

PSYCHIATRIC NEWS

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What You Should Know To Care for LGBTQ Patients

Creating an affirming and trusting environment in which LGBTQ patients feel safe to communicate is key to providing effective care.

BY ERIC YARBROUGH, M.D.

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Suicides Drop During Past Year of Pandemic, Study Finds

Suicide experts have long observed that suicide rates tend to decrease in the aftermath of a communal trauma, possibly reflecting the effects of social cohesion and shared suffering. BY MARK MORAN

Deaths by suicide declined by almost 6% from 2019 to 2020, according to a report in *JAMA* based on data from the Centers for Disease Control and Prevention (CDC).

The decline is good news in an otherwise grim report that revealed a 17.7% increase in overall deaths in 2020, with most of those directly attributable to COVID-19.

"The reported decrease in deaths by suicide makes us hopeful that protective mental health measures are having a positive impact amid a time of collective

distress," said Christine Moutier, M.D., chief medical officer for the American Foundation for Suicide Prevention (AFSP), in a statement. "While we don't know the exact contributors to the reported decline in suicides, research does show us that prioritizing and having open, honest dialog about mental health on the individual and national levels, implementing practices that reduce suicide risk in clinical and community settings, and seeking help early and when indicated can reduce suicide deaths."

In the *JAMA* report, Farida B. Ahmad, M.P.H., and Robert Anderson,

Ph.D., of the CDC's National Center for Health Statistics looked at deaths that occurred from January through December 2020, as reported in the National Vital Statistics System. A total of 44,834 deaths by suicide occurred in 2020, a decrease of 5.6% from the 47,511 suicides in 2019. In contrast, the overall number of deaths increased by 503,976 (17.7%) in 2020, with 345,323 of those attributable to COVID-19.

While the reported decline in suicide deaths is encouraging, Moutier cautioned that much remains unknown about the impact of COVID-19 on suicides. "Suicide is complex, risk is dynamic, and an individual's personal risk factors combined with precipitants such as evolving experiences with isolation, depression, anxiety, economic stress, suicidal ideation, and access to lethal means may lead to periods of increased risk," the AFSP statement noted.

Importantly, the decrease in the total number of suicide deaths could possibly mask increases among subgroups that have been disproportionately affected by the pandemic. "We do not yet have the data to consider suicide in specific populations based on demo-

graphic factors such as age, gender, and racial/ethnic background or social determinants such as income, access to health care, and stressors that minoritized communities may experience," Moutier said. "Additionally, we know there can be a time lag in the manifestation of distress even months after the acuity of a traumatic or stressful period is over."

AFSP President Maria A. Oquendo, M.D., Ph.D., who also is a past APA president, agreed and noted especially the increase documented in a 2019 *Pediatrics* report on Black adolescents showing that suicide attempts rose by 73% between 1991 and 2017, and injury by attempt rose by 122% (*Psychiatric News*, <https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2019.11b17>).

"The data for 2020 are not yet available, but increases in suicide rates among Black youth and other minority populations in the prior few years require attention," Oquendo told *Psychiatric News*.

Regarding the overall drop in suicide in 2020, Oquendo said it is not entirely surprising that people are less likely to die by suicide in the wake of a

see **Suicides** on page 27

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The Knee on the Other's Neck

Seeking justice is hard work. It requires all of us to accept responsibility for finding a role to change things and make progress. At the core of making this meaningful change is spiritual humility. **BY EZRA E. H. GRIFFITH, M.D.**

"If we—and now I mean the relatively conscious whites and the relatively conscious blacks, who must, like lovers, insist on, or create the consciousness of the others—do not falter in our duty now, we may be able, handful that we are, to end the racial nightmare, ... and change the history of the world."

—James Baldwin
The Fire Next Time (1963)



Ezra E. H. Griffith, M.D., is professor emeritus of psychiatry and African American Studies at Yale University.

The recurring visual tableau of Derek Chauvin's knee on the neck of George Floyd is the unavoidable central scene of all stories focused on this historic trial, *State of Minnesota v. Derek Chauvin*. Commentary on the jury's verdict will reverberate for a long time. In contemplating my reactions to the *Chauvin* verdict, I thought it would be helpful to look back at an unusual encounter I had with a police officer some years ago. I wanted a personal point of reference as I proceeded writing this article. So, with my memories at hand, I examine several reports about the legal decision. They came to my attention by chance, in unsolicited email messages or through my haphazard perusal of daily news media.

My experience with the police officer might not meet the standards evident in Erik Erikson's discussions of "the event" in Gandhi's life. I cannot claim that my encounter constituted a fateful turn in my life course. Or a fork at which I worried about the path I had been forced onto. However, I have mulled over that soundless, fleeting interaction with my officer on numerous occasions. I know its indelibility, its singularity, and its invisibility. There were no cell phones present to record it for the future. I have used the memory in sifting the chaff from the wheat in the discourse surrounding *Chauvin*.

I was driving along a narrow city street on the Yale University campus when I spotted a Black colleague I had not seen in a long time. I parked the

car in the open space next to a fire hydrant and invited him to chat. I kept the car running to make it obvious that I could easily move if asked to do so. We were both dressed in jacket and tie and calmly minding our own business in the middle of the day.

After a few minutes, a uniformed white police officer approached from behind, on the driver's side. Seeing him, I lowered the window. He gave me a summons for parking there, said nothing, and walked back to his own vehicle. My friend and I simultaneously asked why he had not just ordered us to move or at least said something that recognized his official act. We then considered the option of complaining and decided to avoid any further interaction with this officer. We felt he was unfriendly and seeking some sort of confrontation. Since we were Black and outnumbered him, we thought he might try to escalate things and get us all into an unnecessary struggle. We felt it would be silly to turn the joy of our mini reunion into something we might regret for a long time. We said goodbye to each other, and I drove off.

We have rediscussed this circumstance several times over the passing months, pleased that we returned home safe that day. The officer could

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APA Reports Results of Member Survey on MOC

Respondents who participated in an APA survey on maintenance of certification (MOC) reflected deep dissatisfaction with the process as well as an appreciation of the value of continuing medical education. **BY MARK MORAN**

An APA survey about members' attitudes toward maintenance of certification (MOC) reflects members' endorsement of continuing medical education (CME) and lifelong learning—as well as deep dissatisfaction with the time, expense, and perceived irrelevance of other components of MOC required by the American Board of Psychiatry and Neurology (ABPN).

For instance, 63% of respondents agreed with the statement, “The Continuing Medical Education (CME) component of the MOC process is relevant to my practice.” Yet only 39% agreed that the “self-assessment component of MOC is relevant to my practice,” and just 16% said that the Part IV Improvement in Medical Practice component is relevant to practice.

“Maintenance of certification is a contentious issue for physicians of all disciplines, and many of our members believe aspects of the ABPN program are onerous, expensive, and not relevant to their practice,” said immediate past APA President Jeffrey Geller, M.D., M.P.H. “Our survey of more than 1,400 members who are participating in the MOC process confirms this impression. It also shows that a sizeable number of psychiatrists believe in the importance of ongoing education.

“APA has been and will continue to be actively engaged with the ABPN to reform the process of maintenance of certification to make it more meaningful and useful to members, to enhance those aspects of MOC that psychiatrists find valu-

able, and to alter or eliminate altogether those aspects that don't work,” Geller said.

APA randomly selected 4,999 ABPN-certified members and invited them to complete the survey; 2,153 members responded. The data in the survey report are confined to the 1,446 of the respondents who are currently participating in MOC.

“This approach allowed us to be sure we were soliciting the perspective

evenly spread out among the district branches in APA's seven Areas, with Area 5 having the highest percentage of respondents (26.96%).

Beliefs about the value of MOC were mixed. While 41% agreed or strongly agreed with the statement that “MOC helps me keep up to date with current information,” 38% disagreed or strongly disagreed. But just 21% agreed with the statement that MOC “improves patients' confidence in their physicians”; 56% disagreed or strongly disagreed.

The impact of MOC on career and professional status was likewise mixed:

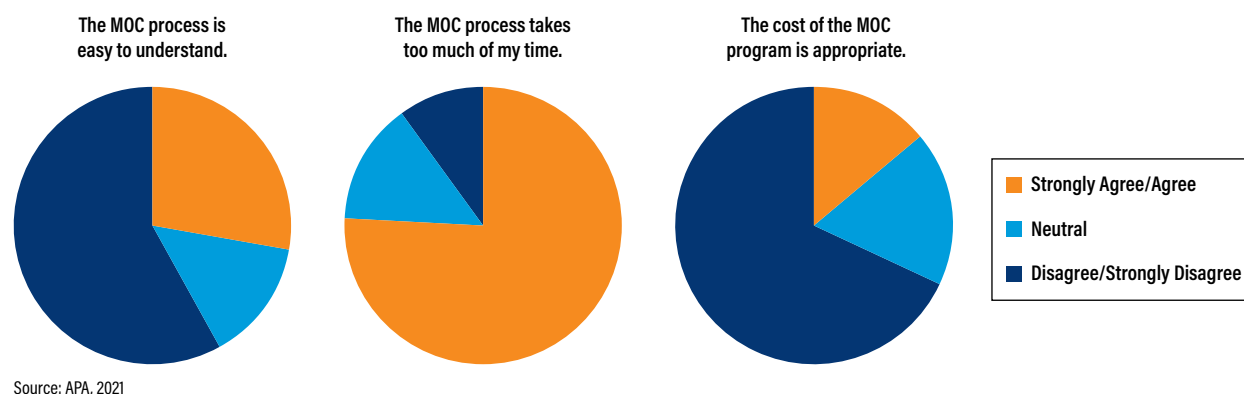
- 36% said that participation in MOC is required by one or more insurance panels.

The most widely shared beliefs were about the time and expense of the ABPN process. A total of 76% of respondents participating in MOC said it “takes up too much time,” while 68% strongly disagreed with the statement “The cost of the MOC program is appropriate.”

However, the new journal-based alternative to the 10-year knowledge exam is highly popular: 89% of respondents said they favor it over the 10-year exam (*Psychiatric News*, <https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2020.11a16>).

APA Members Weigh In on MOC

A total of 2,153 APA members responded to a survey regarding Maintenance of Certification (MOC). Of those respondents, 1,446 are currently participating in MOC. The data below reflect their responses.



of those most impacted by MOC and at the same time hearing from a representative sample of members,” said Tristan Gorrindo, M.D., director of the APA Division of Education.

Of the 1,446 respondents, 48% were women; 30.36% were within 10 years of graduation from medical school, and 60.72% were 10 to 30 years from graduation. Respondents were roughly

- 46% said that participation in MOC is required for ongoing employment; 54% said it is not.
- 39% said that participation in MOC affects career advancement; 61% disagreed.
- 21% said participation in MOC affects salary or bonuses.

“Among those participating in MOC, these data show us that it's not a simple ‘MOC is all good or all bad’ story,” said Gorrindo. “Many psychiatrists are unhappy with MOC, but there are also many who find value in some parts of the MOC process. The impact of MOC on an individual's employment, ability to participate in MOC, and financial compensation is also highly variable. This underscores APA's need for a thoughtful and nuanced approach to MOC-related issues.”

Ranga Ram, M.D., chair of APA's Caucus on MOC, highlighted the finding about the link between MOC and ongoing employment. “Forty-six percent said MOC is required for employment, which I see as something APA needs to fight,” Ram said. “In every state, we need model legislation that [prohibits requiring MOC as a condition of employment].”

(APA has official policy opposing use of MOC as a condition of licensure.)

Earlier this year, the Board of Trustees approved a study on the feasibility of APA's creating its own certification process, something Ram said the caucus strongly supports (*Psychiatric News*, <https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2021.5.24>). **PN**

Comments Invited on ABMS's Draft Standards for MOC

The American Board of Medical Specialties (ABMS) in April released new draft Standards for Board Continuing Certification. These standards will shape the maintenance of certification (MOC) programs for all ABMS boards, including the American Board of Psychiatry and Neurology, for years to come.

APA is conducting a thorough analysis regarding how the revised MOC standards will impact physicians' ability to practice medicine and care for patients. Once the analysis is done, *Psychiatric News* will provide details in an article posted at psychnews.org.

“APA members have sent a consistent message that they want a lifelong learning and continuing certification process that is less burdensome, less expensive, and more relevant to their clinical practice,” APA CEO and Medical Director Saul Levin, M.D., M.P.A., told *Psychiatric News*. “The new standards have the potential to impact all parts of the ABPN's maintenance of certification program

and will directly impact all psychiatrists who are currently board certified. Our Division of Education and our advocacy staff will review the standards closely for how they will affect members immediately and in the future.”

APA encourages all members to review the new standards and submit comments directly to the ABMS regarding how the revised MOC standards will impact physicians' ability to practice medicine and care for patients. APA is also encouraging members to submit their comments to APA at MOCfeedback@psych.org.

“It is imperative that we make our voices heard during the public comment period,” Levin said.

The deadline to submit comments is Thursday, July 8, at 11:59 p.m. ET.

The ABMS draft standards are posted at <https://www.abms.org/wp-content/uploads/2021/04/Standards-April-2021-public-comment.pdf>.



As Pandemic Winds Down, Who Are We Now?

Emerging from an extraordinary global experience of pandemic, we have all been changed. Exactly how we have changed may take some time to realize. **BY GLEN O. GABBARD, M.D.**

The COVID-19 pandemic has changed us all. As we begin to emerge from this nightmare, many of us are out of touch with members of our families and old friends. Most of us have spent more time in our homes this past year, searching for something to watch on television, looking out the window to see if the sky has changed, or reading a book or an article only to find out that our attention span isn't as reliable as it used to be. Spending so much time at home often feels like solitary confinement. In a cruel twist of fate, the opposite is equally challenging: Being crammed into a finite space with too many family members can try the patience of all parties concerned. Conflict is inevitable in such situations, and physical and emotional altercations can erupt.

Waistlines may be bulging because



Glen O. Gabbard, M.D., is a clinical professor of psychiatry at Baylor College of Medicine and the author or editor of 29 books, including *Psychodynamic Psychiatry in Clinical*

Practice: Fifth Edition; Long-Term Psychodynamic Psychotherapy: A Basic Text; and Narcissism and Its Discontents.

of the frequency with which the refrigerator and the liquor cabinet are opened. A growth of beard may be present because there is not much need to shave. We are also aware of anxiety and depression creeping into our consciousness. Indeed, from August to February, these two conditions ballooned up to a sobering level: 2 in 5 adults met criteria for depression or anxiety.

The notion that time is our master has a long history in our discourse. But during the pandemic the phrase has taken on new meaning. Those in the mental health field, of course, have always placed an emphasis on time. Indeed, our days have traditionally been structured by the ticks on the clock. But now time seems to have taken a holiday. When we glance at the grandfather clock, it seems to have paused. Father Time himself seems to have become capricious in some way. In fact, it is hard for us to tell the difference between Tuesday and Saturday. Reality and truth seemed to have changed.

Alas, all of us have not become demented. Neuroscience teaches us that there are executive functions like focusing, planning, and abstract thinking that are impaired under the influence of stress. The prefrontal cortex is more or less out of commission, so both patients and clinicians may feel sluggish and doubt their reasoning in the midst of a clinical session.

Perhaps it is time to reconsider who we are now. The task is a formidable one because we aren't the best judges of ourselves. Moreover, we aren't all the same. The impact of the pandemic varies from person to person. Some like the peace and quiet of reading a book or watching segments of a Netflix series into the fifth season as the hours drag on. Others *loathe* the prospect of being stuck at home. Some love the freedom of having no social obligations and no fancy dinners to fuss over. Many yearn for some time with the grandchildren, while others are grateful for peace and quiet.

One thing is for sure: We won't be going "back to normal." As the title of this piece implies, we aren't sure who we are at this point. "Normal" must be re-defined. None of us knows how all this will settle out. I think it's fair to say, however, that we can assume that it will never be quite the same. The shift to virtual meetings has been a necessity. They are less expensive, more convenient, and safer, and you can turn off your video if you don't like what you are seeing. However, we may be losing the old familiar chats in the hallways or dinners with our friends that made a sometimes exhausting and overwhelming professional meeting a rewarding experience. Seeing our colleagues on a Zoom screen is just not the same as chatting with them over a good meal.

In any case, whatever it is we are going through won't ever be truly "over." There will be some form of transition that each of us will experience differently. It won't be easy to generalize what exactly is happening, but common sense suggests that things rarely go backward in time.

Maybe the best answer to the question "Who are we now?" is a straightforward one: "We're not sure yet." **PN**

Nominations Sought to Reflect APA's Diverse Membership



My presidential year saw a time of great change and reckoning for APA and psychiatry. I am proud of what we did as an organization and in confronting issues like structural racism head-on. As part of that, the Board of Trustees worked hard to begin to ensure that at every

level, APA became a more welcoming place for everyone. One of the factors that made our response and our organization stronger was having diverse voices on the Board.

Members of the Board of Trustees make the important decisions that ultimately steer the organization and have a real-life impact on patients. I therefore would like to encourage anyone with the passion to serve to run for office this year, particularly those from minority

and underrepresented groups. If you are ready to help lead, please run.

These are the Board of Trustee offices in APA's 2022 election: president-elect, treasurer, trustee-at-large, Area 3 and 6 trustees, and resident-fellow member trustee-elect. **You may nominate yourself or a colleague**—the important point is that you get involved. The deadline is **Wednesday, September 1.**

It was an honor to serve you this past year as APA president. I hope you will consider this opportunity—for me, working with my colleagues on the Board was an experience for which I am truly grateful.

To submit nominations, please use the form posted at psychiatry.org/election. Thank you.

Jeffrey Geller, M.D., M.P.H.

Immediate Past President of APA (2021-2022)
Chairperson, Nominating Committee (2021-2022)

Record Number of Anti-Trans Bills Filed in States This Year

APA has expressed firm opposition to bills that would criminalize physicians for providing gender-affirming care to transgender and gender diverse patients—care that many psychiatrists argue is lifesaving. **BY KATIE O'CONNOR**

Grant Allen, M.D., a pediatrician in Florence, Ala., had a patient who made it clear at the age of 2 that she knew she was a girl. Since then, she has received counseling and support from her medical team. As she's gotten older and progressed through school, she's done very well, Allen said, especially with managing her anxiety, which transgender patients commonly experience.

But the week Alabama's legislature began discussing a bill that would make it a felony for her doctors to care for her, Allen's patient had a 14-hour psychotic event.

"This legislation does real harm to real people who already feel isolated," Allen said. "They feel they're on the margins of society, and there are so few places where they feel supported. Taking away their medical care is going beyond backwards."

Allen's patient is just one of many whose lives could be upended by legislation filed in many states. According to the Human Rights Campaign, there have been more than 250 anti-transgender bills—a record number—filed in more than 20 states this year. Some criminalize physicians for providing gender-affirming care, such as in Alabama, while others prohibit trans youth from participating in sports teams or accessing restrooms that align with their gender identities.

While the bills hold many similarities, some stand out. Bills filed in Texas's House and Senate would change the definition of child abuse to include providing gender-affirming care and would apply to anyone involved in providing such care, including parents and guardians. In North Carolina, a bill would require state employees to notify parents or guardians in writing if their child displayed "gender nonconformity, or otherwise demonstrates a desire to be treated in a manner incongruent with the minor's sex."

"This state-sanctioned prejudice

communicates a clear hostility to patients, many of whom have already experienced this hostility from family, friends, and beyond," said Jacob Lee, M.D., a PGY-3 psychiatry resident at the University of Missouri-Kansas City and executive board member of the Missouri Psychiatric Physicians Association. In Missouri, multiple anti-transgender bills have been filed this year, and Lee provided testimony against a bill that would prohibit physicians from administering any medical or surgical treatment for the purpose of gender reassignment to patients under 18. He testified against similar legislation last year.

The concerns over the anti-transgender bills have left many organizations, including APA, adamantly expressing their opposition.

"We recognize health as a basic human right for every person, regardless of gender identity or sexual orientation," stated a news release issued by APA and its five partner organizations, collectively known as the Group of Six. "Patients and their physicians, not policymakers, should be the ones to make decisions together about what care is best for them."

