms with minimal intensity in terms of time or cognitive

demands on patients," the researchers wrote. "The low cost (requiring only a laptop and joystick, freely available software, and a few minutes of nonspecialist staff time per session) makes implementation of CBM feasible, including in low-income countries in which resources and treatment options are more limited."

Manning V, Garfield JBB, Staiger PK, et al. Effect of Cognitive Bias Modification on Early Relapse Among Adults Undergoing Inpatient Alcohol Withdrawal Treatment: A Randomized Clinical Trial. *JAMA Psychiatry*. November 4, 2020. [Online ahead of print] <https://jamanetwork.com/journals/jamapsychiatry/article-abstract/2772631>



iStock/RawTherapee 5.2

Pandemic Gun Buyers May Have More Suicidal Thoughts

A study in the *American Journal of Preventive Medicine* reports that people who bought firearms during the COVID-19 pandemic are more likely to have experienced prior suicidal ideation than both people who did not own firearms and those who own firearms but did not buy any weapons during the pandemic.

"These findings indicate that individuals already at risk for death by suicide are introducing a pronounced risk factor for suicide into their homes during a time of extended social isolation, economic uncertainty, and general upheaval," the authors wrote. People who purchased firearms during the pandemic who reported recent or lifetime suicidal ideation were more likely to use some safe storage methods than other firearm owners, they added.

Researchers at Rutgers University and colleagues collected data from an online survey of 3,494 adults, which included 2,330 people who did not own firearms and 1,164 people who owned firearms; of the latter group, 201 adults had purchased a firearm since the pandemic began. The team found that adults who purchased firearms during the pandemic had much higher rates of both lifetime suicidal ideation than other firearm owners (69% vs. 37%). Similarly, those who purchased fire-

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ECT

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meaningful improvements in depression symptoms.

"This rate is vastly more impressive than any other strategy that has been discussed for treatment-resistant bipolar depression," Kellner said. He hopes that more of his colleagues will consider discussing ECT with patients who have bipolar disorder and do not respond to first-line interventions, and not put off this option in favor of less evidence-based approaches that may leave patients in a depressed state longer than they need to be.

"Most of my colleagues have seen firsthand how rapidly bipolar depression can resolve with ECT and are glad to accept help from our team," Rosen-



David Hathcock

When considering ECT for a patient with refractory depression, do not focus on polarity but instead on disease severity and accompanying symptoms such as delusions, notes Charles Kellner, M.D.

quist said. "We provide ECT to some of the most severe and persistently ill inpatients in the Georgia State Hospital system and our outcomes speak for themselves." **PN**

"Association of Treatment Facets, Severity of Manic Symptoms, Psychomotor Disturbances, and Psychotic Features With Response to Electroconvulsive Therapy in Bipolar Depression" is posted at <https://www.tandfonline.com/doi/full/10.1080/15622975.2020.1770860>. "ECT Beyond Unipolar Major Depression: Systematic Review and Meta-analysis of Electroconvulsive Therapy in Bipolar Depression" is posted at <https://onlinelibrary.wiley.com/doi/abs/10.1111/acps.12994>. The *NEJM* review titled "Bipolar Disorder" is posted at <https://www.nejm.org/doi/full/10.1056/NEJMra1906193>.

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ity (see <https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2020.10a28>). This enabled Schuman-Olivier to shift his new projects toward online screenings and online mindfulness interventions.

"We were able to develop a remote presence quickly, but it made life very complicated," Schuman-Olivier acknowledged. There were issues like replicating a quiet, distraction-free environment needed for neuropsychological tests and finding a secure way to collect remote data.

"Our researchers were at home too, and they couldn't just keep patient data on their personal hard drive," he said. Collecting specimens for studies involving patients with substance use disorders also became more complicated, as routine in-person visits had to be replaced with observed oral fluid collection via videoconference. The center had to make plans to collect salivary samples with deliveries and pick-ups of specimen kits packed in dry ice.

But while modifying a newly funded project could be cumbersome, the studies already going full steam proved to be bigger problems, Schuman-Olivier said. For instance, he was overseeing a study involving a stress intervention at multiple primary care sites that was about 75% complete. "When COVID-19 hit, all of our participants became overwhelmed with stress and anxiety, and our data just completely blew up," he said. "Primary care as we knew it also disappeared, and many staff were assigned to inpatient COVID units, so the study had to end prematurely." For another study that required periodic brain scans, one entire cohort of participants missed their designated window because the imaging facility was shut down.