Setting a Dangerous Precedent

Across the country, anti-transgender bills are being met with varying levels of success. In some states, they linger in committees, unlikely to be taken up before the state's legislative session ends. But in others, they are creeping through the legislature or have already passed.

In Arkansas, Gov. Asa Hutchinson, a Republican, vetoed the Save Adolescents From Experimentation (SAFE) Act, which prohibits health



Decision-making in medicine is nuanced and involves more than all-encompassing rules, says Lindsey Wilbanks, M.D. Legislation should reflect the fact that medicine is not one-size-fits-all.

During a press briefing, Hutchinson said the SAFE Act represents "government overreach." He continued: "The state should not presume to jump into every ethical health decision."

Lindsey Wilbanks, M.D., a forensic psychiatrist and the legislative representative with the Arkansas Psychiatric Society, wrote a letter urging Hutchinson to oppose the SAFE Act. It concerns Wilbanks for numerous reasons, she told *Psychiatric News*, including the impact it will have on transgender youth, who already have a high risk of mental illness and suicide. Further, one of the most concerning aspects is the dangerous precedent the law sets.

"This is a step in the wrong direction," she said. "Decisions in medicine should be made between patients and their doctors, as well as their parents or guardians [for youth] under 18." Questions of whether physicians are providing appropriate care to their patients are for the Arkansas State Medical Board to answer, not the legislature, she said.



In Alabama, the legislation approaches clinical care as though clinicians are using sledgehammers to fit a square peg into a round hole, says Paul O'Leary, M.D.

Harming the Therapeutic Alliance

In Alabama, a bill titled the Vulnerable Child Compassion and Protection Act would prohibit health care professionals from providing gender-affirming treatment. The Alabama Psychiatric Physicians Association opposes the bill, noting in its monthly newsletter that patients who have gender dysphoria and no support have a higher risk for suicidal ideation and that, while the government serves a valuable role in protecting public health, it should not interfere with the patient-physician relationship.

The therapeutic alliance between a patient and physician is extremely important, explained Paul O'Leary, M.D., chair of the APA Assembly Nominating and Rules committees, a clinical assistant professor at the University of Alabama at Birmingham, and president of the Birmingham Psychiatric Society. "If you want patients to do better, you have to create a therapeutic alliance with them so they trust that you have their best interests at heart," he said. "Whenever you put up barriers to addressing what's at the root of the distress, you impact the alliance and that patient's care."

O'Leary and Heather Austin, Ph.D., president of the Alabama Psychological Association, which also opposes the bill, said the legislation represents a basic misunderstanding of how clinical decisions are made and, specifically, how transgender youth are treated.

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"Finding Our Voice" brings the viewpoints and opinions of the next generation of psychiatrists—including residents, fellows, and early career psychiatrists—to the forefront. Host Sanya Virani, M.D., M.P.H., leads discussions with guests who offer fresh perspectives on difficult issues by sharing their own stories and patient experiences. Dr. Virani is APA's resident-fellow trustee, a PGY-6 forensic psychiatry fellow at Brown University's Alpert School of Medicine, and a Laughlin Fellow of the American College of Psychiatrists. You can listen on major podcast services or at <https://psychiatryonline.org/finding-our-voice>.

care professionals from providing gender-affirming treatment, such as hormone therapy and puberty-blocking medications or referring patients to other physicians for gender-affirming services. It even applies to patients who have already started such treatments. The veto, however, was overturned by the state's legislature, and the bill was enacted on April 13. The American Civil Liberties Union announced in a statement that it plans to challenge the law in court.

**This was the last story for which Paul O'Leary, M.D., provided an interview for Psychiatric News before he passed away on May 12. APA will sincerely miss Dr. O'Leary, who was a passionate advocate for his patients and the field of psychiatry.*

continued from facing page

"At its core, this is a human rights issue," Austin said. "Our youth today think of gender as a more fluid construct than we did when we were younger, and that has to be respected and appreciated."

Legislation Would Remove Lifeline

In July 2020, APA issued a position statement on the treatment of transgender and gender-diverse youth. In the statement, APA expressed its support of gender-affirming and supportive treatment, including appropriate mental health services, and opposed "all legislative and other governmental attempts to limit access to these services for trans and gender-diverse youth."

With the swell of anti-transgender legislation this year, Evan Eyler, M.D., who was the principal author of APA's position statement, said he worries about the mental health of trans youth. "Many adolescents who are trans refer to puberty-blocking medications as a lifeline, and that can be literally true," Eyler told *Psychiatric News* in an email. Eyler is a professor of psychiatry at the Robert Larner, M.D., College of Medicine at the University of Vermont and has done clinical work with people who are trans or gender nonconforming for over 25 years.

Bills that would prohibit trans youth from playing on sports teams that align with their gender identities are yet another means of making life difficult for transgender youth, Eyler pointed out. Such bills have been filed all over the country and so far have passed this year in Arkansas, Tennessee, and Mississippi. There are numerous resources available that address concerns regarding gender identity and athletics, and the National Collegiate Athletic Association has policies regarding the participation of trans athletes, Eyler said. "This has already been studied extensively, and reasonable policies have been developed," he said.

The anti-transgender legislation sends a chilling message to transgender youth, Eyler said. "The message of these bills is, essentially, 'You shouldn't be who you are' or 'Being trans is so unacceptable that we need to pass laws against you,'" he continued. "This is another enormous psychological burden added to an already vulnerable group of youth." **PN**

The Group of Six news release is posted at <http://www.groupofsix.org/content/dam/AAFP/documents/advocacy/prevention/equality/ST-G6-FrontlinePhysiciansOpposeLegislationThatInterferesInOrPenalizesPatientCare-040221.pdf>. APA's position statement on the treatment of transgender and gender-diverse youth is posted at <https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Position-Transgender-Gender-Diverse-Youth.pdf>.

Briefing Emphasizes Transformative Power Of Crisis Services on Mental Health Care

Matthew Goldman, M.D., M.S., told members of Congress that crisis services have a wealth of research behind them, showing that they provide high-quality care in less-expensive and less-restrictive environments. BY KATIE O'CONNOR

For the past five years, Matthew Goldman, M.D., M.S., has worked with mobile crisis teams, seeing firsthand the benefits of treating patients in their homes. "They say a picture's worth a thousand words, but a field visit to somebody's home is worth a million," he said. "The patients are in their own safe, comfortable environments, and they might have the support systems they need right there in the room with us. It's such a different experience compared with being in a white-washed, fluorescent emergency department, waiting for hours to be seen."

Goldman is a member of APA's Council on Advocacy and Government Relations and the medical director of the San Francisco Department of Public Health's Comprehensive Crisis Services. He spoke during a congressional briefing titled "Mental Health Is Not a Crime: How 988 and Crisis Services Will Transform Care."

The briefing was one of a series hosted by the Mental Health & Suicide Prevention National Response to COVID-19, an initiative of the National Action Alliance for Suicide Prevention, of which APA is a partner. The initiative is working to create comprehensive solutions to the pandemic's impact on psychiatric health, according to the website <https://nationalmentalhealthresponse.org/our-partners>.

In addition to Goldman, the speakers included Murphy Paul Jr., the chief of police of the Baton Rouge Police Department; Richard McKeon, Ph.D., chief of the Suicide Prevention Branch at the Substance Abuse and Mental Health Services Administration (SAMHSA); Tonja Myles, a peer support

specialist with Set Free Indeed ministries; and Ron Bruno, executive director of CIT International.

During his talk, Goldman described the data that illustrate the need for mental health crisis care services. Only 50% of adults with suicidal ideation, plans, or attempts report any contact with any mental health service in the previous year, he said. He also detailed the disparities that are revealed in the data. In Maryland, for example, suicides during the COVID-19 pandemic declined by half in the White population but doubled among the Black population.

He also outlined research backing up the efficacy of many of those services. Services such as crisis call centers, mobile crisis teams, crisis facilities (like acute residential or peer-staffed crisis respite units), and post-crisis wraparound have been proven in numerous studies to provide a host of benefits, including decreased suicidality, emergency department (ED) costs, and hospitalization.

He summarized current research including a study he and his colleagues are conducting in Arizona, which he cited as a national leader in crisis services. Using Medicaid claims data, he and his colleagues looked at a one-year sample from 2017-2018 to determine if a mobile crisis, crisis facility, ED, or inpatient service was followed by a higher intensity service within 72 hours. They found that among 126,000 cases of people experiencing a mental health crisis, 41% remained in crisis-only settings (mobile crisis or crisis facility) without needing higher level care. Further, about half of crisis episodes in which a mobile crisis team was



"The research highlights that crisis services are very well positioned to advance better quality care, equity, lower costs, person-centered care, and less-restrictive environments," says Matthew Goldman, M.D., M.S.

involved were not followed by the use of acute mental health services within 72 hours, likely meaning the crisis was resolved in the field.

The findings highlight that a system that has a lot of crisis components built out can effectively maintain patients in settings that are lower cost, involve shorter stays, and are less restrictive, he said.

Communities in America are experiencing trauma, Paul explained. Incidents such as the murder of George Floyd and the COVID-19 pandemic have exacerbated existing suffering and distress in communities across the country. "We know, as law enforcement leaders, we cannot arrest our way out of this problem, and we cannot do it alone," Paul said. "The mental health crisis we're facing is real in America—it's very real. And this requires us to rethink how we approach calls for services involving people experiencing a mental health crisis."

The participants also spoke about the implementation of the new mental health crisis phone number, 988. It will be available nationally by July 2022 and represents an opportunity to build a strong, comprehensive system for mental health crisis care, particularly when combined with other services such as mobile crisis units and crisis facilities.

"For the past half century, 911 has become a system that people rely on all across the country," McKeon said, and 988 may eventually be viewed in exactly the same way. **PN**

The briefing can be viewed at <https://theactionalliance.org/events/national-response-congressional-briefing-series-mental-health-not-crime-how-988-and-crisis>.

APA Members Invited to Apply for Component Appointments

APA's many accomplishments are made possible through the generosity of its members' time, energy, and expertise. APA President-elect Rebecca W. Brendel, M.D., J.D., invites APA voting members to indicate their interest in serving on APA components. Members who are willing to share their expertise and make a significant time commitment to serve APA, the field of psychiatry, and patients are asked to submit their names or nominate a colleague. She seeks APA members who represent the varied demographics of APA's member and patient populations. To submit a nomination through the online nomination form, please visit <https://survey.alchemer.com/s3/5530716/Nomination-Form>. All appointments begin on May 25, 2022.

The deadline to submit nominations is **Tuesday, August 31**. Please email questions to appointments@psych.org.



SAMHSA Minority Fellow Pursues Dream To Level Playing Field for Disadvantaged Youth

A young psychiatrist's goal to help youth impacted by inequities led him to a career in child psychiatry and involvement in advocacy. This article is part of a series by APA's Council on Advocacy and Government Relations. BY ERIC WHITNEY, M.D., M.S.ED.

My first dream job was to be a public defender. As a junior in college, I took a course on capital punishment, based on the professor's pro bono work in Alabama and Texas. Inspired, I spent the next summer as a paralegal at the San Francisco Public Defender's Office. I was motivated by the knowledge that many of my clients' legal experiences were the result of their skin color or their lack of means. Every day in jail and in court, I saw firsthand how our country's most powerful institutions reflect and reinforce racial and class inequities.

Convinced that I could effect greater change through education, I joined Teach for America and taught for two years in Bedford-Stuyvesant, Brooklyn. Once again, I was driven by the disparities in my students' opportunities compared with their peers' in whiter and wealthier neighborhoods. Still, I

was frustrated by how ill equipped I felt to address my students' most serious challenges. I did not have the training to properly assess or treat attention-deficit/hyperactivity disorder, depression, or trauma. Though I loved teaching, I decided to become a child psychiatrist to acquire broader and deeper skills to support children's long-term success and to build better systems for those most in need.

Nine years later, I have a new dream job, one that unites the threads of my professional goals. As an NYU resident, I have had the opportunity to collaborate with the Bellevue Juvenile Justice Mental Health Service (BJJMHS), which provides psychiatric care to all New York City youth remanded to juvenile detention. The BJJMHS has implemented an innovative, trauma-informed treatment and training model with impressive results. With the sup-



on Advocacy of Government Relations.

Eric Whitney, M.D., M.S.ED., is a PGY-3 psychiatry resident at the NYU Grossman School of Medicine, an APA/APAF SAMHSA Minority Fellow, and a fellow on APA's Council

port of an APA/APAF SAMHSA Minority Fellowship, I have been able to develop an independent project comparing the diagnoses and treatment of youth before and after assessment by the BJJMHS. This has enabled me to contribute to a larger movement that demands that children in detention facilities get the high-quality, evidence-based mental health care they deserve. Moreover, it is the first step toward beginning my own career in the juvenile justice system.

Beyond financial support, my fellowship has helped me grow even further as an advocate. Whereas I once may have felt that to work in the courtroom, the classroom, or the hospital was enough,

the events of the past year have me wholly convinced that to be a public psychiatrist in the 21st century means to pursue substantive change in our society both inside and outside the systems in which we are employed. To successfully enact such change requires us to use our platform as physicians to engage directly with government.

As a fellow, I have had the privilege of serving on APA's Council on Advocacy and Government Relations, where I've learned how to develop relationships with lawmakers from experienced physician advocates and APA staff. I have also discovered the APA programs that support this work, such as APAPAC (the APA political action committee) and the Congressional Advocacy Network. Moving forward, I hope to use my experiences and skills to encourage my fellow psychiatrists to advocate for our patients not just in the clinic or hospital, but also in City Hall, in the State house, and on Capitol Hill. **PN**

More information about the APA/APAF Minority Fellowships is posted at http://apapsy.ch/SAMHSA_Minority_Fellowship. APA members who want to learn more about APA's advocacy programs and become involved should go to <https://www.psychiatry.org/psychiatrists/advocacy>.



APA'S GOVERNMENT, POLICY, AND ADVOCACY UPDATE

APA Provides Congress With Testimony On MH Parity, Telehealth

APA provided testimony to the House of Representatives' Health, Employment, Labor, and Pensions (HELP) Subcommittee for its hearing, "Meeting the Moment: Improving Access to Behavioral and Mental Health Care." Witnesses during the hearing discussed network adequacy; enforcement of mental health parity; and last year's mental health parity legislation, which APA helped enact.

In written testimony, APA emphasized the importance of ensuring equitable access to mental health and substance use disorder (SUD) treatment. APA applauded the inclusion of new parity compliance requirements for health insurers in last year's appropriations package and recommended additional funding so states and federal agencies have the resources necessary to ensure health plans are in compliance with the law.

The testimony also outlined data related to health disparities. "[W]e cannot begin to improve our country's overall mental health without concurrently addressing health disparities," the testimony stated. APA urged Congress to investigate opportunities to recruit and retain more Black, Indigenous, and People of Color into health care to improve access to culturally competent care and to invest in community-based support systems to help communities address social determinants of health.

APA similarly provided testimony to the House Ways and Means Committee for its hearing, "Charting the Path Forward on Telehealth." The testimony explained how telehealth flexibilities allowed during the COVID-19 public health emergency enabled large numbers of people to access care.

"APA agrees that telehealth should not replace in-person services; it should amplify and enhance access to needed services when clinically appropriate," the testimony stated. "We encourage Congress to extend the current telehealth flexibilities beyond the current public health emergency to avoid an abrupt halt and disruption to the access and delivery of mental health and SUD services via telehealth."

Senate Passes COVID-19 Hate Crimes Act

APA-supported legislation addressing the rise of hate crimes and violence toward Asian Americans and Pacific Islanders during the COVID-19 pandemic passed the Senate in late April.

Sponsored by Sen. Mazie Hirono (D-Hawaii), the legislation would assign a designated Department of Justice employee to facilitate the review of hate crimes; require the department to issue guidance to state, local, and tribal law enforcement agencies to establish online hate crime reporting processes; and establish grants for states to create reporting hotlines for hate crimes.

Group of Six Praises Investment In Gun Violence Interventions

APA and its five partner organizations, collectively known as the Group of Six, issued a news release praising the recent Biden administration's announcement of actions it will take to address gun violence. "Gun violence is a public health epidemic, and recent mass shootings around the country, along with other sources of firearm violence and injury, underscore that this remains a serious issue," the release stated.

The Biden administration announced six initial actions to address gun violence, such as investing in evidence-based community violence interventions, publishing model red flag legislation (which allows family members or law enforcement to petition courts to bar people in crisis from accessing firearms) for states, and requiring the Department of Justice to issue an annual report on firearms trafficking.

"The administration's commitment to investing in programs and resources at the local level for violence intervention is a welcome first step to help provide for healthy and safe communities," the release stated. It further urged legislative action to comprehensively address the gun violence epidemic.

APA Develops Quality Measures To Advance Measurement-Based Care

In 2018, the Centers for Medicare and Medicaid Services announced that APA was awarded funding to develop a suite of measures aimed at promoting and advancing measurement-based care (MBC). The set includes a measure assessing adherence to MBC processes, outcome measures based on patient-reported assessments of function and recovery, and measures assessing suicide safety planning processes and outcomes. The measures were recently posted for public comment, and submitted comments were reviewed by the project's Technical Expert and Consumer and Family panels. More information is posted at <https://www.psychiatry.org/psychiatrists/practice/quality-improvement/measure-development>.

How to Incorporate Anti-Racism Into Psychiatric Practice

Psychiatrists share suggestions about how to center racial equity and adopt anti-racist practices both within and outside of clinical practice. **BY KATIE O'CONNOR**

Equity, and the fight for it, is a concept with which all psychiatrists are intimately familiar, said Michael Mensah, M.D., M.P.H. "Psychiatry has been marginalized as a specialty in medicine, and psychiatrists have been pushing for mental health equity for their patients for a very long time," said Mensah. He is APA's immediate past resident-fellow member trustee and a PGY-4 psychiatry resident and co-chief of the residency program at the Semel Institute of Neuroscience of the University of California, Los Angeles.

Yet, psychiatrists haven't routinely talked about equity in the most urgent and important sense, Mensah said: racial equity. "Patients who have mental illness who are Black or Brown end up being even more marginalized than they may otherwise be," he said. "A lot of patients are suffering, and if we want to be the psychiatrists we say we are, we need to center racial equity."

It is not possible to be a passive observer within a racist system, or to simply declare oneself "not racist," said Rahn Bailey, M.D., APA's minority/underrepresented trustee, the assistant dean of clinical education at the Charles Drew University School of Medicine, and chief medical officer of the Kedren Community Health Systems in Los Angeles. To eradicate racism, in all its forms, everyone must embrace the concept of anti-racism. Anti-racism is proactive and assertive, he said. "It is taking an active stance against racism in every facet of your life and career."

Mensah, Ruth Shim, M.D., M.P.H., and Lucy Ogbu-Nwobodo, M.D., M.S., wrote a report published January 12 in *Psychiatric Services* explaining that all

policies and actions have consequences for racial equity. "By centering racial equity as the standard of anti-racism, the responsibility to pursue anti-racist action is not only applicable to individuals but also scalable to mental health institutions," they wrote.

The authors listed some of the steps necessary for mental health professionals to center racial equity: increase awareness and acknowledge that racism exists everywhere, take an honest individual and institutional inventory, and apply a racial equity lens to mental health advocacy. Shim is the Luke and Grace Kim Professor in Cultural Psychiatry and a professor in the Department of Psychiatry and Behavioral Sciences at the University of Cal-



Michael Mensah, M.D., M.P.H., encourages his colleagues to rely on the resources available to them in their efforts to incorporate anti-racism into their practices. Such resources include fellow psychiatrists, district branches, and APA's staff.



Psychiatrists must adopt anti-racist attitudes both within and outside of their clinical work, says Rahn Bailey, M.D. "An anti-racist agenda is one that is comprehensive and touches all aspects of our lives, and patients can see that."

ifornia, Davis, and the co-author of *Social (In)Justice and Mental Health* from APA Publishing. Ogbu-Nwobodo is an APA/APAF SAMHSA Minority Fellow and PGY-3 psychiatry resident and incoming Massachusetts General Hospital administrative chief resident at the Harvard Massachusetts General Hospital/McLean Psychiatry Program.

"In medicine, we sometimes think that racial equity is not in our lane or our issue to tackle," Ogbu-Nwobodo said. "But unless we all think of it as our duty as physicians to address these issues, they're never going to be tackled. We all need to roll up our sleeves and get into the discomfort of this work."

Acknowledging Racism and Sitting With the Discomfort

The first step to centering racial equity is starting the process of self-re-

flection and self-education, Ogbu-Nwobodo said. "It's being willing to take an honest inventory of yourself, your role, and who you are in society," she continued. "Acknowledge your privilege and the areas in your life where you can do better."

"If you look for racism, you'll find it everywhere. It's like looking at the world through a new pair of glasses and realizing how impaired your vision has been all along," said Jessica Isom, M.D., M.P.H., a psychiatrist at Codman Square Health Center and a voluntary faculty member at Yale School of Medicine. Isom emphasized that building awareness of racism is a skill that individuals must hone over time by committing themselves to doing so. "You have to make it a habit to see the world through this lens and learn to address it, especially when you're working with patients."

Ogbu-Nwobodo stressed that practicing anti-racism does not mean pointing moral blame or shame at some people. "There's no utility in that," she said. But she also emphasized that this work is not easy. "There's nothing easy about dismantling a white supremacist system that has been set up to reinforce and boost some of our White colleagues," she said. "It won't feel good to try and dismantle a system that has been in place to protect you for so long."

Acknowledging racism's role both individually and within the field of psychiatry can lead to vastly better outcomes for patients. In their *Psychiatric Services* article, Mensah, Ogbu-Nwobodo, and Shim pointed out that "the false, racist narratives that exist about Black dangerousness and hostility" might skew the risk assessments that inform whether a patient requires seclusion or restraint. "Clinicians who are aware of the existence of racism will acknowledge that a lower threshold exists for seclusion and restraint for Black patients than for White patients," the authors wrote.

Similarly, Ayala Danzig, M.D., M.S.W., pointed out that diagnoses within psychiatry are not equally distributed among populations. "Black males are more likely to be diagnosed with schizophrenia than White males with similar symptoms," said Danzig, a fourth-year resident in the Yale University Department of Psychiatry, chair of the Assembly Committee of Resident-Fellow Members, and the Assembly's Area 1 resident-fellow member representative. She regularly audits her own panel of patients, for example, to see if she is disproportionately diagnosing her Black patients with psychotic illnesses or if she's prescrib-

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Taking a Trauma-Informed Approach to Anti-Racism Conversations

At the end of 2020, Jessica Isom, M.D., M.P.H., published an essay on the website "Medium" titled "When Anti-Racism Becomes Trauma." In it, she described her personal experiences having conversations about racism and anti-racism via Zoom, especially over the past year. She noted how, at one such meeting, a White woman asked her to share her personal experiences with racism. "Her curiosity compelled my mouth to open before my brain could even register the warning signals," Isom wrote.

Isom's article urges a trauma-informed approach to anti-racism. People having those conversations too often pay little attention to the toll such discussions have on the people who experience racism firsthand. "The re-experiencing evoked by lack of preparation in groups discussing racism is shaving years off of my life," she wrote.

"There is a lot of guilt and shame in these spaces," Isom told *Psychiatric News*. "A lot of people having these conversations about anti-racism are just coming into their

own level of racism awareness. That early journey is very self-involved, and people are so internally preoccupied that they don't recognize what's happening for other people in the room. It's not necessarily intentional, but it's still harmful."

In her article, Isom lists "The Four R's of a Trauma-Informed Approach to Anti-Racism," which she adapted from the Substance Abuse and Mental Health Services Administration's trauma-informed care recommendations. These are the four R's: Realize how racial trauma affects families, groups, and individuals, Recognize the signs of trauma, Respond to the trauma that has been witnessed, and Resist the retraumatization of Black, Indigenous, and People of Color.

"Some people are so early in their journeys that they don't understand they might be trampling on other people in the room," Isom said. "I'm not always interested in sharing my personal experiences with you, but I am interested in finding out what you're going to do about it."

Will Telehealth Rules Change After Pandemic? Prepare Now

While it is not yet known whether current telehealth rules will be in effect after the pandemic, it's wise to think ahead in case they are not. BY TRACEY LEMAY, B.S.N., C.P.H.R.M.

Telemedicine has exploded with the COVID-19 global pandemic with changes to state and federal telemedicine requirements. Telemedicine is here to stay: 94% of mental health professionals participating in the COVID-19 Healthcare Coalition survey plan to continue telemedicine after the pandemic.

The Department of Health and Human Services Office for Civil Rights announced in 2020 that it would waive certain HIPAA penalties related to telehealth services during the public health emergency. The federal declaration will likely be extended through the end of 2021; however, state and local governments may return to pre-COVID-19 regulations earlier. Staying current on the regulations and following the most stringent regulations in jurisdictions where both you and the patient are located is essential.

There are bills before Congress supporting continued widespread access to telehealth, but the telehealth landscape remains uncertain. Now is the time to

review the basics of telemedicine and ensure compliance with legal and regulatory requirements post-COVID-19.

Best Practices

• Licensure:

- Providers must be licensed in the state where the patient is physically located at the time of the visit. Ensure that you are aware of the regulations in the state where the patient is located, such as civil commitment and child endangerment reporting.
- Check the Interstate Medical Licensure Compact when applying for a state medical license to specify additional states where you intend to practice. Participating states will issue licenses to physicians who meet eligibility criteria, thus eliminating the need to file multiple license applications.

- **Informed consent:** Prior to initiating telepsychiatry sessions, obtain informed consent from the



Tracey LeMay, B.S.N., C.P.H.R.M., is an assistant vice president in the Risk Management Group of AWAC Services Company, a member company of Allied World. Risk manage-

ment services are provided as an exclusive benefit to insureds of the APA-endorsed American Professional Agency Inc. liability insurance program.

patient. States may have laws requiring verbal or written consent and specific elements for the consent. Include considerations for confidentiality and information security, especially if using approved platforms that are not HIPAA compliant during the public health emergency. Record evidence of the consent in the patient's medical record. At each session, verbally confirm and document consent.

- **Telepsychiatry platforms:** Use a HIPAA-compliant audiovisual platform and confirm that the platform vendor provides a Business Associate Agreement (BAA), ensuring its responsibility to

appropriately safeguard protected health information. Platforms such as FaceTime, Skype, and Messenger, while convenient for some patients and permitted for use during the public health emergency, are not HIPAA compliant.

- **Prescribing:** The Ryan Haight Act has waived in-person evaluation for controlled substances during the public health emergency, but each state may have specific rules and regulations about prescribing through telepsychiatry. The waiver from the Drug Enforcement Administration (DEA) during the public health emergency allows a provider to have only one DEA registration to prescribe controlled substances instead of separate registrations in each state where prescribing.

- **International telepsychiatry:** Before providing telepsychiatry to patients located in another country, be sure you understand and comply with international licensure regulations and prescribing requirements; identify local resources in the event of a mental health emergency; understand the cultural practices of the region; ensure privacy, security, and confidentiality are protected via secure internet; and confirm with your malpractice insurance carrier that coverage extends to international telemedicine.

- **Documentation:** Document the telepsychiatry progress note as if an in-person visit *plus* informed consent, the patient's location, your location, type of equipment used, and other participants in the session and their role. Include the emergency services contact information where the patient is located if needed.

- **Malpractice insurance coverage:** Obtain written confirmation from your professional liability insurance carrier that your policy affords coverage for telepsychiatry services. **PN**

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ing more controlled substances to her White patients.

Psychiatrists must adopt anti-racist attitudes both within and outside of their clinical work, Bailey said. "An anti-racist agenda is one that is comprehensive and touches all aspects of our lives, and patients can see that," he said.

Incorporating Anti-Racism Into Everyday Practice

There are many ways to bring anti-racist values into psychiatric practice, Mensah said. "Ask yourself: What does it look like for you to center anti-racism?" he said. "Does it mean introducing a sliding scale to help patients who can't pay? Does it mean taking more Medicare and Medicaid patients than before? Does it mean taking a more active role in your local residency program to advocate for a more diverse residency class?"

APA is a great resource, Mensah said. Staff can direct psychiatrists to anti-racism advocacy opportunities, and district branches may be able to help identify local anti-racism experts who can offer valuable insights. He encouraged psychiatrists to reach out to other experts to ask for guidance.

Last year, Isom founded Vision for Equity LLC, a consulting company made

up of anti-racism coaches and trainers. She and her team are developing a diagnostic tool that they hope to roll out for individuals and organizations later this year. The tool allows participants to determine where they are on their journey to embracing anti-racism and offers interventions to help them along the way. "It's hugely important to address structural racism, but organizations are made up of individuals," Isom said. "We are all soaked in racism."

The APA Task Force to Address Structural Racism Throughout Psychiatry has curated a list of resources of which psychiatrists can take advantage. Many of APA's councils are also working on resource documents that provide practical suggestions about incorporating anti-racism into clinical practice.

APA's Council on Children, Adolescents, and Their Families, for example, released a resource document that includes advice and instruction on discussing race and racism with patients and their families. It includes questions psychiatrists can ask to start conversations, such as if the patient

has ever felt targeted or negatively treated due to his or her race or if the patient has ever treated someone else unkindly due to race.

Psychiatrists Play Major Role in Goal of Racial Justice

Ogbu-Nwobodo pointed out that, compared with other medical specialists, psychiatrists are uniquely equipped to take on the work of achieving racial equity.

In their article, Ogbu-Nwobodo, Mensah, and Shim explained that the associations between racism and mental health are stronger than those between racism and physical health. Further, psychiatrists have the skills necessary to stand against racism. "We need to leverage that opportunity and take the lead on this," Ogbu-Nwobodo said.

"As a psychiatrist, patients come to me seeking direction and influence so they can feel empowered," Bailey said. "If I don't appreciate the culture in which they live and all the challenges they're facing, I'm much less likely to be effective." **PN**

2 "Racism and Mental Health Equity: History Repeating Itself" is posted at <https://ps.psychiatryonline.org/doi/10.1176/appi.ps.202000755>. "When Anti-Racism Becomes Trauma" is posted at <https://jisomndmph.medium.com/when-antiracism-becomes-trauma-77922b188ebb>. APA's structural racism task force hub, including resources, is posted at <https://www.psychiatry.org/psychiatrists/structural-racism-task-force>. "How Psychiatrists Can Talk to Patients and Families About Race and Racism" is posted at https://www.psychiatry.org/File%20Library/Psychiatrists/Directories/Library-and-Archive/resource_documents/Resource-Documents-2020-How-Psychiatrists-Can-Talk-About-Race-Racism.pdf.

APA Announces New Campaigning Rules For Next Two Elections

The new rules are meant to level the playing field for all candidates for APA office.

APA's Board of Trustees voted at its December 2020 meeting to launch a two-year pilot campaign plan for candidates and their supporters starting with APA's 2022 election. To level the playing field for all candidates, all campaigning is prohibited except through APA-managed activities and other activities as the APA Elections Committee may permit.

The pilot project is part of the Board's efforts to ensure that APA's leadership reflects the diversity of the APA membership and thus includes candidates who are from minority and underrepresented groups. Examining and changing the process were recommended by the APA Presidential Task Force to Address Structural Racism Throughout Psychiatry.

At the beginning of 2021, the Elections Committee, chaired by Justin Schoen, M.D., outlined the new campaigning rules based on feedback from



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past candidates and outside organizations. The approved campaign activities are as follows:

1. Live "Meet the Candidates" webinars will be held during the campaigning period.
 - These one-hour live sessions will be open to all APA members.
 - Sessions will be recorded and posted on the APA election website for viewing by members who are unable to attend.
2. A "special edition" APA election newsletter of candidates' platforms will be emailed to all voting members.
3. *Psychiatric News* will publish the names and photos of the candidates and election details in its December issue.
4. The APA election website will be expanded to serve as a centralized location for all

election and candidate-related information.

To review the new election guidelines in detail, visit the APA election website (www.psychiatry.org/election). Highlights include the following:

- ✓ Campaign emails, phone calls, and letters to members are **not** permitted.
- ✓ Use of any and all APA listservs, including the Member-to-Member listserv, for campaigning is **not** permitted.
- ✓ Endorsement by organizations is **not** permitted. Candidates may submit a list of individual endorsements to be included as part of their information posted on the APA election website.
- ✓ Sanctions for violations are included in the new guidelines.

The Elections Committee appreciates the cooperation of the membership and outside organizations for a smooth election process in 2022 and 2023. If you have any questions, contact the APA Election Office at election@psych.org. **PN**

Advertisement

Do You Care About Human Rights? Make Your Pledge Now

"Chester Pierce's career was exemplary on many fronts. He was an academician and a researcher. He conducted pioneering studies on stress in varying environmental conditions including the extreme climate of Antarctica. He was an expert in early childhood education and contributed immensely to 'Sesame Street.' His intention was to project by a TV series his philosophy and vision for equality and accessibility. All children should be provided with the opportunity to aspire. ... Personally he had a quiet sense of humor, was deeply inspiring, and was an excellent listener."

—Samuel Okpaku, M.D., Ph.D.

President and Founder of the Center for Health, Culture, and Society and a former president of the Black Psychiatrists of America

The APA Foundation (APAF) has launched an endowment campaign for one of APA's most prestigious awards—the Chester M. Pierce Human Rights Award, which recognizes the extraordinary efforts of individuals and organizations to promote the human rights of populations with mental health needs.

The endowment campaign seeks to secure \$100,000 in pledges between April 1 and September 30, with APA/APAF contributing a matching \$50,000 to endow this award in perpetuity. The endowment will cover the costs of the

winner's presenting a lecture at APA's Annual Meeting and receiving a honorarium.

The award was originally established in 1990 as the APA Human Rights Award. It was renamed in 2017 to honor Pierce for his dedication as an innovative researcher on humans in extreme environments; an advocate against disparities, stigma, and discrimination; and as a pioneer and visionary in global mental health.



chiatrists of America, and the following year Pierce and his colleagues confronted the APA Board of Trustees with the need to address racism as a public health issue. He wrote and spoke widely about racism and published dozens of articles on the way Black and White people interacted with each other, first coining the term "microaggressions."

Pierce was the senior advisor on the creation of the acclaimed children's television series, "Sesame Street." He spent the majority of his career as a psychiatrist at the Massachusetts Institute of Technology and a professor of psychiatry and education at Harvard Medical School. He was the first African American full professor at Massachusetts General Hospital, where in 2009 the hospital's global psychiatry program was named after him. He was also a trailblazer outside of psychiatry—as a football player at Harvard, he was the first African American to play in a major college football game south of the Mason-Dixon line (University of Virginia).

APA members are asked to pledge a gift by downloading the pledge form at psychiatry.org/pierceaward and emailing it to apafdev@psych.org. All donors will be honored by having their names placed in a book to be on display at APA headquarters. **PN**

APA Fireside Chat Addresses Awareness About COVID-19 Vaccination

"Vaccine inquisitiveness" may be a more accurate term than "vaccine hesitancy" for patients who question vaccination, say experts. BY TERRI D'ARRIGO

In April APA hosted a two-part webinar series that examined strategies and opportunities to improve the mental health of Black people during the COVID-19 pandemic. The webinars, the first of APA's Mental Health Equity Fireside Chat series, also aimed to raise awareness of the COVID-19 vaccines and build trust in their safety and efficacy. The first part was for the general public and the second part was for APA members. The chat was moderated by Regina James, M.D., deputy medical director and chief of APA's Division of Diversity and Health Equity.

During the chat, Kizzmekia Corbett, Ph.D., a viral immunologist, research fellow, and team lead for the development of the Moderna vaccine at the National Institutes of Health, discussed the term "vaccine inquisitiveness" as an alternative to "vaccine hesitancy."

"When you call it inquisitiveness, you are giving patients the power to ask questions," Corbett said. "Often times it is not that they're hesitant, but that they just want to know about the

vaccine, like what's in it, how it was developed, does it cause infertility—things like that."

APA Distinguished Life Fellow and President-elect of the Black Psychiatrists of America Cynthia Turner-Graham, M.D., spoke of the importance of patient autonomy and being a con-



The term "vaccine inquisitiveness" empowers patients to ask questions.
—Kizzmekia Corbett, Ph.D.

duit of information for those seeking to learn about the vaccines.

"For my patients, it really helps them to understand that I am there just to give them information and satisfy their inquisitiveness. It is their decision and body, not mine," she said. "My job is to give them the best information I can so they can make the best decision for themselves."

Corbett noted the importance of



Psychiatrists are in a position to address the needs of "long haulers," patients who still have not completely recovered from COVID-19 weeks or months after their first symptoms.

—Cynthia Turner-Graham, M.D.

professionals in various fields each doing their part in addressing the challenges of the pandemic.

"If you're a scientist, you're learning the science so you can help others make informed choices on the vaccines. [If you are a mental health professional], you understand the way this affects mental health so you can treat people better," she said.

Turner-Graham addressed psychi-

atrists directly.

"To my fellow psychiatrists, we are in an interesting moment as a profession in which we have opportunities to impact the way this pandemic plays itself out and [address issues] after the pandemic is over," she said. She spoke of the challenges faced by "long haulers," people who had COVID-19 and still have not fully recovered weeks or months after first experiencing symptoms, some of whom may also develop neuropsychiatric problems. "We are in a position to make a difference for people who are suffering and in educating others about how to care for them." **PN**

A video of the public chat is posted at <https://vimeo.com/541343476>.

Documentary Chronicles Removal Of Homosexuality From *DSM*

The APA Foundation's archives helped inform the documentary, "CURED," with photos and other documents. The Foundation will host a town hall during which a panel will discuss the documentary on June 23. BY KATIE O'CONNOR

Fifty years ago, during the 124th APA Annual Meeting in Washington, D.C., demonstrators from the Radical Caucus and the Gay Liberation Movement disrupted the convocation presentation, demanding equal representation on panels discussing homosexuality.

A grainy, black and white photo was taken of the moment, and though it was taken 50 years ago, the image still evokes the protesters' passion. For years, the photo was tucked within APA's Archives, and now it is one of many featured in a new documentary chronicling the push by advocates and psychiatrists to remove homosexuality from *DSM*.

"CURED" tells the story of the years leading up to 1973, when APA removed homosexuality from *DSM*; it details the implications of the medical establishment's view that homosexuality was a mental illness. It largely focuses on the activists who pushed to change the way mental health professionals viewed homosexuality, as well as the psychiatrists who took up the cause themselves.

Psychiatrists featured in the documentary include John Fryer, M.D., who spoke about being a gay psychiatrist at APA's 1972 Annual Meeting in Dallas while masked and identifying himself as Dr. Anonymous; past APA President Lawrence Hartmann, M.D., who pushed for change within APA and worked with colleagues in the Northern New

England District Branch in early 1973 to write a resolution calling for the removal of homosexuality from *DSM*; and Richard Green, M.D., one of the first heterosexual psychiatrists to speak out about removing homosexuality from *DSM*.

The APA Foundation provided outreach and engagement sponsorship for the documentary. It will host a town hall on June 23, during which panelists will discuss the documentary and participants will be able to view the film ahead of time.

"The activists in the film changed APA, and their actions changed LGBTQ people's lives, as I know personally," said APA CEO and Medical Director Saul Levin, M.D., M.P.A., in a statement on the "CURED" website. "I am grateful that their experiences are being told and also that APA has made forward progress on LGBTQ issues over the past decades."

Amy Porfiri, M.B.A., the Foundation's interim executive director, explained that the producers reached out to the Foundation in late 2018 to access photos and documents within the Archives. At the time, the Foundation's librarian and archivist, Deena Gorland, M.S.L.I.S., was beginning the laborious task of organizing APA's Archives; the collection had been stored in thousands of poorly labeled boxes when APA moved to smaller quarters.



"'CURED' chronicles an important chapter in our organization's history," says Saul Levin, M.D., M.P.A.