Weiss understands the impact of brain imaging disruptions all too well, as part of her portfolio involves the ABCD Study. This multi-institute effort is assessing nearly 12,000 children with periodic questionnaires and brain scans over a decade to better understand human brain development. "ABCD started so strong; we exceeded our recruitment goal and had a great retention rate. When everything started shutting down in March, it was concerning," she said.

It took some scrambling, but NIDA worked with the ABCD investigators across the country to make almost all the behavioral and cognitive assessments virtual, though some imaging data could not be completed. "Losing some data is always difficult, but at the same time, we now have a chance to study the short- and long-term effects of COVID on the well-being of thousands of families," she said, noting that the study now includes specific assessments related to the pandemic.

New Projects Examine Effects of Pandemic

NIDA has not been alone in looking for ways to leverage scientific resources to better understand how this pandemic is affecting mental health and substance use. At the National Institute of Mental Health (NIMH), the Dimensional Traumatic Stress Research Program has been on the forefront in coordinating the institute's postpandemic response.

"In every major disaster over the past 40 years, researchers have mobilized quickly to understand and try to mitigate the mental health impact," said program director Susan Borja, Ph.D. "They know which tools to bring and what questions to ask in various scenarios, and they take on the challenge even though it is unexpected extra work."

Borja added that several investigators funded by her program were familiar with what to expect with a virus outbreak, given the far smaller but still consequential SARS outbreak that occurred in 2003.

"Looking back at [the] SARS [outbreak in 2003], we knew that a coronavirus outbreak would lead to disruptions in medical care and supply chains in the short term, while paving the way for long-term mental health risks," she said. "What we did not know early on was how deadly and how fast this virus would spread. Looking at ways to extend our limited mental health resources through technology is a current focus of our program."

Several projects to meet this goal have recently launched. Gregory Simon, M.D., M.P.H., a senior investigator at the Kaiser Permanente Washington Health Research Institute, is examining how the rapid shift from office-based to virtual psychiatric therapy has affected patients' illness severity and quality of care. Patricia Arean, Ph.D., a professor of psychiatry at the University of Washington, is testing several mobile apps that may help reduce suicide risk in essential workers and other high-risk groups.

Creativity, Resiliency Will Likely Benefit Research

Though it took months, Vilardaga has managed to adapt his protocol for his large clinical study to be fully virtual in recruitment and follow-up. As with some of Schuman-Olivier's projects, a big obstacle was how to incorporate virtual biochemical verification of smoking abstinence. (His team will send periodic in-home breath tests and have participants take the tests on video calls to ensure accuracy). The new protocol will also include questions related to COVID-19 to assess how this pandemic has affected smoking habits and overall well-being of people with serious mental illness (SMI).



LETTERS TO THE EDITOR

Medicine Needs to Step Up to the Plate

I held my breath as my patient paused, turned his attention to my unwitting attending, and asked, "Do I have to talk to her?" Immediately, I knew what was coming next. My heart sank into my stomach; I could hear it beating in my ears. My attending naively pried, "Why do you ask?"

Exhale. Silence. Awkward smiling. *Here it comes.* "Because of the color of her skin! I don't want to talk to her!" What followed seemed like an eternity of grueling vitriol and hatred, though it may have really been only five minutes. My attending clamored to salvage the session—offering that I had more questions to ask the patient—as I sat in silence and trembled on the inside. Then came relief, as the patient abruptly stood up, removed his headphones, and slammed the tablet down, ending our visit.

I stared at the screen like a bewildered deer caught in headlights. My feelings bubbled. I asked to be excused. I had never been more grateful to be working from home than at this very moment. I tore into the bathroom of my apartment and let out a wail, followed by an outpouring of tears that represented my hurt, angst, and sheer sadness. And then, I did what I always do: I wiped my tears and patted the blotchy red spots on my face. I made every attempt to pull it together, but something was different this time as I sat down at my desk and faced my attendings. I could not, and would not, be resilient in that moment. I would not power

through, continuing to see the remainder of the patients. I would not smile and reassure my attendings that I was fine. I would not suppress the immense frustration I felt in that moment. I was not OK, and I needed to vocalize it.