Gorland dove into the collection, looking specifically for items from the late 1960s and early 1970s that would be relevant to the producers' work, such as Annual Meeting programs and photos, including the photo of the protesters at

the 124th APA Annual Meeting. She worked closely with the producers as she identified the items they could use in the documentary and digitized the materials. "I found some amazing photos—the types of images that tell stories in themselves," Gorland said. "The treasures we have in our collection are vast."

"CURED," Gorland explained, educates the world about a pivotal moment in the history of LGBTQ rights. "It's amazing how far we have come and how far the medical community has evolved," she said. "My hope is that a film like this will not only educate the public about the history, but also encourage people to advocate, especially with their lawmakers, to change laws and policies that still stand in the way of equality."

"This documentary provides members with an opportunity to see how far the field of psychiatry has come," Porfiri said. "'CURED' emphasizes that you can make your voice heard, and it can make a difference." **PN**

Town hall participants will be able to view "CURED" prior to the discussion. More information on the town hall and registration is posted at <https://apafdn.org/news-events/news/save-the-date-cured-documentary-screening-and-town>. Also, explore the new virtual Melvin S. Sabshin, M.D. Library and Archives at <https://legacy.psychiatry.org/>.

APA Announces Two New Membership Categories

Beginning in January 2022, APA is instituting two new membership categories approved by the Board of Trustees and Assembly in 2018. The membership categories are "semi-retired" and "retired," and qualified members can opt into these categories for the 2022 membership renewal year at my.psychiatry.org and select the "Retired Opt in" tab.

A semi-retired member is defined as a general or life member who is near retirement age and works less than 15 hours a week in all administrative or clinical roles. A retired member is defined as a general member who has reached retirement age and is fully retired from all administrative or clinical roles. These categories will replace the "Rule of 95" starting with the 2022 renewal year. Those in the life category prior to 2022 can remain there or can move into one of the new categories. Once moved into a new category, it is not possible to move back into the life category.

The Rule of 95 allowed members whose age and years of APA membership equaled or exceeded 95 to become life members and pay dues on a graduated basis. The new categories provide more flexibility for a more diverse and changing workforce and simplifies the membership structure. Life status will no longer be tied to the Rule of 95 but will be achieved by either being a member for 30 or more years or paying lump-sum dues.

More information is available at <https://www.psychiatry.org/join-apa/semi-retired-and-retired>.

Advertisement

FDA Approves Qelbree for ADHD

Viloxazine is not a stimulant and is not a controlled substance.

BY TERRI D'ARRIGO

In April the Food and Drug Administration (FDA) approved Qelbree (viloxazine extended-release capsules), a selective norepinephrine reuptake inhibitor, for the treatment of attention-deficit/hyperactivity disorder (ADHD) in pediatric patients aged 6 to 17 years. Qelbree is not a stimulant and is not a controlled substance.

In three separate phase 3 trials involving 1,118 patients aged 6 to 17 years, patients who took Qelbree experienced a greater improvement in ADHD symptoms compared with those who took placebo, as measured by the ADHD Rating Scale and the Clinical Global Impression-Improvement score. Doses during the trials ranged from 100 mg to 400 mg.

The recommended starting dose for patients 6 to 11 years old is 100 mg once daily. The recommended starting dose for patients 12 to 17 years old is 200 mg once daily. Dosages for both age groups may be titrated up to 400 mg once daily. Qelbree is taken once daily, and capsules may be broken open and sprinkled on applesauce or swallowed whole.

David Rettew, M.D., the medical director of the Child and Adolescent and Families Division of the Vermont Department of Mental Health and an associate professor of psychiatry and pediatrics at the University of Vermont, said he sees where Qelbree may provide a new treatment option for several patient populations.

"One would be the child or adolescent who can't take stimulant medications due to side effects," Rettew told *Psychiatric News*. "Since Qelbree doesn't have the on/off quality of stimulants where the benefits wear off during the day, there also could be interest in patients and families looking for a more even effect throughout the day. Finally, its use might be considered in individuals with substance use histories where there could be concern about using controlled substances like stimulants."

Qelbree's label contains a boxed warning that the medication may increase the risk of suicidal thoughts and behaviors. The warning advises health professionals who prescribe Qelbree to monitor patients closely for "clinical worsening and emergence of suicidal thoughts and behaviors, especially during the initial few months of drug therapy, and at times of dosage changes."

Data from the clinical trials also suggest that the medication may induce manic or mixed episodes in patients with bipolar disorder, and the label cautions that patients should be screened to determine if they are at risk for bipolar disorder.

Between 22% and 31% of patients who received Qelbree in the clinical trials experienced an increase in heart rate of at least 20 beats a minute and a 15-point increase in their diastolic blood pressure. The label advises that health professionals should assess their patients' heart rate and blood pressure prior to initiating treatment and when increasing dosages. However, this may be easier said than done during the pandemic.

"Right now, so many medical appointments are being done via telemedicine, and vital signs are more difficult to get," said Rettew.

Rettew noted that viloxazine was marketed as an antidepressant in other countries before being marketed as a treatment for ADHD in the United States.

"[Qelbree] therefore has many of the same warnings [as antidepressants], such as the potential for increased suicidal thoughts and activation of mania. Some of the blood

pressure and pulse increases have also been found with antidepressants that have norepinephrine reuptake properties such as venlafaxine," he said.



Valerie Harder

Qelbree may be an option for patients with a history of substance use for whom there may be a concern about using controlled substances like stimulants, says David Rettew, M.D.



VIEWPOINTS

The Case for Moving Forward on Eliminating X-Waiver

BY DAVID MARCOVITZ, M.D., AND BRIAN BARNETT, M.D.

During the final days of the Trump presidency, the administration announced elimination of the buprenorphine X-waiver requirement. ("X-waiver" refers to the special Drug Enforcement Administration [DEA] license required by the Drug Addiction Treatment Act of 2000 that allows health care professionals to prescribe buprenorphine to outpatients for treatment of opioid use disorder [OUD].) However, only two weeks later, the incoming Biden administration surprised many by reversing the decision due to legal and procedural barriers to its implementation. Though this about-face means the X-waiver will live on for now, once these barriers are addressed, we believe the Biden administration should quickly move forward with its elimination.

Many arguments for X-waiver elimination have been advanced recently, one of the most notable being that although buprenorphine is safer than full opioid agonists, prescribing them requires no additional certification. Furthermore, as noted by Kevin Fiscella, M.D., M.P.H., and colleagues, X-waiver elimination would expand buprenorphine access by decreasing provider fears of DEA scrutiny, easing the process for physicians to find



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Brian Barnett, M.D., is an assistant professor of medicine in the Department of Psychiatry and Psychology at the Cleveland Clinic.

cross-coverage, and providing patients a surer path to buprenorphine initiation when transitioning between emergency rooms, inpatient units, and correctional facilities. X-waiver elimination might also reduce nursing home refusal of patients on buprenorphine. Finally, expanded access may decrease buprenorphine diversion.

Some have argued that since surveyed physicians don't frequently cite the X-waiver as an obstacle to buprenorphine prescribing—and nearly half of X-waiver holders don't even prescribe buprenorphine—elimination is

"While the medication is touted as working as a norepinephrine reuptake blocker, there is some research suggesting that it also acts on serotonin, similar to many other antidepressants."

Rettew said he will keep an open mind about Qelbree, but that it would not surprise him if it is seen as similar to another nonstimulant medication for ADHD, Strattera (atomoxetine).

"[Strattera] is often pretty well tolerated but there have been some data suggesting that it may not result in as much improvement in core ADHD symptoms as the stimulants. From some of the data from initial trials, it looks like Qelbree could be in the same boat," Rettew said.

"It is also worth noting that all of the ADHD trials [for Qelbree] have been short, just a matter of weeks. Long-term data are really needed, although we do have a long track record of [viloxazine's] use as an antidepressant."

Rettew is not affiliated with Supernus Pharmaceuticals and was not involved in clinical trials of Qelbree. **PN**

Full prescribing information for Qelbree is posted at <https://www.supernus.com/sites/default/files/Qelbree-Prescribing-Info.pdf>.

unlikely to meaningfully expand OUD treatment. However, stigma consistently ranks high among obstacles cited by physicians, and we believe that the X-waiver's very existence perpetuates stigma by reinforcing the notion of OUD as being totally distinct from other diseases, preventing the kind of primary care expansion of OUD pharmacotherapy previously witnessed in France and elsewhere.

Regarding underprescribing by those with X-waivers, we shouldn't dismiss the possibility that the X-waiver itself may be significantly contributing to this by limiting trainee exposure to buprenorphine prescribing. Surveys of family practice physicians and psychiatrists show that experience with buprenorphine during residency significantly increases the odds of buprenorphine prescribing post-residency. However, only 23% of internal medicine, family medicine, and psychiatry residency training directors report that their programs encourage or require obtaining an X-waiver, with a lack of waived preceptors being the most frequently cited barrier to expansion. This regulatory barrier makes it extremely difficult for trainees to create new buprenorphine preceptors through "teaching up," which occurs when enthusiastic younger physicians

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Numerous Hurdles Hinder High-Quality Cannabis Research

Experts described the obstacles preventing researchers from conducting well-controlled clinical studies at the inaugural symposium of the Medical Cannabis Research Advocacy Alliance. **BY NICK ZAGORSKI**

Pundits like to discuss movements like “red waves” or “blue waves,” but the past decade has borne witness to the “green wave” of cannabis legalization. With South Dakota making medical cannabis legal as of July 1, cannabis is legal for medical and/or recreational use in 35 U.S. states plus the District of Columbia. Thirteen other states have legalized cannabidiol (CBD) products with lower tetrahydrocannabinol (THC) content.

With growing legalization and use of cannabis and CBD, experts say there remains a need for higher quality studies of cannabis to protect patients. Representatives from pharmaceutical companies, medical societies, academia, and patient groups recently formed the Medical Cannabis Research Advocacy Alliance (MCRAA)—a coalition seeking to advance medical cannabis research and regulatory prac-

tices. In March, MCRAA held its first virtual educational symposium that highlighted the current cannabis research and policy challenges.

While some people may think that the problem with cannabis research is a lack of studies, the issue is not quantity but quality, said Jordan Tishler, M.D., an instructor of medicine at Harvard Medical School, president of the Association of Cannabis Specialists, and a member of the MCRAA Board of Directors. He noted that there are thousands of studies dealing with the medical effects of cannabis, but almost all are observational or retrospective studies. “We need more rigorous, controlled trials,” he added.

Experts at the virtual symposium spoke of several factors standing in the way of such controlled trials.

The greatest barrier to cannabis research is the designation by the Drug Enforcement Administration (DEA) of



The dizzying array of medical cannabis strains available complicates research studies that rely on one specific strain approved by the National Institute on Drug Abuse.

cannabis as a Schedule I substance, said Ziva Cooper, Ph.D., during her session on the cannabis research landscape. Cooper is an associate professor of neuroscience and psychiatry at the University of California, Los Angeles, and director of the UCLA Cannabis Research Initiative. In addition, the supply of approved research-grade cannabis is limited.

Research-grade cannabis—which is grown and distributed by the National Institute on Drug Abuse—offers a consistent product in terms of CBD and THC levels, thus making studies in different labs comparable. “But the NIDA supply is not reflective of what’s available in the dispensaries across the country,” Cooper said. If a study finds some therapeutic benefit in the NIDA strain, it may not be applicable to the strains that people can buy.

Cooper added that working with CBD is not much easier, even though it is not listed under the five DEA schedule categories. The Food and Drug Administration requires certain standards for clinical purposes, so researchers must buy pharmaceutical-grade CBD from approved vendors, which again limits real-world applicability.

Another significant obstacle to overcome is the lack of a good placebo for inhaled cannabis, Cooper said. “If a product does not look or smell like the real thing, it is hard to do controlled clinical trials,” she said.

Yet another challenge facing cannabis research is the limited interest cannabis companies have in conducting large studies, explained Tishler. “Why would a company spend millions of dollars on research when it can make millions of dollars putting its cannabis product on shelves?”

Tishler recommended that federal agencies find ways to incentivize cannabis companies to conduct quality

research while also encouraging more research from academic centers.

The MCRAA symposium also highlighted the need for better product labeling of marketed cannabis or CBD-containing products. The only item required to be on a cannabis product label in every jurisdiction is the THC content, noted Jahan Marcu, Ph.D., the co-founder of Marcu & Arora, a multiservice firm aimed at supporting cannabis and psychedelic companies. Anything else is optional, which leads to most companies leaving out information or filling the labels with so much information that relevant items like recommended dose are hard to find. Marcu noted in his talk that even the “universal” symbol for cannabis-containing products varies from state to state—unlike other universal symbols such as for poison or radiation.

“Having clear and consistent product labeling keeps providers informed and patients safe,” Marcu said. He added that ASTM International (a prominent technical standards organization) is working on proposed standards for cannabis products, and he is hopeful that the United States will adopt them and ensure they are consistent across states.

In the meantime, he offered some practical suggestions to physicians and patients who may be interested in medical cannabis or CBD products. First, look for products that have features like tamper-proof containers, child-resistant caps, and nontransparent packaging. Ideally, products should also provide a clear CBD dose in milligrams and have an expiration date.

“Also, every cannabis dispensary should have a health professional readily available on site or over the phone who can clearly explain each product label,” he said. “If someone is not available, then find another location.” **PN**

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disseminate novel clinical practices to older physicians.

Of course, as with any regulatory change, there would likely be downsides to X-waiver elimination, perhaps the most serious of which would be that generalists newly empowered with buprenorphine prescribing ability would face pressure to overprescribe. However, generalists already face such pressure for many medications. Efforts to address such pressure have helped fuel quality initiatives in areas like chronic pain management, which has included increased education among primary care trainees on multimodal pain treatments and more thoughtful partnerships with pain specialists. Therefore, increased pressure to prescribe buprenorphine might also motivate generalists for more comprehensive education on OUD as a brain disease and also inspire similar partnerships with addiction specialists.

We may encounter other unexpected benefits of X-waiver elimination as well. For example, medicine might face increasing pressure to improve addiction training, and addiction specialty societies might also expand efforts to help generalists and patients recognize high-quality treatment.

Finally, because we could dispel the misconception that having an X-waiver confers expertise in addiction medicine, eliminating it might encourage other

specialties to rely on addiction specialists for addiction treatment education and assistance with complex cases.

If we eliminate the X-waiver, we should replace it by expanding OUD-focused medical education, particularly that delivered by addiction specialty societies (through the Providers Clinical Support System; among its partners are the American Academy of Addiction Psychiatry and APA). Furthermore, we should call for new OUD training requirements for all DEA license applicants, already proposed in bipartisan legislation like the Medication Access and Training Expansion (MATE) Act introduced by Rep. Lori Trahan (D-Mass.).

In taking these actions, we may find that physicians of all types will become better equipped to treat and prevent OUD, addiction specialists will be more frequently called upon to provide education and consultation on complex addiction cases, and patients with OUD will face fewer barriers to treatment with evidence-based pharmacotherapy across health care settings. **PN**

2 “Buprenorphine Deregulation and Mainstreaming Treatment for Opioid Use Disorder: X the X Waiver” is posted at <https://pubmed.ncbi.nlm.nih.gov/30586140>. “Training in Office-Based Opioid Treatment With Buprenorphine in U.S. Residency Programs: A National Survey of Residency Program Directors” is posted at <https://pubmed.ncbi.nlm.nih.gov/29513136/>. The Providers Clinical Support System can be accessed at <https://pcssnow.org/>.

Is Magnetic Seizure Therapy Ready to Round the Corner?

An ongoing phase 3 trial comparing magnetic seizure therapy with electroconvulsive therapy may finally provide the proof needed to get this promising intervention into clinical use. BY NICK ZAGORSKI

In May of 2000, Sarah Lisanby, M.D., then an assistant professor of psychiatry at Columbia University, was flying over to Bern, Switzerland, to test out a new tool in the fight against depression. She had spent the previous five years building and testing a device that used strong magnetic waves to stimulate controlled seizures in the brain. The hope was that this new approach to neuromodulation might provide severely depressed patients welcome relief from their symptoms without some of the risks associated with electroconvulsive therapy (ECT), which uses electricity to stimulate controlled seizures.

Lisanby's colleague Thomas Schlaepfer, M.D., had identified a young woman with treatment-resistant depression who lived in Switzerland and was willing to undergo the experimental procedure. So, with a suitcase full of spare machine parts, Lisanby set out to conduct the first in-human trial of magnetic seizure therapy (MST).

The results of that trial, which were published 20 years ago this spring, were promising, setting magnetic seizure therapy on a long clinical journey that may soon reach fruition.

Magnetic Pulses Have Advantages

The research by Lisanby, now the director of the Noninvasive Neuromodulation Unit at the NIH Clinical Center, followed decades of work by others to increase options for patients with treatment-resistant depression. Lisanby is also the director of the Division of

Translational Research at the National Institute of Mental Health (NIMH).

"Attempts to modify how ECT is given are nearly as old as ECT itself," she explained. By adjusting the amount of current delivered and changing where the electrodes are placed on the scalp, researchers looked for ways to increase the efficacy and reduce the side effects of ECT, including short-term memory loss. One of the most significant safety advances in ECT

practice was shifting the placement of electrodes from bilateral (one on each side of the scalp) to unilateral (one on the right side and one on the center top of the head), she noted.

"But physics limits how far we can advance with electric stimulation," Lisanby said. Electrical currents meet heavy resistance and diffuse as they pass through skin and skull, thus making it difficult to target a specific region of the brain. Additionally, excess electrical energy spills out to surrounding brain regions, which leads to side effects.

In contrast, magnetic waves can pass through biological tissue unimpeded.

The idea of triggering brain seizures via magnetism was conceptualized in the early 1990s by Columbia's Harold Sackeim, Ph.D., one of Lisanby's mentors and a leading authority on ECT. At that time, a novel approach known as transcranial magnetic stimulation (TMS) was making headlines as a potential depression treatment. Though TMS relied on low-level magnetic energy to "gently" modulate brain activity, these pulses were found to induce seizures in rare instances. Sackeim reasoned that stronger magnetic pulses could induce more focalized seizures and mimic ECT's antidepressant effects with fewer unwanted side effects.

see **Magnetic** on page 33



Sarah Lisanby, M.D., prepares to administer magnetic seizure therapy to the first human volunteer in 2000.

Courtesy of Sarah Lisanby, M.D.

Neuromodulation May Help Depressed Patients With Borderline Personality Disorder

Depressed patients with comorbid borderline personality disorder tend to be less responsive to antidepressants and psychotherapy. Electroconvulsive therapy and transcranial magnetic stimulation might be viable options for these patients. BY NICK ZAGORSKI

Many, but not all, patients with treatment-resistant depression benefit from electroconvulsive therapy (ECT). For years researchers have believed that depressed individuals with comorbid borderline personality disorder were less likely to benefit from ECT than those without this comorbidity. A recent study in the *Journal of Affective Disorders* may help change this view, while also pointing to transcranial magnetic stimulation (TMS) as another viable option for treating depression in these patients.

The hesitation toward treating patients with borderline personality disorder with ECT stems in part from a 2004 clinical trial involving 139 patients with treatment-resistant depression. That prospective study found that patients with treatment-resistant depression and comorbid bor-

derline personality disorder were significantly less likely to achieve depression remission after eight to 12 ECT sessions than patients without borderline personality disorder or those with another personality disorder.

Stephen Seiner, M.D., the medical director of the ECT Service at Harvard-affiliated McLean Hospital, noted that at the time, researchers were not surprised by these findings; people with borderline personality disorder tend to have more severe depression and often don't respond to antidepressants or psychotherapy. However, in the years since, other studies have suggested that some patients with borderline personality disorder may respond to ECT.

One limitation of the 2004 trial was that the researchers used remission of depression as the outcome, Seiner explained. Given that individuals with both depression and borderline person-



Clinicians can feel confident that they have multiple treatment options when working with patients with depression and borderline personality disorder, says Stephen Seiner, M.D.

full remission. Borderline personality disorder is itself associated with mood swings and dysphoria, he added.

"The goal of ECT with depressed borderline patients is not to eliminate their depression, but to get it to a manageable point where established personality disorder therapies have a greater chance of success," he said.

Seiner and colleagues analyzed data from over 1,400 patients who received ECT between 2011 and 2018. They compared the overall symptom improvement of the patients, as assessed with the Quick Inventory of Depression Symptomatology Self-Report (QIDS-SR).

As anticipated, the patients with comorbid borderline personality disorder had higher QIDS-SR scores than those without throughout ECT treatment, but both groups showed a similar response over time. QIDS-SR scores for patients with or without borderline personality disorder dropped by about eight points after the first five ECT sessions, followed by a period of stability over the next 10 to 15 sessions.

Seiner and his team also assessed the outcomes of 356 patients with treatment-resistant depression who received TMS therapy. While TMS was approved for treatment-resistant depression in

see **Neuromodulation** on page 27

Abuse of Older People Increases During Pandemic

One in five older adults report experiencing physical, emotional, or financial mistreatment.

BY TERRI D'ARRIGO



istock/coldnowstorm

Most studies and news stories about COVID-19 and older people have focused on risk, infection, and mortality rates, but the pandemic has had another devastating impact on this population, one that is less visible, frequently ignored, and often a source of stigma: elder abuse. A study in the *American Journal of Geriatric Psychiatry* suggests that 1 in 5 older people has experienced elder abuse during the pandemic, a jump of nearly 84% over pre-pandemic estimates.

"We know that violence tends to surge during social unrest and troubled times, especially abuse that happens behind closed doors. Elder abuse is no exception," lead author E-Shien Chang, M.Phil., told *Psychiatric News*. She is a fifth-year doctoral candidate in the Department of Social and Behavioral Sciences at Yale School of Public Health.

Chang and her colleague, Becca R. Levy, Ph.D., a professor of epidemiology at Yale School of Public Health and a professor of psychology at Yale University, conducted a survey of 897 people aged 60 years and older via two online platforms from April 23 through May 5, 2020, when all states had stay-at-home orders. Drawing from the Hwalek-Sengstok Elder Abuse Screening Test and the Vulnerability to Abuse Screening Scale, the researchers created a 10-item elder abuse assessment and asked participants if they experienced any of 10 possible incidents of elder abuse since the beginning of the pandemic. The incidents included whether someone close to them tried to hurt or harm them, no one wanted them around, whether they were afraid of someone in the family, whether someone had taken their money or belongings without their consent, and other indicators of abuse.



Yale School of Medicine

Every health professional who treats older patients should screen them for elder abuse, says E-Shien Chang, M.Phil.

The researchers then compared their results with those of two other studies that were conducted before the pandemic: the National Elder Mistreatment Study (NEMS), which reported on the prevalence of elder abuse in 5,777 people between 60 and 97 years old, and a survey conducted by investigators in the National Social Life, Health, and Aging Project (NSHAP), which assessed the prevalence of elder abuse in 3,005 people between 57 and 85 years old.

Roughly 21% of the participants answered "yes" to at least one question during the assessment by Chang and Levy, compared with 11.6% reporting past-year abuse in the NEMS. In the current study, 5.4% of participants reported that someone tried to hurt or harm them during the pandemic, compared with 1.6% in the NEMS who

reported overall physical abuse. The prevalence of financial abuse rose as well: 7.5% reported that someone had taken their money or belongings without their consent compared with 3.5% in the NSHAP.

"I think overall the pandemic has just highlighted how much work that is to be done in preventing elder abuse and raising awareness of elder abuse on a societal level, as well as [in providing] greater education and training in detecting and reporting elder abuse for health care professionals," Chang said.

Risks Abound

The pandemic has brought with it myriad ways that may create the opportunity for abuse or exacerbate abusive situations.

"Abuse may occur when older adults are living either with spouses who are impaired or with adult children who are stuck in the middle caring for both their own children and their aging parents," said Brent Forester, M.D., M.Sc., president of the American Association for Geriatric Psychiatry (AAGP), chief of the Division of Geriatric Psychiatry at McLean Hospital in Belmont, Mass., and a member of APA's Council on Geriatric Psychiatry.

"A lot of this may have to do with the struggles of some of those in younger generations, whether it's financial problems or their own mental health challenges that they take out on older adults," Forester added.

In the August 2020 *American Journal of Geriatric Psychiatry*, Lena K. Makaroun, M.D., M.S., a geriatrician at the University of Pittsburgh and a core investigator at the VA Pittsburgh Center for Health Equity Research and Promo-

tion, and colleagues outlined several ways the pandemic may raise risk, including increased demands on caregivers' time and resources, increased substance and alcohol use among caregivers, and a decreased availability of in-person treatment or support systems. They also noted a substantial increase in the purchase of firearms and ammunition early in the pandemic.

"If mood disorders and substance use increase, both on the part of older adults and their caregivers, having easy access to lethal means at home may significantly increase the ability of violence to become deadly," they wrote. "With social distancing requiring a higher bar for in-person evaluations not only from health care and crisis professionals, but also from police and Adult Protective Services, these violent situations in the home may be less likely to be identified and intervened upon."

Protective Factors

Chang and Levy used a three-item scale that was used in the Midlife in the United States Study to determine the participants' sense of community. They also asked the participants questions about their engagement in physical distancing such as avoiding group gatherings and avoiding going to stores often. The researchers found that participants with a greater sense of community had a lower risk of abuse, even when they also reported other risk factors for abuse such as financial strain.

"We know that getting strong social support can enhance older people's safety, but what is reassuring is that the protective effects of strong social support and feelings of being part of a community can go a long way," Chang said.

see **Older People** on page 35

It Takes a Village: Mothers With SUDs Often Lack Support in Getting Treatment



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Fear, controlling partners, judgmental health care professionals, and a lack of resources weigh heavily on the minds of mothers and mothers-to-be with SUD. BY TERRI D'ARRIGO

Mothers who have substance use disorder (SUD) are like most other mothers in that they want to make their children's lives better and keep their children safe. Many, if not most, would seek treatment for their SUD as part of their drive to be the best mothers they can be, yet they encounter barriers at every turn, ranging from unsupportive friends and family to logistical issues with transportation to laws that make them feel threatened by the prospect of losing their children if they get the help they need.

A recent meta-analysis in the *Journal of Substance Abuse Treatment* took a deep dive into how mothers and mothers-to-be with SUDs felt about treatment—what motivated them, what would make it easier for them to enter and stay in treatment (dubbed “facilitators” by the researchers), and what barriers they faced. The results, gleaned from 23 studies, revealed that they often feel like they have to choose between competing priorities. For example, many felt that spending money and time on treatment would take away from the money and time they needed to take care of their children.

“What kept rising from the data were the binds that mothers are put into if they make the choice to go to treatment. It felt like for every facilitator, there was a barrier,” lead author Erin R. Barnett, Ph.D., an assistant professor of psychiatry at the Dartmouth Geisel School of Medicine, told *Psychiatric News*.

Barnett and her colleagues separated the facilitators and barriers into three key themes: internal factors within the woman; relational factors involving health care profes-

sionals, family, and friends; and structural factors such as systems and treatment programs.

The Fears Within

The most common facilitator in the analysis overall, and the most common internal facilitator, was the desire to be a good mother. If the women were maltreated as children or their own parents had SUDs, they often made a conscious decision to try to be better parents themselves and to break the intergenerational cycle of maltreatment and substance use. They also wanted to retain custody of their children or regain custody if they had lost it.

Overall, and internally, the most common barrier to seeking treatment was the fear of losing custody of their children should the women come under the scrutiny of health care professionals and the authorities. The fear is well-grounded, given most state statutes require that health care professionals report infants who are born exposed to opioids or other substances.

“Not all states automatically remove the baby, but many states require reporting of substance use during pregnancy, and for a good reason,” Barnett said. She explained that when families first appear in court or in custody hearings, often it is not so much the substance use that mandates children's removal from their parents' custody, but whether there is any sign of neglect or abuse. Most notably, a parent's abuse of prescription opioids, heroin, or methamphetamines acts as a red flag to look for neglect because often in such cases there are no other caregivers who can step in to look after the children, Barnett added.

Moreover, more than a dozen states

have statutes that impose criminal or civil penalties on pregnant women who have opioid use disorder (OUD). A study published in *JAMA Network Open* in March 2019 suggests that such statutes may be keeping pregnant women with OUD from seeking treatment (*Psychiatric News*, <https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2019.4a26>).

Connection Counts

The women often spoke of the importance of relationships in facilitating treatment, notably relationships with health care professionals. They valued health care professionals who had gained their trust, supported their desire for treatment, and helped them find the right treatment program without making them feel judged. Yet some described health care professionals and staff who lacked empathy as barriers to seeking treatment, as such health care professionals did not inspire their trust. Other internal barriers included feelings of guilt, embarrassment, or stigma.

It would be beneficial for health care professionals who work with pregnant women and mothers with SUD to reflect on societal attitudes and stigma, said Shelly F. Greenfield, M.D., M.P.H., a professor of psychiatry at Harvard Medical School, the chief academic officer of McLean Hospital in Massachusetts, and a member of APA's Council on Addiction Psychiatry.

“Psychiatrists and other mental health professionals can facilitate engagement in addiction treatment by examining their own potential implicit biases toward individuals with sub-

stance use disorders and adopting empathic stances to all people with substance use disorders,” said Greenfield, who was not involved in the research. “As this study demonstrates, this is especially true for women who are mothers, given the societal bias and internalized stigma of women with SUDs in general.”

The women in the analysis also noted the importance of their own parents—mostly their mothers, siblings, older children, and female friends as important facilitators. In contrast, many of the women considered their relationships with their romantic partners to be barriers, often describing their partners as unsupportive. Some of the partners were physically and financially dominating, and some women were worried about how their relationships would change or worsen if they got treatment for their SUD.

“This is another bind, where if they get treatment, they risk losing their relationship, making their partner angry, or being ostracized from their community of friends,” Barnett said. “Choosing life without addiction may mean choosing to lose partners and friends who use drugs. But they may have good reasons to stay with a partner. The partner may be paying the rent or the partner's mother may be helping out with watching the kids.”

Some partners may not see SUDs as a medical matter, said Kimberly Yonkers, M.D., the Katz Family Chair in the Department of Psychiatry at the University of Massachusetts Medical School/UMass Memorial Medical Center, who was not involved in the research.

“They may view substance use disorders as a moral weakness. Most people still do not see addiction as an illness,” Yonkers said.

Many of the women said that group treatment was beneficial because of the connections they made with others who had similar experiences. This comes as no surprise to Greenfield, who was lead investigator in the treatment development trial for the Women's Recovery Group (WRG), an evidence-based, gender-specific group therapy to address the needs of women with SUD.

“In our trial, these motivators and barriers were discussed extensively, including stigma toward women, especially mothers, and the role of other primary relationships, including the presence or absence of partners,” Greenfield said. She added that women in the WRG trial discussed caregiving, notably motherhood, as both a barrier and a motivator with respect to treatment for SUD.

Structural Hurdles

The most common structural facilitators among the women centered on childcare, such as childcare during appointments at outpatient treatment

see **Mothers** on page 30



Addiction psychiatrists and other mental health professionals should check themselves for implicit biases against people with SUD, says Shelly F. Greenfield, M.D., M.P.H.

PSYCHIATRIC NEWS

Special Report

What You Should Know To Care for LGBTQ Patients

The recognition that sexual orientations and gender identities are expanding has presented new treatment challenges to psychiatrists. BY ERIC YARBROUGH, M.D.

In 2004, I started seeing a therapist. He was not an LGBTQ specialist—none existed that I could find in Alabama at that time. Without knowing his stance on gay people, I told him my one and only goal was to develop enough courage to leave a place I had lived my entire life. It was the only place I had ever known, and everyone I knew, with the exception of a few close friends, was trying to convince me not to move elsewhere for residency. I did not come out until age 22 because the idea of being gay was buried somewhere deep in my mind, covered with years of negative attitudes about gay people instilled in me—the same attitudes and hostilities that existed in my everyday life even as an adult.

My own medical school had discouraged me and a few other gay students from starting an LGBT medical organization. We were told it would be in our best interest to keep “these things” secret. I

told the therapist I had to leave to find a more supportive environment. It was clear to me that if I did not, my destiny there would have been to end up as another statistic—probably ending my own life. Fate fortunately provided me an escape route, and it took me to New York.

The specialty of LGBTQ psychiatry is a continuously growing field. The view of human sexuality has historically been very narrow. People were typically thought of as “normal” or something else—that something else was ultimately labeled as gay. It has largely been in the past 100 years, with research dedicated to sexual behavior, that our understanding of the range of human sexuality has expanded. More and more people have begun to identify as bisexual, and the “sexuals” haven’t stopped there, further expanding into asexual, pansexual, demisexual, polysexual, and omnisexual, among many others.



Eric Yarbrough, M.D., is chair of APA’s Council on Minority Mental Health and Health Disparities and past president of the Association of LGBTQ Psychiatrists. He is the author of *Transgender Mental Health* from APA Publishing. APA members may purchase the book at a discount at

<https://www.appi.org/Products/Sexuality/Transgender-Mental-Health?page=1&SearchText=Transgender>.

Psychiatrists who identify and/or work with the LGBTQ community often become overwhelmed as new research findings are published and the cultural landscape constantly changes with words and phrases about the community coming in and going out of fashion. Making matters more complicated, traditionally held views of gender and sexual identity are also becoming increasingly questioned and challenged. What were believed to be the foundational corners of human civilization, such as what it means to be a man or a woman, are being questioned and debated.

What we know is that both gender and sexuality

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appear to exist on a spectrum. Given that most human traits are also on a spectrum, this isn't a surprise. Hair color, skin color, eye color, extroversion, energy level, temperament, mood, and a whole host of other human conditions are never questioned in their unending variations present in humans. Why, then, do many people react negatively when a person's sexual orientation doesn't align with strict heterosexuality? What is so troubling about a person who is female acting in masculine ways or vice versa? People are complicated, and if history has taught us any lesson, particularly recently, it is that trying to put people into specific boxes doesn't go well.

A major part of the healing work that can be done with LGBTQ people in a therapeutic setting focuses on identity and their acceptance of not who they wish to be but of who they are. This internal struggle over identity—gender and sexuality—is painfully obvious in many who are given a chance to tell the story of their lives in a psychiatric interview. In addition, a therapist can play a major supportive role by providing emotional relief. Even

those who are lucky enough to have an extremely accepting support system can still struggle with the process because of what they read and hear about from the larger world.

The internal burden carried by the LGBTQ community can easily explain why so many have a difficult time accepting their identities. The process of “coming out” is a phenomenon unique to LGBTQ experience in which LGBTQ individuals, either internally in their mind or externally to those around them, come to realize their sexual orientation and/or gender identity. Mood swings, irritability, angry outbursts, isolation, depression, panic attacks, and suicide attempts are all commonly associated with the experience of coming out—this being greatly dependent on the individual's environment and mental health status. Many of these symptoms are largely caused by society systematically teaching them that they are deviant. In short, LGBTQ people are taught to hate themselves. Those who are surrounded by supportive family and friends may have a much easier experience.

In addition to reactions of family and friends, LGBTQ individuals face the potential for negative

repercussions in their work environment. In many places, LGBTQ people can be fired from their job simply because of their sexual or gender identity. Only certain states have protections to prevent discrimination based on sexual orientation or gender identity. Because of this, coming out can have serious financial and long-term career implications. While overall, the world might be moving toward acceptance of diversity, LGBTQ people still need to be concerned with the individual beliefs of those who can keep them or fire them.

Like other people, LGBTQ individuals are impacted by social determinants of health—aspects of a person's social environment or situation that contribute to their mental and physical health in positive or negative ways. Common negative ones for LGBTQ people are higher rates of homelessness, poorer access to health care, lack of accepting and affirming physicians, and social isolation. One example of social isolation is living in a rural area where it can be difficult to identify others who also might be part of the queer community, and doing so incorrectly can create a dangerous situation because of stigma.

**“Like other people, LGBTQ individuals are impacted by social determinants of health—
aspects of a person's social environment or
situation that contribute to their mental and
physical health in positive or negative ways.”**



Case Examples of Gender-Affirming Care

Case 1

Edward was a 55-year-old man who came to see me for help with depression. He had been married for the past 30 years and had an adult son. He and his wife lived together but had developed into strangers over the years. Edward disclosed to me he had been keeping a secret from both his wife and his son all these years. He would take “business trips” as an excuse to go to other towns to be the identity he felt most comfortable as—female. It was only in the safety of anonymity that he could dress in the clothing in which he felt most appropriate. He could wear makeup and a wig, and he could be seen by everyone else as female—something he had known himself to be for decades.

My therapy with Edward was focused only on affirming interventions. I asked him what name he would prefer I use and if she/her pronouns were appropriate. Edward, now Samantha, had thought I would give her a diagnosis and try to change her views of herself as a female. She was surprised that I validated her identity and encouraged her to do what she felt to be best. Over a series of sessions, Samantha started to present as female at all times, outed herself to her wife and son, and discussed with me the option of starting estrogen.

Although the road was initially rocky, her wife and son accepted Samantha's saying that it explained her secretive behavior for so many years. She told me she had never been so happy in her life, and now that she could fully express herself for who she was, she could never see her life any other way.

Case 2

Madison was a young woman just turning 20 years old. She initially started seeing me because of frequent panic attacks. After starting her on a medication to help decrease her anxiety, we explored her life in weekly sessions.

Much of her anxiety had started after her best friend moved away. She described the two of them as very close. They were so close, in fact, that they would spend most days together, sleep in beds together, and often cuddle. While Madison had dated men in the past, she had never had romantic feelings for them. She did, however, have those feelings for her friend. These feelings surfaced when her friend moved away, breaking Madison's heart.

In therapy, Madison was given the space to talk about her feelings and desires. She was able to express what she fantasized about in a nonjudgmental environment. The more we spoke, the less anxiety she had, ultimately stopping the medication she had been on since our first visit. By the end of treatment, Madison identified as gay and was dating women in the hopes of establishing a new romantic relationship.

Case 3

Timothy and Charles were both men in their 30s who had a difficult time with their sexualities early in life. They both had grown up in very religious settings, and only one of their families was accepting of their relationship. They had been dating for three years and were discussing getting married. As plans for a wedding were unfolding, Timothy and Charles found themselves fighting more and more. When Timothy suggested that marriage might not be right for them, they opted to try couples therapy first.

When talking to the couple, it became apparent very quickly that they both secretly held views about their own sexualities that they did not often disclose. Charles had grown up Mormon, and although he openly supported LGBTQ rights, he had a lingering feeling that his being gay was immoral and he was going against the values he had been raised to believe. While Timothy did not hold these same negative views to the same extent, he did have questions about whether two men could be in a relationship and married like a “normal couple.” His using those words provided a gateway to start to dismantle both Timothy and Charles's views on homosexuality and relationships.

Through couples treatment, they were both able to express fears they had kept hidden for many years. The main goal of treatment was to affirm not that they conform to the idea of marriage they had been taught growing up, but what marriage would look like for them. They were provided the space to create their own fantasies about their life and the way it would look going forward. New skills of communication were encouraged, and they learned the process of verbalizing their worries. By being more vulnerable with each other, their relationship strengthened.

LGBTQ people also remain the target of socially conservative politics that can put them in an unwanted spotlight at election time. Some candidates can drive their base to the voting booth by using the existence of LGBTQ people as an example of how the world is headed in an immoral and deadly direction.

The fear of diversity and change create a strong resistance away from self-acceptance. For young people to hear their identity used in such a hateful way further contributes to the painful internal experience they face each day as they move about the world. For some, the hate toward them turns into violence and even results in their death.

Because LGBTQ people are often taught to see themselves as deviant, it is not surprising that many choose to remain in the closet and not disclose their sexual orientation or gender identity to anyone. To fit into the larger society, they learn to hide certain aspects about themselves to avoid being found out. Over time, they can develop what is colloquially known in mental health circles as a “false self.” A false self is a version of a person that is shown to the outside world in an effort to mask what lies underneath. This is done usually as a way

ways. Sex is supposed to mean particular behaviors.