Resilience is born out of trauma. In order to sustain as a person of color in this field—as a Black woman in this field—you must be able to effectively dissociate and compartmentalize. But there comes a time when this burden is too heavy to bear.

I channeled the weight I felt into speaking up. I challenged my program leadership, faculty, and colleagues to protect residents of color in moments like these. Racism should not be tolerated. To endure attacks, whether in the form of direct blows like my patient stating he didn't want a Black doctor or in the more subtle ways that microaggressions chip at you, you ultimately reach a breaking point. Mine happened in the middle of a pandemic, during a telepsychiatry visit in which I was subjected to unwarranted discrimination simply due to the color of my skin. At a time when I am reminded daily that my life may matter less to some people and my friends and allies are marching in the streets seeking justice for Breonna, George, and other victims, I learned that I could break. And I learned that a system I've dedicated my life to, the institution of medicine, isn't equipped to help put me back together without first realizing its own faults and complicity in this vicious cycle. **PN**

BRITTANY TARRANT, M.D., M.D.

PGY-3 Psychiatry Resident, UCLA Resnick Neuropsychiatric Hospital

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.

His experiences during this time have made him appreciate people involved with carrying out a clinical trial. "It's not just that we can't see patients," he said. "I had staff who needed time off to help take care of children, and I couldn't hire new staff for a while since the campus shutdown included a hiring freeze." The reduced personnel capacity also slowed the pace of the institutional review board that oversees his trial and approves every addition or amendment to his protocol.

Despite these challenges, Vilardaga remains positive. "So far, NIDA and the National Cancer Institute (which funds some of his smoking research) have been very understanding, and even with the delays, I still hope to start early next year," he said. He is also cautiously optimistic that the change to a virtual study will boost recruitment. "There are barriers to retaining people with SMI in traditional trials requiring in-person visits; if people can partici-

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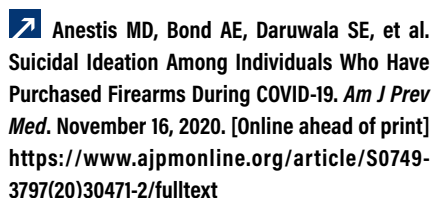
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arms during the pandemic reported higher rates of past-year and past-month suicidal ideation compared with other firearm owners (56% vs. 24% and 25% vs. 12%, respectively). There was no difference in suicidal ideation between people who did not own firearms and those who purchased firearms prior to the pandemic.

Among the 201 adults who purchased a firearm during COVID-19, those who reported past-month or past-month suicidal ideation were significantly more likely to report using locking devices like a trigger lock than those who did not report suicidal ideation. The groups did not differ in the likelihood of using any other firearm storage methods.

“Although there was substantial variability within groups in the frequency of endorsement for various reasons for acquiring firearms during COVID-19, that variability was not apparent between groups,” the authors wrote. “Regardless of suicidal ideation, safety and protection at home were the most frequently endorsed reason for firearm acquisition.”

 Anestis MD, Bond AE, Daruwala SE, et al. Suicidal Ideation Among Individuals Who Have Purchased Firearms During COVID-19. *Am J Prev Med*. November 16, 2020. [Online ahead of print] [https://www.ajpmonline.org/article/S0749-3797\(20\)30471-2/fulltext](https://www.ajpmonline.org/article/S0749-3797(20)30471-2/fulltext)



Targeted Therapy Can Benefit Youth At Risk of Depression

Personalizing depression prevention therapy for at-risk youth based on the types of depression risk they face may lead to better outcomes,

continued from facing page

pate from their own homes, they may be more engaged.”

“We cannot forget how this pandemic has also brought health disparities, particularly for racial and ethnic minorities, to light,” Borja added. “As we think about digital tools, we want to ensure we are reaching the most vulnerable people right now and that includes addressing a digital divide in access and use.” **PN**

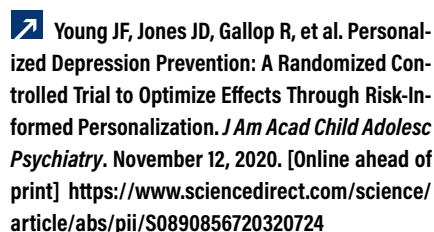
according to a study published in the *Journal of the American Academy of Child and Adolescent Psychiatry*.