All these programmed beliefs are slowly teased apart in affirming therapy. People get to decide individually what it means to be a man or a woman. People get to decide individually who they are attracted to and what they like to do in and outside the bedroom. Providing patients with the freedom and space to make these decisions can be very therapeutic. With this information at hand, it becomes more obvious why affirming therapists are necessary and should be easily found. Given that in the past 50 years homosexuality was labeled a mental illness (and in many ways gender diversity still is), it makes sense that LGBTQ people might be hesitant to seek mental health care out of fear of judgment. There are still therapists who practice conversion therapy and attempt to “correct” a person’s sexual orientation or gender diversity. Conversion therapy is rightfully being banned in many parts of the country due to the psychological harm it can cause.

Issues Related to Transgender Care

Approaching people as individuals and not as part of a larger group can be at odds with how

firming treatments should be made available to them. It falls upon transgender individuals to decide which options are best for them and their lives. Some psychiatric symptoms might be due to the dysphoria that some people experience with their body. These can improve with gender-affirming treatments. Therapists can be most helpful by making space for the transgender individuals to discover what is best for them and then help them along the path.

Navigating LGBTQ Relationships: No Model to Follow

Affirming care can be useful in other ways such as in the realm of dating and relationships. LGBTQ people, while approaching treatment either individually or as a couple, will likely have many of the same concerns as heterosexual couples. The main difference is the extra layer of judgment and pressure—the “minority stress” mentioned earlier—that comes from the outside world. Young people learn about relationships through modeling from their family, friends, community, television, and movies. These modeled relationships have been

“When LGBTQ people run into the same relationship problems as straight people, instead of accepting the issue as commonly experienced by couples, they sometimes blame their LGBTQ identity status.”



to protect the person from negative or traumatic experiences. LGBTQ people may spend years working on and developing this false self, with some remaining in this state for their entire life.

Importance of Providing Affirming Care

A significant part of therapy with LGBTQ people is often working with undoing this false self. It can become such a common state for people that it is often difficult for them to tell the difference between who they have pretended to be for so many years and who they really are. Helping LGBTQ individuals discover and express their real self, outside of the fear of judgment and in a place of safety provides a firm foundation in what can be called “gay-affirming” or “gender-affirming” therapies. Regardless of the symptom or concern that brings a person in to see a therapist, affirming care should always be given. It resides in the way a therapist approaches a patient’s treatment, asks questions, and responds to difficulties the patient is experiencing.

Fundamental to providing affirming care is understanding, as mentioned earlier, that gender identity and sexual orientation fall on a spectrum. Given that knowledge, it is necessary to approach each individual just as that—an individual. All of us are subject to the collective influence that culture has on our thinking. As mentioned before, we are taught from an early age what it means to be a boy or girl, man or woman. Marriage is supposed to look like this, and relationships are supposed to look like that. Men should have a particular set of skills and work, and women should behave in certain

health care professionals are taught to practice. Psychiatrists and mental health professionals are taught to group people into categories. Making a diagnosis requires that patients fit a certain number of criteria as listed in the *Diagnostic and Statistical Manual (DSM)*. For instance, recent data have shown that about half of transgender people have attempted suicide. This shocking information should lead many mental health professionals to take extra care regarding suicide assessment when working with transgender individuals. While this statistic can be used to direct clinical care, the same extrapolation should not be applied to aspects of an individual person’s transgender identity. After all, what does it mean to be transgender?

Transgender people have been typically thought of as people who transition (medically) from male to female or vice versa. While this may be true for some, there is no set way in which a person should be expected to transition. Clinicians who rarely work with transgender people might assume that all transgender people want the same set of needs met—a name change, a gender marker change on documents, access to hormones, and access to surgery. While all of these may be important, it is necessary to first address the mental health concerns that have brought the individual into treatment—be that depression, anxiety, substance abuse, or whatever else might be burdening them. If a transgender person comes to treatment seeking gender-affirming care, validation, and acceptance of their real gender identity, gender-affirming

exclusively heterosexual until the recent past. When straight people run into relationship problems, they often have these models to turn to as a way to validate and normalize their experience. LGBTQ people have had no normalizing presence available to them by which to examine their own relationships. When LGBTQ people run into the same relationship problems as straight people, instead of accepting the issue as commonly experienced by couples, they sometimes blame their LGBTQ identity status—that is to say, they believe their relationship problems would not exist had they been straight, further invalidating and pathologizing their experience. Therapists can help reframe these views to normalize LGBTQ relationships and provide a significant amount of relief through that action alone.

As the world slowly evolves to accept other sexual orientations and gender identities, traditional views on what relationships are and expectations attached to them are also under examination. Because the right to marry has only recently become possible for same-sex couples, the expectations associated with marriage were not completely present. Ideas about monogamy and being together “until death do you part” have not historically been part of LGBTQ romantic relationships. While many LGBTQ people do choose the path of monogamy, many do not—relationships can be non-monogamous or “open.” Some relationships involve more than two people—polyamory. These nontraditional relationships are becoming more

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common among heterosexuals as well. Therapists need to challenge their own views of traditional relationships to provide affirming treatments for their patients. What works well for one person isn't necessarily going to work well for another. Taking an individual approach and examining a person's values and desires will likely lead to the most affirming care.

What Does It Mean to Be Part of the LGBTQ Community?

Another source of stress for LGBTQ individuals resides within the community itself. While the LGBTQ community prides itself on diversity, many rifts and tensions occur not only between L, G, B, T, and Q people but also within the letters. Gay people often disagree about what it means to be gay. Sometimes it is defined as completely sexual while others believe there is a large cultural component. Some men might be labeled as "too gay" or "not gay enough." Bisexual people find themselves facing stigma from the community as being confused or wanting the best of both worlds. They often hide their bisexual status to prevent judgment from the communities that surround them—gay

forms of racism, ageism, and bodyisms. Part of therapy is helping individuals discover what it means for them to be LGBTQ. So many are taught that LGBTQ looks this way or behaves that way that those who seek out acceptance find themselves in a more constricting environment than before they came out.

The concept of pride can help combat some of these queer divergences. LGBTQ Pride Month, often celebrated in June, is a time for LGBTQ people to celebrate their identity and the identity of others in their community. It is also a time of discussion and appreciation. Pride parades provide an opportunity for LGBTQ people to see others who are like and not like themselves. It can be a transformative experience for some and lead to a consolidation and integration of a person's identity.

The first pride parade consisting of gay men and women in 1970 has blossomed into a celebration of a more colorful and more diverse palate of individuals. LGBTQ is just the beginning of a community that now encompasses asexuals, pansexuals, intersexuals, and allied individuals. As people change, so will the LGBTQ community to embrace more identities. It will take ongoing vigilance and emotional readiness for the community to continue to evolve and stay together. **PN**

• **Mental Health Facts for Lesbian, Gay, Bisexual, Transgender, Queer/Questioning (LGBTQ)**

LGBTQ individuals are more than twice as likely as heterosexual men and women to have a mental health disorder in their lifetime.

• **Stress & Trauma Toolkit for Treating LGBTQ in a Changing Political and Social Environment**

Violence against the LGBTQ community has increased over recent years. In 2017, anti-LGBTQ hate crimes rose 86% from 2016. LGBTQ people of color—particularly transgender people—are disproportionately affected by these hate crimes.

• **A Guide for Working With Transgender and Gender-Nonconforming Patients**

This introductory guide offers an array of topics that are essential to understanding how to work with transgender and gender-nonconforming patients. It provides basic information to raise awareness of their needs and how to incorporate gender-affirming care in psychiatric practices.

• **Intimate Partner Violence: A Guide for Psychiatrists Treating LGBTQ IPV Survivors**

LGBTQ survivors of intimate partner violence face increased barriers to obtaining consistent access to culturally competent services. Without access to identity-affirming advocacy, intervention, and other critical services,

"Views about what it means to be bigender, agender, and nonbinary are as plentiful as there are people who associate with those identities."



or straight. Within the transgender world, there are strong beliefs about who is transgender and if someone is transgender enough. Some people see their transgender status as complete once they have had gender-affirming surgeries, while others hold tight to their transgender identity as a significant part of who they are regardless of whether they have had surgery. Views about what it means to be bigender, agender, and nonbinary are as plentiful as there are people who associate with those identities. Q for queer or questioning also is subject to scrutiny. The word "queer" was previously used in hateful ways.

Identity is just one part of the puzzle causing tension within the LGBTQ community. Because much of what is associated with LGBTQ is physical attraction to people of one or more specified genders, perceptions and judgment around bodies and body image are paramount. Because so many LGBTQ individuals have fought for a space to be present in the larger world, it may be difficult for them to associate with other LGBTQ people who do not look like them or believe as they do.

Once LGBTQ individuals are firmly secure in their identity, being open to the diversity of others naturally causes them to reexamine themselves. The anxiety around examining oneself, depending on how secure the person is, can be too triggering and result in the person's shutting out others who are different. This leads to many

APA Resources

Dr. Yarbrough is the author of *Transgender Mental Health* from APA Publishing. APA members may purchase the book at a discount at <https://appi.org/Products/Sexuality/Transgender-Mental-Health>. The following resources can be accessed at <https://www.psychiatry.org/psychiatrists/cultural-competency/education/lgbtq-patients>:

- **Best Practice Highlights: Working with LGBTQ Patients**
Learn more about working with LGBTQ patients, including demographics, significant history, best practices, and disparities.

- **Mental Health Facts for Bisexual Populations**
Research shows that bisexual individuals are at increased risk of adverse health outcomes compared with monosexual individuals. A significant contributor is stress that is related to stigma and discrimination.

- **Mental Health Facts for Gay Populations**
Gay men experience adverse mental health outcomes including mood disorders, substance use, and suicide more frequently than heterosexual men. They also face additional barriers to accessing mental health treatment.

- **Mental Health Facts on Questioning/Queer Populations**
Like other minority groups, questioning and queer people are often misunderstood, overlooked, and underrepresented in the health care system and societal institutions.

LGBTQ IPV survivors will continue to suffer from violence and adverse consequences of victimization.

• **Learning Modules on APA's Learning Center (CME credit available)**

"Transgender Mental Health": This course introduces core concepts of working with gender-variant patients and provides a roadmap to providing gender-affirming care.

"Transgender Mental Health Pulsed Learning": This course discusses the medical spectrum of gender in caring for transgender patients, such as asking for gender pronoun preferences.

"Impact of Microaggression on Mental Health Outcomes": This activity focuses on microaggressions and their relationship to mental health and physical illness.

"Cultural Formulation Interview": This course focuses on the impact of culture on the practice of psychiatry and the foundational basics of the *DSM-5* Cultural Formulation Interview.

"Engagement Interview Protocol": This course teaches participants how to perform culturally sensitive psychiatric interviews to engage patients from different cultures to receive appropriate treatment.

"Gay Men's Mental Health": This course will educate clinicians on the various facets of gay mental health.

Antipsychotics Stimulate Pancreas to Make More Hormones

Exposure to clozapine, haloperidol, or olanzapine led to increased production of glucagon and insulin. **BY NICK ZAGORSKI**

During his psychiatry residency, Zachary Freyberg, M.D., Ph.D., saw firsthand the profound benefits and costs of antipsychotic medications for patients with schizophrenia—as patients’ hallucinations subsided, they would experience significant weight gain in a short amount of time.

“Psychiatrists were asking patients to make this serious choice about their health [whether or not to take antipsychotics], yet they knew so little about what these medicines did and how they did it,” Freyberg, now an assistant professor of psychiatry and cell biology at the University of Pittsburgh, told *Psychiatric News*. The one thing the field could agree on was that dopamine receptors were involved, so once Freyberg completed his residency, he set out to study the mysteries of dopamine signaling.

Earlier this year, he and colleagues added a major piece to the puzzle of why antipsychotics and metabolic problems, including weight gain and diabetes, are inextricably linked.

They found that antipsychotics directly inhibit dopamine signaling in the pancreas, which leads to uncontrolled production of two hormones that regulate blood sugar: glucagon, which is produced by pancreatic alpha cells and increases blood glucose, and insulin, which is produced by pancreatic beta cells and lowers blood sugar. Their analysis also suggested that glucagon is as important as insulin, or maybe even more critical, in causing antipsychotic-induced metabolic problems.

Though dopamine is primarily known as a neurotransmitter, dopamine receptors are present in multiple cell types in the body, including pancreatic alpha and beta cells. Freyberg and others have shown that the dopamine D2 and D3 receptors (the primary targets of all antipsychotics) are important in regulating insulin production by beta cells. Alpha cells have been less studied, Freyberg noted, in large part because glucagon degrades more rapidly than insulin.

But once Despoina Aslanoglou, Ph.D., a postdoctoral researcher in Freyberg’s lab, designed a fluorescence-based assay to rapidly measure glucagon in cultured pancreatic islets, the researchers could start to peek inside these cellular black boxes.

“What we found was that at low concentrations, dopamine bound to alpha cell D2 and D3 receptors and triggered a reduction in glucagon production,” Aslanoglou said. “At higher concentrations, all the dopamine receptors were occupied, and dopamine started binding to

norepinephrine receptors. And that led to elevated glucagon production.”

Freyberg and his team next exposed pancreas tissue to one of three antipsychotics (clozapine, haloperidol, or olanzapine) or an inert control molecule. They found that compared with the control molecule, clozapine increased glucagon production by 200%, olanzapine increased glucagon production by 106%, and haloperidol increased glucagon production by 67%. The antipsychotics also triggered increased insulin production, but at lower levels (20% for clozapine, 44% for olanzapine, and 24% for haloperidol).

Glucagon increases of the magnitude seen in this study can quickly trigger hyperglycemia, which can eventually lead to diabetes, Freyberg noted. At the same time, the lower but still relevant increases in insulin can gradually lead to insulin resistance, thus providing a second avenue for diabetes.

“We also discovered that pancreatic alpha cells have the full set of molecular machinery needed to make dopa-



The discovery that pancreatic alpha cells, which produce glucagon, can also make their own dopamine highlights how little is still known about dopamine signaling in the body, says Zachary Freyberg, M.D., Ph.D.

mine from scratch,” Aslanoglou said. (Beta cells can also synthesize dopamine, but require the precursor molecule L-DOPA as a starting point.) Though alpha and beta cells normally

secrete their hormones in response to changes in external dopamine levels during fasting and eating states, these new data suggest that alpha cells may use their in-house production capabilities to fine-tune dopamine concentrations as needed.

“This illustrates how little we know about the fundamentals of dopamine signaling, above the neck or below it,” Freyberg explained. He said that he is hopeful that additional studies of the role of dopamine in the pancreas might reveal some drug development targets, as well as provide clues about dopamine’s activity in the brain.

This study was published in *Translational Psychiatry* and supported by grants from the Department of Defense, National Institute of Neurological Disorders and Stroke, and U.S. Department of Veterans Affairs, with additional support from the John F. and Nancy A. Emmerling Fund of The Pittsburgh Foundation. **PN**

“Dopamine Regulates Pancreatic Glucagon and Insulin Secretion via Adrenergic and Dopaminergic Receptors” is posted at <https://www.nature.com/articles/s41398-020-01171-z>.

Ezogabine Shows Promise As Antidepressant

A 45-subject clinical study suggested ezogabine is associated with rapid and robust improvements in anhedonia symptoms, though accompanying MRI data failed to detect any changes in the brain’s pleasure centers.

BY NICK ZAGORSKI

A study in the *American Journal of Psychiatry* has found evidence to suggest that the anticonvulsant ezogabine might be a promising antidepressant candidate,

especially for patients who have a difficult time experiencing pleasure, or anhedonia.

Adults with depression and high levels of anhedonia who received ezogabine for five weeks experienced superior symptom improvements compared with those who received placebo. However, neuroimaging analysis failed to definitively show how ezogabine produced a change in brain activity. This may slow down clinical development of the medication as funding agencies want more biomarker data for drug candidates.

Ezogabine, also known as retigabine,

is an anticonvulsant that binds to proteins known as KCNQ potassium channels. These channels control the flow of electrical currents across neurons but have also been implicated in resilience to stress. For example, studies in mice have found that animals that did not develop depressive behaviors in response to stressful situations had more KCNQ channels in the reward centers of their brains than animals that developed stress-induced depressive behaviors. Further studies in mice then showed that KCNQ activators like ezogabine can make the mice more resilient to stress.

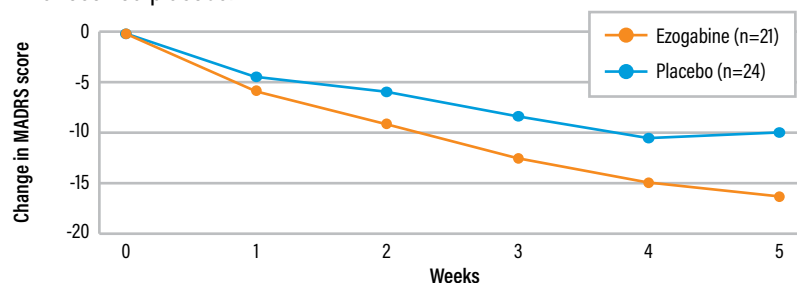
To assess whether people might respond similarly to ezogabine, investigators at the Icahn School of Medicine at Mount Sinai in New York and Baylor College of Medicine in Houston recruited 45 adults with a depressive disorder that included clinically significant levels of anhedonia for a trial. The participants were randomly assigned to either daily ezogabine (up to 900 mg/day) or placebo for five weeks.

In addition to monitoring the participants’ depression and anhedonia over the course of the trial, the investigators assessed whether ezogabine altered brain activity in the ventral striatum—a control center for reward and pleasure. The participants were asked to complete a guessing task for a chance to win money while receiving an MRI; scans were conducted at the beginning and end of the trial.

see **Ezogabine** on page 35

Ezogabine Shows Rapid Antidepressant Activity

Depressed patients with elevated levels of anhedonia who received the anticonvulsant ezogabine showed significantly larger improvement on the Montgomery-Åsberg Depression Rating Scale (MADRS) compared with those who received placebo.



Source: Sara Costi, M.D., et al., *AJP in Advance*, March 3, 2021

How to Overcome The Limitations Of Diagnosis In Psychiatry

Clinical staging beginning at the earliest period before acute symptoms appear can help psychiatry break out of the “straitjacket” of applying rigid diagnostic categories to over-determined syndromes.

BY PATRICK MCGORRY, M.D., PH.D.



iStock/Matthieu Louis

Diagnosis is a cornerstone of medical practice, succeeding only to the extent that it provides an accurate roadmap to treatment and, to a lesser extent, outcome. At best it is an imperfect process of applying shorthand labels to complex conditions by subgrouping patients according to their differential treatment needs.

In general medicine, diagnosis has been enhanced through two refinements: accurate staging of illness and accurate understanding of the biology of disease. But even within general medicine, individual variation within classes of patients means that the shorthand doesn't always work optimally. There is an element of uniqueness about every patient. Judged purely by utility, diagnosis works fairly well in general health care, at least where a range of effective treatments is available, and even if it is not, then for prognostic and palliative purposes.

How about in psychiatry?

The fundamental problem for psychiatry is that diagnosis remains largely syndromal. Syndromes inevitably are produced by a range of causal mechanisms, and conversely each causal mechanism can produce a range of syndromes. Hence the link between the syndrome and the treatment may not be as tight as within more diagnostically evolved domains of medicine. Psychiatry aspires to this more advanced stage but has arguably taken a premature shortcut by equating syndromes (often weakly and polythetically formulated) with discrete diseases. This wishful thinking has created a kind of spurious precision, encouraged by drug regulators who require specific indications for licensing medications.

How can we break out of this straitjacket?

Arguably, clinicians already have, though they are criticized for doing so. This is reflected in the use of multiple medications in patients with a single hierarchical diagnosis and multiple comorbid subsyndromes that clinicians treat with different medications. Derided as polypharmacy, there is a real downside to this approach, and it lacks rigor and a scientific basis. However, at another level, it is responding to a perceived reality, and the notion that any of the current medications are specific to single DSM-defined categories is just not credible. How can we do better?

The first step is to appreciate the complexity of mental disorders and that the distress and psychopathology that we recognize are overdetermined. At one extreme, we have the pure psychotherapeutic stance in which every single person is unique. While it is partly true, it also implies that what we learn about one individual patient cannot be translated to the experience of other patients or to how we as clinicians treat them.

At the other extreme, we have a premature neurobiological reductionism that equates syndromes with diseases; by itself, this reductionism can never do justice to the mind or the social world of the patient. Neurobiology is certainly altered in mental illness, but the changes may be primary or secondary and recovery may be achieved with or without medications. But in every case, a secure therapeutic relationship and psychosocial interventions are necessary, even when medications are essential.

How can diagnosis, which enables subclassification, be refined in a way that



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Mental Health in Melbourne, Australia. He is known worldwide for his development and scaling up of early intervention and youth mental health services and for mental health innovation, advocacy, and reform.

really contributes to holistic care of mental illness? Based on my clinical and research experience with people with emerging mental distress and mental illness, a transdiagnostic approach supported by a sequential or clinical staging framework is one part of the answer.

A second pillar of collaboration with the patient is to develop a comprehensive clinical formulation that draws upon the life history and social context of the person. This concept is, of course, by no means new and has been part of the training of psychiatrists and mental health professionals for decades. Yet sadly, health care systems continue to undervalue this and constrain psychiatrists and mental health professionals to a frustratingly narrow professional role and seriously shortchange patients and families.

Staging involves recognition at the point of engagement of where a patient sits along a continuum of (potential) illness progression.

It is an optimistic and preventive conceptual framework, not a deterministic concept, and progression or remission is possible at each stage. A staging approach seeks to proactively reduce

the rate of progression to the next stage. Those who don't progress are sometimes seen as “false positives,” and critics then argue that treatment was unnecessary. However, increasing this false-positive rate can also be seen as an index of success. The chances of remission typically reduce as progression occurs, but remission can still occur at any stage in psychiatric syndromes, including schizophrenia. The other cardinal principle is while almost all effective treatment involves some risk, the benefits must outweigh the risks at each stage. What does this look like in real life?

Since most of the mental disorders that impact across the decades of adult life emerge during the transition from childhood to adulthood (roughly 12 to 25 years), clinical staging works well in youth mental health settings designed for them to guide prevention and early intervention. A focus on young people in this age range has become increasingly important since we have witnessed a global trend for a worsening in their mental health, a trend that is likely to accelerate sharply in the wake of the COVID-19 pandemic for socioeconomic reasons. Over the past decade, youth-friendly and enhanced “one-stop-shop” primary care services for young people have been developed in Australia and a growing number of other high-income countries, and there is growing clinical experience of and exposure to the earliest stage of what may progress to acute mental illness.

The staging model ranges from stage 0 to stage 4. Stage 0 is the pre-illness stage when symptoms and impairment are not present, but there is a variable

continued on facing page

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level of risk or vulnerability. This is the stage when prevention strategies, either universal ones for the whole population or targeted ones for high-risk groups, are indicated.

Stage 1 typically involves emotional distress, with anxiety and lowered mood, resulting in impact on social and educational functioning and often triggered by social or developmental stress such as bullying (stage 1a). Until these new primary youth mental health care services were created, patients at this stage were rarely seen. A subset of these young people (stage 1b) have warning signs of other syndromes, such as psychosis, mania, OCD, or the borderline syndrome. The interventions to be offered at stage 1 are simple: They include problem-solving for immediate stressors and predicaments, emotional and practical support, and monitoring of risk and progress over a period of a few weeks.

A transdiagnostic approach and the largely subsyndromal nature of the psychopathology mean that assigning a specific diagnostic label is not necessary to deliver stage-specific care, and medication is very rarely a first-line option. If the distress, impairment, and need for care do not subside or the warning signs are prominent or worsen, then more intensive psychosocial interventions—notably cognitive-behavioral therapy, dialectical-behavior therapy (DBT), and individual placement and support/vocational support—can be flexibly drawn upon, depending on the complexion of the presenting features. These are still offered from a transdiagnostic perspective, though the emphasis might intuitively shift for a variety of reasons, including patient preference and engagement. The risks of offering treatment in this way to help-seeking individuals with a light diagnostic touch in stigma-free youth primary care settings are greatly outweighed by the risks of *not* offering care, as well as by the benefits.

Either because they respond to transdiagnostic psychosocial interventions or due to natural remission, fortunately only a minority of stage 1 patients progress to stage 2. Stage 2 is marked by a worsening in severity of one or more of the major syndromes, such as psychosis, depression, mania, borderline syndrome, or other symptom dimension and increasingly impaired functioning, indicating a change in treatment. Hence the threshold for recognizing stage 2 psychosis is the point at which antipsychotic medication is indicated, or in the case of depression, a more intensive psychosocial intervention or the addition of an antidepressant. Ultimately, sequential clinical trials are needed to provide a firmer evidence base for this in several areas. For mania, the transition to a full manic episode would be the indi-

cator that stage 2 had been attained.

Stages 3 and 4 are marked by varying levels of recurrence and persistence of syndromes of increased clarity, one or more of which may have become most prominent or dominant. At this stage, the illness will resemble more traditional diagnostic concepts such as schizophrenia and bipolar disorder. However, even during these later stages, comorbidity is very common, and the early clinical features of anxiety and depression are especially tenacious. The treatment needs of people in these later stages are diverse and involve medications, expert psychosocial care, and high-quality general medical care to prevent and treat these patients for the medical illnesses that they are at very high risk of developing. This preventive mindset for physical illness and premature death must be adopted from stage 1.

Suicides

continued from page 1

collective, community trauma.

“Suicidologists have long observed that suicide rates tend to decline after a catastrophe,” she said. “The reason is unknown, but some hypotheses include the possibility that individuals become more externally focused given the environmental threat, that the community cohesion that sometimes follows catastrophe has beneficent effects, or that community suffering makes personal suffering more tolerable.”

Beyond the encouraging overall decrease in suicide, the *JAMA* report is a stark portrait of the grim toll the pandemic has taken on the American population. Along with the more than 345,000 known COVID-19 deaths in 2020, increases were also noted for several other leading causes of death (see chart).

“These increases may indicate, to some extent, underreporting of COVID-19—that is, limited testing in the beginning of the pandemic may have resulted in underestimation of COVID-19 mortality,” the authors wrote. “Increases in other leading causes, especially heart disease, Alzheimer disease, and diabe-

Clinical staging in psychiatry aspires to evolve into clinicopathological staging via the inclusion of pathophysiological biomarkers, so that diagnosis can be further refined and personalized. This is a longer-term project, but this objective lies at the heart of the ground-breaking Accelerating Medicines Partnership Schizophrenia Project funded by the National Institute of Mental Health. This project aims to identify promising biological and behavioral markers that can help identify those at risk of developing schizophrenia as early as possible, track the progression of symptoms and other outcomes, and define targets for treatment development. Senior investigators at Orygen, our research institute in Australia, and our global collaborators (including the funders and partners at the National Institute of Mental Health/Foundation

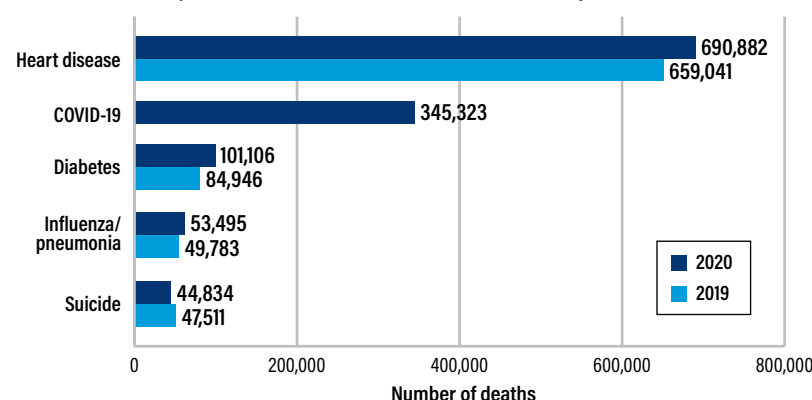
for the National Institutes of Health) are proud to be playing a leadership role.

The other way we can personalize care and balance the current limitations of psychiatric diagnosis right now is the clinical formulation, which captures the unique story and context of each patient. This must be developed collaboratively with the patient. The therapeutic process will be further enriched and strengthened if continuity of care, with one or more key mental health professionals, can be assured over time for as long as mental health care is required. Continuity of care is typically given scant regard in most systems of mental health care globally, yet it is the cornerstone upon which diagnosis and treatment rest. **PN**

References for this article are posted at http://apapsy.ch/Clinical_Staging.

Suicides Decline During Grim Year of Pandemic Deaths

Between 2019 and 2020, the number of deaths increased due to COVID-19 and several other major causes while the number of deaths by suicide declined.



Source: Farida B. Ahmad, M.P.H., Robert N. Anderson, Ph.D., *JAMA*, March 31, 2021

tes, may also reflect disruptions in health care that hampered early detection and disease management. Increases in unintentional injury deaths in 2020 were largely driven by drug overdose deaths. Final mortality data will help determine the effect of the pandemic on concurrent trends in drug overdose deaths.”

They added: “The effects of the pandemic are likely to continue through

2021 as well because COVID-19 has already caused more than 100,000 deaths this year. However, the effects of COVID-19 on mortality trends may be mitigated in 2021 given better detection and treatment options as well as increasing natural and vaccine-related immunity.” **PN**

“The Leading Causes of Death for the U.S. in 2020” is posted at <https://jamanetwork.com/journals/jama/fullarticle/2778234>.

Neuromodulation

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2008, the impact of borderline personality disorder on responsiveness to TMS had yet to be examined. As with ECT, Seiner’s analysis found that patients with depression and borderline personality disorder had similar responses to TMS as did patients who did not have borderline personality disorder.

TMS appeared to be slightly more effective at reducing depression than ECT for patients with comorbid borderline personality disorder (QIDS-SR scores dropped by about 10 points in

those in the TMS group compared with eight points in the ECT group). One difference between the response of patients who received TMS versus ECT was that QIDS-SR scores dropped gradually but continually declined across all treatment sessions rather than dropping rapidly and plateauing.

“This was a really exciting finding,” Seiner noted. “Now clinicians can feel confident that they have a choice when evaluating patients with depression and borderline symptoms. If a patient has severe bipolar depression or psychotic depression, then ECT would be preferred; but if not, they can try TMS and

avoid some of the side effects of ECT.”

Seiner told *Psychiatric News* that people with borderline personality disorder can be more sensitive to the cognitive side effects of ECT, such as transient memory loss, which is another factor for physicians to take into account when considering treatment options for these patients.

The study was funded by the Sidney R. Baer Jr. Foundation. **PN**

“Borderline Personality Traits Do Not Influence Response to TMS” is posted at <https://www.sciencedirect.com/science/article/pii/S0165032720329840>.



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Updated Physician-Aid-in-Dying Law Sparks Controversy in Canada

The legislation broadens the legal use of medically assisted suicide and is slated to permit assisted suicide for people with serious mental illness starting in 2023. BY RICHARD KAREL

The Canadian Parliament and Senate passed legislation in March codifying major changes in Canada's laws regarding medical assistance in dying (MAID), as physician aid in dying is known there. According to the government's official website, the revised law permits MAID for a range of conditions immediately, while for individuals with serious mental illness seeking such assistance, the law will not take effect until March 17, 2023.

Addressing the changes for people who may be weighing MAID for severe mental illness, the government stated the following:

"If you have a mental illness as your **only** medical condition, you are **not** eligible to seek medical assistance in dying. ... This temporary exclusion allows the Government of Canada more time to consider how

MAID can safely be provided to those whose only medical condition is mental illness.

"To support this work, the government will initiate an expert review to consider protocols, guidance, and safeguards for those with a mental illness seeking MAID and will make recommendations within a year (by March 17, 2022).

"After March 17, 2023, people with a mental illness as their sole underlying medical condition will have access to MAID if they are eligible and the practitioners fulfill the safeguards that are put in place for this group of people. ..."

While many physicians and others have long been sympathetic to allowing medical professionals to help those with terminal illness die peacefully, the fear has been that medically



John Maher, M.D., says that the new law cannot be justified when Canadians do not have universal access to mental health care.

assisted death could become a substitute for adequate—and more costly—medical care. Those concerns are growing with the expansion of MAID in Canada.

During a hearing before the Canadian Senate's Committee on Legal and Constitutional Care on February 4, psychiatrist John Maher, M.D., criticized the proposed legislation. Maher is the editor-in-chief of the *Journal of Ethics in Mental Health* and a specialist in medical ethics with a focus on competency issues. Maher said that he treats people only with the most severe and persistent mental illness.

Canada now offers MAID, but not universal palliative care, disability support, or mental health care, Maher commented. "Do we congratulate ourselves for our compassion in giving people an easier way to die while depriving them of the resources they need to live?" Such legislation cannot

be justified while the health care rights of Canadians are ignored, said Maher.

"Clinical relationships are already being profoundly undermined," said Maher. "My patients are saying 'Why try to recover when MAID is coming, and I'm going to be able to choose death?' Some of my patients keep asking for MAID while they're actually getting better but can't recognize that yet.

"Social engineering always begins with language engineering," he observed. "Terminal illness means sure death and no hope, while mental illness 'means no death and sustaining hope—profoundly different states of being.'"

Offering medically assisted death because effective treatment is not available is indefensible, Maher said. "Death versus no treatment is not an autonomous choice. When the parents of a young woman recently asked me if I was going to help their daughter get better or kill her, the moral perversion of all this couldn't have been clearer to me."

That the new Canadian law would eventually permit medically assisted death for people with mental illness considered "irremediable" prompted psychiatrist Mark Sinyor, M.D., to tell the committee that he, like many other Canadian psychiatrists, shares the concern that there is no clear definition of "irremediable" in the context of psychiatric illness.

Sinyor is the former vice president of the Canadian Association for Suicide Prevention and an associate professor of psychiatry at the University of Toronto. He specializes in the treatment of adults with complex mood and anxiety disorders at Sunnybrook Health Sciences Center in Toronto. His research focuses on how media and messaging influence suicide.

Helping patients with serious mental illness die should not be called MAID but rather "physician-induced death" "as it is different in kind from facilitating a death process already occurring," Sinyor commented.

see **Assisted Suicide** on page 36

Status of Physician Aid in Dying in Other Places

As of 2021, medically assisted suicide for defined terminal illness is legal in the United States in nine states and the District of Columbia. The nine states are California, Colorado, Hawaii, Maine, New Jersey, New Mexico, Oregon, Vermont, and Washington. The practice is not permitted for people with a disability or mental illness. In Montana, assisted suicide is legal through a Montana State Supreme Court ruling; there is no legislation to regulate it.

In 2002 the Netherlands and Belgium widened their assisted suicide guidelines to permit euthanasia, and over time the guidelines have broadened to include not only patients with terminal illness but also those with severe disability and constant and unbearable psychological pain. Since then, this has been applied to patients suffering solely from severe psychiatric illness, with the prevalence of voluntary euthanasia for psychiatric illness increasing over time.

Other countries where voluntary euthanasia and/or doctor-assisted suicide is legal include Colombia, Luxembourg, Switzerland, and parts of Australia.



Why Are Psychiatrists Hesitant to Refer Patients For Interventional Treatments?

BY RICHARD A. BERMUDES, M.D.

The evidence for FDA-cleared interventional treatments for treatment-resistant depression is robust and has been demonstrated across multiple large trials and meta-analyses. These treatments include electroconvulsive therapy (ECT), transcranial magnetic stimulation (TMS), and esketamine. In fact, ECT is the oldest approved interventional treatment and is often referred to as the “gold standard” for patients with treatment-resistant depression. However, psychiatrists are hesitant to refer patients, and many consider interventional treatments as “alternatives” rather than integral to the treatment of depression (see box at top right). Prior to practicing TMS and ECT, I was in the same boat; I had very little direct patient exposure when it came to incorporating interventional treatments into my clinical practice. An article posted November 20, 2020, in *Psychiatric Services* highlights some of these issues. The article was written by Dr. Rebecca Barchas, a physician who received ECT for her depression and had a phenomenal treatment response:

“I was ignorant about something very important—the full range of patients who could receive the broad spectrum of benefits from electroconvulsive therapy (ECT). I rarely referred patients for ECT and always thought of it as a last resort. I was not sufficiently knowledgeable of the benefits of ECT until I myself was the beneficiary.”

Not unlike ECT, TMS and its far-reaching benefits are not widely understood. After our practice, Mindful Health Solutions, purchased our first TMS system in late 2009, we received very few referrals from psychiatrists in the region. Most psychiatrists were not familiar with the technology and had little-to-no experience with the modality. Many believed that TMS did not work, and those who referred patients thought of it as a treatment of last resort. Insurance did not adequately cover the treatment, and many psychiatrists felt the treatment was too costly. Even today, more than 10 years after FDA approval and with broad payer coverage, most of our patients “self-refer.” Like many of our ECT patients, they wish their physicians would have referred them earlier. In fact, some of my pharmacotherapy patients whom I delayed referring in the past have said to me, “What took you so long?”

Why are psychiatrists so hesitant to refer patients for interventional treatments? There has not been a systematic



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review of psychiatrists’ attitudes, but two separate surveys examined psychiatrists’ attitudes toward TMS and ECT (see <https://pubmed.ncbi.nlm.nih.gov/26435222/> and <https://pubmed.ncbi.nlm.nih.gov/20966767/>).

When psychiatrists were asked if they knew how to refer patients for TMS treatment, 67% had a negative response. However, referral knowledge did change positively if there was a TMS or ECT program at their institution. Surprisingly, the majority of respondents disagreed with the statement “I know and understand the indications for TMS,” and only three of 122 respondents indicated that they strongly agreed.

A survey of psychiatrists’ understanding of ECT found that although most psychiatrists had a favorable opinion of ECT, those who viewed ECT as a “treatment of last resort” referred patients sparingly. Other factors that decreased the probability of referral included patients’ negative attitudes toward ECT, the logistics of arranging support and transportation, and financial constraints.

Most psychiatrists receive very little exposure to interventional treatments during their training. In a 2010 survey, most programs devoted less than four hours of lecture time to ECT. Even when there is a TMS, ECT, or esketamine-ketamine program at their institution, only a minority of trainees are exposed to these clinical service lines. Many private practices with high clinical throughput have electives for third- and fourth-year residents, yet only a very small number of trainees are hosted in these settings each year.

So, how can you begin to educate yourself and incorporate interventional treatments into your clinical practice? My recommendations are as follows:

- Contact local interventional practices near or in your

Barriers to Interventional Treatments

- Belief among psychiatrists that interventional treatments should be used as a last resort.
- Lack of education and exposure to interventional treatments.
- Misconception that interventional treatments are not covered by insurance.
- Patient acceptance: “How will patients react if I refer them to ECT?”
- Patient retention: “Will I lose patients if I refer them to an interventional psychiatrist?”
- Conceptualization of mental illness: “situational depression.”

Information to Include With a Referral

- Diagnosis or indication—for example, “treatment-resistant depression”
- Concise summary of treatments tried in the last two to three years
- Prior interventional treatments
- History of suicide attempts
- The patient’s insurance and demographic information
- Your contact information as the referring psychiatrist or an office contact
- The role you want to play in the treatment going forward (for example, full transfer vs. co-management)

Ideal Referral Partners

The interventional psychiatrist does the following:

- Provides more than just one interventional therapy.
- Accepts insurance and has an efficient system of authorizations.
- Highly regards patient service and experience.
- Communicates clearly with referring psychiatrist and has transparent interoperability of electronic medical record.
- Utilizes measurement-based care and aggregates/tracks patient outcomes.
- Spends time with the patient and the patient’s support or family and is accessible to staff for supervision of services.
- Provides FAQs on the procedures that are accessible on websites with clear and concise information.

community. Some of these practices offer ECT, TMS, and esketamine-ketamine, but some offer only one modality.

- Consider committing a few hours to interview the interventional psychiatrist in your community or shadow the service, especially if you have not had exposure to ECT, TMS, or esketamine-ketamine during your training.