Researchers at the University of Pennsylvania and colleagues enrolled 204 youth aged 11 to 18 without current depression for this study. The youth were broken into four groups based on how they responded to questions about their cognitive risks (such as dysfunctional attitudes) and interpersonal risks (such as low peer support) for depression.

The youth were then randomly assigned to receive either a cognitive-behavioral therapy called Coping with Stress (CWS) or an interpersonal therapy for adolescents (IPT). Both behavioral therapies entailed eight weekly group sessions followed by individual booster sessions if needed. Changes in depressive symptom score, according to the Children’s Depression Inventory (CDI) and/or a depression diagnosis were assessed during an 18-month follow up.

In total, 18.7% of children receiving the CWS and 16.9% receiving the IPT developed depression. Youth who received the treatment that matched their risk profile (for example, CWS for those with high cognitive risk factors and IPT for those with high interpersonal risk factors) had significantly greater changes in CDI scores and a lower incidence of depression than youth given a mismatched therapy (10.1% vs. 25.2%).

“Taken together, the findings from [personalized depression prevention] provide initial evidence that personalization, focused on cognitive and interpersonal vulnerabilities for depression, may enhance the effects of evidence-based depression prevention programs,” the authors wrote.

 Young JF, Jones JD, Gallop R, et al. Personalized Depression Prevention: A Randomized Controlled Trial to Optimize Effects Through Risk-Informed Personalization. *J Am Acad Child Adolesc Psychiatry*. November 12, 2020. [Online ahead of print] <https://www.sciencedirect.com/science/article/abs/pii/S0890856720320724>



Age May Impact Effects Of Sertraline-Olanzapine On Weight, Cholesterol

Older patients with psychotic depression experience less weight gain and cholesterol increases than younger patients

when treated with sertraline plus olanzapine. These findings were published in the *American Journal of Geriatric Psychiatry*.

“Older adults are more likely to experience psychotic features during a major depressive episode than younger adults. In addition, the incidence of diabetes mellitus type 2 and hyperlipidemia increase in later life,” the authors wrote. “It is therefore important to determine whether there are age-related differences in anthropometric and metabolic outcomes associated with the treatment of psychotic depression with antipsychotic medication.”

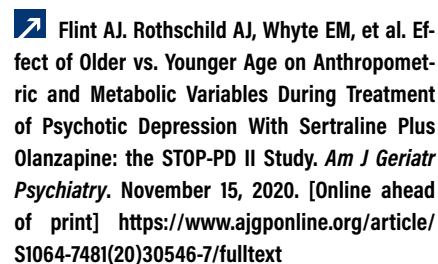
The trial, known as STOP-PD-II, compared whether long-term treatment with sertraline plus olanzapine was more effective than sertraline plus placebo at preventing relapse of psychotic depression. In the first part of the study, all participants received open-label sertraline plus olanzapine for up to 12 weeks, and those who achieved remission entered the long-term phase of the trial.

The investigators from the University of Toronto and colleagues took a closer look at the metabolic data from those first 12 weeks in participants aged 18 to 59 and those aged 60 and older. While both younger and older

participants experienced weight gain and an increase in total cholesterol levels when treated with sertraline-olanzapine versus sertraline-placebo, the increases were more pronounced in younger adults; average weight gain was 16.9 pounds for adults under age 60 and 9.5 pounds for adults 60 and over.

After reviewing the participants’ medical history, the investigators found that, on average, adults 60 and older lost 14.4 pounds between the onset of their depressive episode and enrollment in the study, whereas the weight of younger adults stayed stable.

“These findings suggest that the weight gained during the acute and stabilization treatment of psychotic depression was partial restoration of lost weight in older patients [during depressive episodes] but clinically significant excess weight in younger patients,” they wrote.

 Flint AJ, Rothschild AJ, Whyte EM, et al. Effect of Older vs. Younger Age on Anthropometric and Metabolic Variables During Treatment of Psychotic Depression With Sertraline Plus Olanzapine: the STOP-PD II Study. *Am J Geriatr Psychiatry*. November 15, 2020. [Online ahead of print] [https://www.ajgp-online.org/article/S1064-7481\(20\)30546-7/fulltext](https://www.ajgp-online.org/article/S1064-7481(20)30546-7/fulltext)

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