- Refer! If 30% of depressed patients do not obtain sustained remission after four trials of antidepressant medication, the average full-time general psychiatrist could refer three or four patients a month for an FDA-cleared interventional

treatment to improve the patients’ chance of sustained remission. Consistent referrals of 30 to 40 cases a year will give you an indication of the clinical significance and utility for your patients.

In the center box, I listed the information to include in a referral, and in the bottom box, I described the characteristics of an “ideal referral partner.”

In future columns, I will discuss who is an ideal patient for ECT, TMS, and esketamine-ketamine as well as discuss why patients hesitate to try interventional treatments. **PN**

References appear in the online version of this article at <https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2021.6.33>.

Spanking Linked to Aggression in Young Children

Children who are spanked at age 3 are more likely to have externalizing behaviors at age 5 than those who are not spanked.

BY TERRI D'ARRIGO

Spanking has effects on early childhood behavior similar to those of adverse childhood experiences (ACEs) such as physical or emotional abuse or neglect, parental mental illness, parental substance use, and others, a study in the *Journal of Pediatrics* has found. Children's exposure to spanking and ACEs when they were age 3 had statistically indistinguishable associations with externalizing behaviors at age 5, such as destroying their own belongings, being mean to others, or physically attacking others.

The results strongly suggest that spanking should be considered an ACE, lead author Julie Ma, Ph.D., M.S.W., told *Psychiatric News*.

"With spanking, you are showing kids that it is OK to hit people if you would like them to stop what they are doing. Kids learn that this is an appropriate behavior, and it prompts them to become more aggressive," Ma said. "If more [mental health] programs thought of spanking as an adverse childhood experience, we could then talk about adjusting social norms and attitudes and parental behavior."

Ma and colleagues analyzed responses from 2,380 families in the Fragile Families and Child Wellbeing Study (FFCWS), which included children born between 1998 and 2000 in 20 U.S. cities and their mothers. Mothers in the FFCWS were interviewed in person shortly after giving birth and interviewed again by phone when their children were 1, 3, 5, 9, and 15 years old. Ma and colleagues drew their study sample from the interviews when the children were 3 years old, which assessed ACEs and spanking, and the interviews when the children were 5 years old, which assessed behavioral problems.

The researchers found that at age 3, 58% of the children had experienced one or more ACE, and 55% of the children had been spanked by their mother in the past month. Not only did spanking and ACEs have a similar association with externalizing behaviors in children at age 5, mothers who spanked were more likely to report externalizing behaviors in their children than mothers who did not spank.

Mothers who spanked were younger and reported lower levels of neighborhood collective efficacy, a phenomenon wherein those in a community agree on what is acceptable behavior and reinforce it in one



Spanking children shows them that hitting is an appropriate behavior, says Julie Ma, Ph.D., M.S.W.

another. This speaks to a need for more support, Ma said.

"Younger parents are more likely to be first-time parents and are more likely to have less stability in terms of finances, careers, and relationship status, and parenting stress tends to be higher among younger mothers," she said. "Health professionals who work with parents should provide them with resources, including ways for parents to connect with other parents so they know they are not alone on their parenting journey. Sharing the challenges and joys of raising a young child helps to relieve stress and normalize their experience as parents."

Psychiatrists are in an excellent position to talk with parents about the potential harms of spanking, said Anish Dube, M.D., M.P.H., a child and adolescent psychiatrist in the juvenile justice system in Orange County, Calif., who was not involved in the research. Dube is a member of APA's

Council on Children, Adolescents, and Their Families.

"Often parents don't think of spanking as hurting their child, and that's



Discussing spanking with parents requires a delicate approach because they may be embarrassed or worried that their children will be taken away, says Anish Dube, M.D., M.P.H.

where the psychiatrist comes in to help them sort out the intent of the spanking versus the actual consequences of it," Dube said.

He said that discussing spanking requires a delicate approach. "Remember that some parents may be scared to talk about physical punishment. They may be embarrassed or afraid that their children will be taken away. We have to have more open discussions about this in a nonjudgmental way."

Dube suggests focusing on the personal and practical rather than the academic when discussing spanking.

"In the medical world, we tend to come at parents with facts and figures and that is not always the best way to appeal to the general public. Instead, it's better to ask what it was like for parents if they were spanked, what the emotional experience was like, and whether there is a better way they might have learned without being spanked," he added. "The idea is that if you are trying to teach the child something, spanking is not the answer because it doesn't necessarily teach children what you want them to learn. Rather, it models behavior that you don't want them to learn, and it doesn't build a better relationship with them."

Instead, psychiatrists can help parents see the benefits of positive reinforcement, Dube said.

"Talk about how rewarding positive behaviors creates positive self-esteem, encourages positive behavior, and leads to better relationships between parents and children," he said.

Ma and colleagues reported no outside funding for their study. **PN**

Adverse Childhood Experiences and Spanking Have Similar Associations With Early Behavior Problems is posted at [https://www.jpeds.com/article/S0022-3476\(21\)00106-2/fulltext](https://www.jpeds.com/article/S0022-3476(21)00106-2/fulltext).

Mothers

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programs or the ability to have their children reside with them at intensive day treatment or residential programs. Not being able to have their children with them served as a barrier as the women felt that treatment would take time away from their children and fulfilling their roles as mothers.

"Treatment that includes residential care for women and their children may decrease risk of loss of custody and enable some women to seek and receive the treatment they need," said Greenfield.

Finances figured prominently in the women's perception of barriers, notably the costs associated with treatment, a lack of insurance coverage, a lack of avail-

able programs, and long wait times. These results bolster the findings of a study published in *JAMA Network Open* in August 2020 that found that pregnant women with OUD face high out-of-pocket costs, a dearth of health care professionals who offer treatment, and difficulty merely getting an appointment with a health care professional who can prescribe buprenorphine (*Psychiatric News*, <https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2020.10a7>).

Given the logistical and financial barriers to treatment, the women noted several structural facilitators such as transportation assistance, including financial assistance to help them pay for gas, and insurance coverage.

"The research had some clear implications, including assistance with

childcare and transportation," said Yonkers. "These are less of an issue in a pandemic with people at home, but people still need to attend some treatment programs—for example, to pick up medication for opioid use disorder."

Barnett said that the analysis highlights a loss of community and support for mothers with SUD.

"We don't have our villages anymore, and there isn't an easy way to fix that," she said. "There need to be system changes to recreate villages, including things like subsidized childcare, longer maternity and paternity leave, and leave for grandparents, that can recreate village life. Otherwise, it's asking way too much of mothers, especially those with addiction."

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Generation Climate Change: Growing Up With Ecological Grief and Anxiety

BY BREANNE AYLWARD, M.Sc., MADISON COOPER, B.A., AND ASHLEE CUNSOLO, Ph.D.

This month's column focuses on the concept of ecological grief with particular emphasis on the impacts on children and future generations. Ashlee Cunsolo, Ph.D., is a preeminent researcher on these issues and their impacts on Indigenous peoples throughout the world, especially eastern Canada and Australia. As clinicians and policy leaders, we must consider the authors' recommendations for us to address the grief and anxiety younger generations are and will be experiencing.

—David Pollack, M.D.

Climate change is a growing threat to mental health globally, both exacerbating already-present mental health challenges and creating new stressors. Increasing evidence indicates that climate change can impact mental wellness directly, indirectly, or vicariously, leading to complex and often-overlapping clinical and nonclinical issues, including increased behavioral and mood disorders, depression and anxiety, suicide ideation and suicide, substance usage, psychiatric hospitalizations, family stress and violence, posttraumatic stress disorder, sleep disorders, and strong emotional reactions.

Ecological grief—the grief experienced due to endured or anticipated ecological losses, the disruption of environmental knowledge, and the loss of place-based identity due to environmental changes—and the related ecological anxiety that emerges due to climate change and resulting impacts to peoples and places are two such terms that are increasing in both academic and popular usage. While ecological grief and anxiety are widespread, children and young people are uniquely vulnerable to these emotions and experiences. For example, children interviewed for a recent *Rolling Stone*

article described feeling overwhelmed by the burden of climate change, expressing feelings of anxiety about their future and the future of their potential children. In a survey by the American Psychological Association in December 2019, 47% of young people aged 18 to 34 indicated that the stress they experience due to climate change affects their daily lives. Similarly, a 2019 poll conducted by the Washington Post/Kaiser Family Foundation in the United States found that 57% of teenagers aged 13 to 17 years old indicated that climate change made them feel scared, and 52% said it made them angry. In the same survey, 68% of young people aged 18 to 29 reported feeling afraid, and 66% indicated they felt helpless.

These are stark and sobering numbers.

Climate change is impacting children and young people during critical stages of physical and psychological development. For example, after climate-related natural disasters (for example, wildfires, flooding, and hurricanes), children and young people demonstrate a higher prevalence and severity of psychological distress and emotional struggles than adults. Additionally, displacement of families or communities due to these natural disasters often exacerbates existing financial hardships, disrupts social support networks, and displaces attachment bonds that play an important role in fostering children and young people's well-being, leading to negative mental health outcomes. In addition to these direct experiences, children and young people may also be more susceptible to outcomes from indirect stressors as they experience increasing stress, anxiety, and grief from anticipating future changes and/or from watching others experience suffering related to climate change—for example, the destruction, displacement, and loss of life felt vicariously through recent wildfires in Australia or in anticipation of major storms, hurricanes, and flooding events.

There is limited understanding, however, of exactly how the medium- and long-term direct and indirect



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stresses and anxieties from climate change will affect children and young people's psychosocial development, behaviors and mood regulation, sleep patterns, and overall mental health and resilience as adults.

Characterizing the experience of ecological grief and anxiety among children and young people, as well as exposing the need for resources to help children and young people cope, is what motivated two of the authors of this article (Breanne Aylward, M.Sc., and Madison Cooper, B.A.) to pursue graduate work on this topic. While the paths that led us to study ecological grief in children and young people differ, we were both troubled by what we were seeing and hearing on this topic in the media, research, and in our own lives. We were witnessing an increasingly widespread use of terminologies, such as ecological anxiety and ecological grief, to describe the intense feelings of children and youth, and we resonated with that. Within our provinces in Canada (Alberta and Ontario, respectively), we are noticing both acute and chronic evidence of climate change—including natural disasters such as wildfires, glacier melt, long-term increases in temperature that prevent lakes from freezing over as they did only a number of years ago—all of which, when combined with what we know about climate change globally, comes with negative mental and emotional consequences for us both.

Indeed, our personal experiences have helped us empathize with those who are suffering, anxious, and/or grieving due to climate change and both inform and motivate our research.

While research has already identified children and young people as vulnerable to climate change, climate-specific strategies to support them in effectively engaging, adapting, and coping in positive and healthy manners are limited. To better inform these strategies, we need the following:

- An increase in research focusing on the specific mental health outcomes of climate change on children and young people.
- Children and young people engaged in developing and adapting school curriculum at all levels about climate change, including space to discuss emotional reactions, such as ecological grief and anxiety.
- Training for educators on how to responsibly teach age-appropriate information about climate change, respond to students' mental and emotional reactions to the climate change curriculum, and support positive mental health coping strategies.
- More mental health professionals who are trained to treat children and young people experiencing climate-related stress.
- The inclusion of children's and young people's voices and priorities in mental health policies and programs related to climate change.

Ecological grief and anxiety are natural and healthy responses to ecological and climate-change-related losses. It is important to legitimize the process of mourning these losses by naming ecological grief and anxiety and supporting children and young people in coping with this grief and anxiety. Beyond helping children and young people cope, we believe that the above strategies could encourage them to engage in climate-related activities that effect change, promote their future health and well-being, and help them thrive and flourish. **PN**

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This study was supported by the U.S. Department of Health and Human Services. **PN**

➤ "Difficult Binds: A Systematic Review of Facilitators and Barriers to Treatment Among Mothers With Substance Use Disorders" is posted at [https://www.journalofsubstanceabusetreatment.com/article/S0740-5472\(21\)00067-2/fulltext](https://www.journalofsubstanceabusetreatment.com/article/S0740-5472(21)00067-2/fulltext). "Association of Criminal Statutes for Opioid Use Disorder With Prevalence and Treatment Among Pregnant Women With Commercial Insurance in the United States" is posted at <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2727267>. "Association of Pregnancy and Insurance Status With Treatment Access for Opioid Use Disorder" is posted at <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2769427>.

➤ The American Psychological Association survey is posted at <https://www.apa.org/news/press/releases/2020/02/climate-change>. The *Rolling Stone* article, "Children of the Climate Crisis," is posted at <https://www.rollingstone.com/culture/culture-features/children-climate-crisis-eco-anxiety-968673/>. The Washington Post/Kaiser Family Foundation poll is reported in the article posted at http://apapsy.ch/WP_KFF.



Pediatric Consultation-Liaison Psychiatry—Yesterday, Today, and Tomorrow

BY DAVID R. DEMASO, M.D., AND RICHARD J. SHAW, M.D.

Pediatric consultation-liaison psychiatry (P-CLP) is a specialized area of psychiatry whose practitioners have particular expertise in the diagnosis and management of psychiatric disorders in complex physically ill children and adolescents. In the relatively short time that P-CLP has been in existence, it has grown into a major subspecialty that provides expert consultation as well as support for pediatricians dealing with the complexity of traumatic medical conditions.

Yesterday

Over 20 years ago, P-CLP was described as a flourishing specialty offering an opportunity for the innovative application and extensive deployment of the special skills of the child and adolescent psychiatrist. Yet major issues facing the field were also apparent, including the lack of a firm patient base, precarious or insufficient funding, lack of research, and a small number of individuals active in the specialty with a resultant lack of mentorship.

Over 10 years ago, the first U.S. survey describing P-CLP practice patterns noted the market forces in the nation's health care system were creating increasing pressure to control medical costs with the effect that the funding of many P-CLP programs seemed in jeopardy, with many national programs reporting a decrease in financial support. Interestingly, this same survey also found an increasing demand for

expert psychiatric consultation in the pediatric setting with few P-CLP services citing the aforementioned "lack of a firm patient base." This apparent escalating service demand was postulated to occur in the context of higher patient medical acuity combined with the growing recognition on the part of pediatricians regarding the impact of mental health conditions on their practices. The survey described the increasing applicability and helpfulness of P-CLP psychiatrists in the diagnosis, management, and disposition of patients with complex conditions in the era of managed health care.

Today

Fast forward to today: The most recent U.S. survey of practice patterns found that P-CLP program expansion, particularly in academic medical centers, has indeed occurred in the context of rising patient medical acuity and the appreciation that the presence of comorbid physical and psychiatric illnesses significantly add to patient and family burden as well as total medical expenditures. Pediatric hospitals are now grappling with some of the most challenging psychiatric issues of our time. These include complex clinical populations, such as patients with complex neurocognitive disturbances (pediatric autoimmune neuropsychiatric syndrome and autoimmune encephalitis); and patients coping with the impact of life-threatening physical illnesses, such as cancer, solid organ



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a professor of psychiatry and pediatrics at Stanford University School of Medicine. They are the authors of *Clinical Manual of Pediatric Consultation-Liaison Psychiatry, Second Edition*. APA members may purchase this book at a discount at <https://appi.org/Products/Child-and-Adolescent-Psychiatry/Clinical-Manual-of-Pediatric-Consultation-Liaison>.

transplantation, and cystic fibrosis. There are also troubling social and service dilemmas, most evident in the tremendous increase in the number of youth boarding in emergency rooms and medical/surgical beds across the nation. Furthermore, the significant increase in the amount of research, funded by the National Institutes of Health and multiple other agencies, has helped establish the emotional and physical health benefits of psychiatric consultation in the pediatric setting, a fact long recognized by primary and specialty care pediatric practitioners.

While adequate resources remained a core issue, the survey found an

increased willingness by hospital administrators to fund P-CLP services, viewing them as mission critical services. Mandates for integrated psychiatric consultants for specific high-risk physically ill patient populations have in part driven this process. According to the results of the survey, the prior focus on sustainability of services based on professional billings, something never considered a viable option given the necessary non-billable liaison work with a patient's pediatric providers, appeared to play a less important role in hospital budgets as population management approaches have become an important strategy for managing their health care systems.

Tomorrow

Looking forward, it is easy to envision the continued strengthening of P-CLP in the context of a national health care system struggling to care for youth with increasingly complex physical and emotional disorders. P-CLP has a demonstrated ability to partner with the pediatric community in the provision of integrated mental health care. P-CLP programs that have taken (and will take) the risk of reaching out and providing embedded point-of-care services within the pediatric subspecialty clinics have seen (and will see) rich rewards in terms of expanding clinical services and critically needed collaborative research. These same efforts are now being expanded to increasing reach beyond specialty care into primary care.

The specialty of P-CLP will allow child and adolescent psychiatrists to remain firmly rooted within the practice of clinical medicine while grappling with some of the most fascinating and complex dilemmas of our time. Knapp and Harris wrote over 20 years ago that the "child psychiatrist's training and skill in the integration of biological, pharmacological, developmental, intrapsychic, and family assessment are more valuable than ever" has proven to be prescient. The P-CLP psychiatrist of tomorrow will provide critically needed consultation and educational services to both primary care and subspecialty pediatric practitioners and in doing so help increase critically needed access to mental health services for children and their families.

Implications for Psychiatry

P-CLP is a dynamic specialty that lies on the interface between pediatrics and psychiatry. It is a bridge that can be leveraged to foster support from hospitals for the development of clinical and education programs as well as research and quality improvement initiatives. However, practitioners in P-CLP also face some unique obstacles.

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Magnetic

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MST is not without risks, as patients who receive the procedure report transient scalp pain and headaches, said Shawn McClintock, Ph.D., an associate professor of psychiatry at the University of Texas Southwestern Medical Center (UTSW) who studies neurostimulation therapies. “But the risk of short-term amnesia and other cognitive problems that have contributed to ECT’s stigma is far less.”

MST Hurdles Left to Clear

In the 21 years since Lisanby successfully treated her first patient with MST, the technology has undergone a steady if plodding progression toward clinical use. Numerous small studies, including a couple of head-to-head comparisons, have shown MST is about as effective as ECT at reducing depressive symptoms with fewer cognitive side effects. Some research centers, notably the Temerty Centre for Therapeutic Brain Intervention in Toronto, have also begun testing whether MST might be effective in patients with treatment-resistant bipolar depression or schizophrenia.

Despite more than 20 years of positive data and the approval of TMS for treatment-resistant depression in 2008, experts say it will likely be years before MST machines appear in clinics.

“MST requires a different device and uses different frequencies than TMS, so it is essentially a brand-new therapy and not a modified form of TMS,” said McClintock. “Seizure therapy is also an intensive treatment, so you want to proceed with the highest rigor, especially when it comes to safety, even if it takes more time.”

Another factor contributing to delays in moving MST to the clinic is that the medical device industry has not invested in this new technology as they did with TMS, Lisanby acknowledged. Currently, only MagVenture (based in Denmark) builds MST devices,



Researchers at the University of Texas Southwest Medical Center demonstrate a contemporary MST device, which is believed to provide the antidepressant efficacy of electroconvulsive therapy with reduced cognitive side effects.

and the company does not have the capital to sponsor large, multicenter studies (though they have donated machines for clinical research).

“NIMH recently stepped up to the plate and agreed to support a phase 3 trial” evaluating MST for treatment-resistant depression—a pivotal step for clinical approval, Lisanby explained. The trial is known as CREST-MST (for Confirmatory Efficacy and Safety Trial of Magnetic Seizure Therapy for Depression). The multicenter trial will be led by Daniel Blumberger, M.D., the director of Toronto’s Temerty Centre, and Carol Tamminga, M.D., the Lou and Ellen McGinley Distinguished Chair and the McKenzie Chair in Psychiatry at UTSW.

Comparison Trial Underway

As the director of the largest ECT service in Canada, Blumberger knows firsthand that ECT is the most effective treatment for severe treatment-resistant depression. He also knows it is the treatment option most refused when suggested to patients.

“If we could offer patients an alternative, we could help so many more,” he said. The same belief was held by the Centre’s prior director, Jeff Daskalakis, M.D., Ph.D., who in 2011 led the effort to obtain an MST device and funding to start clinical trials in Canada.

A decade later, the Temerty Centre has become a leader in clinical neuromodulation research and is a fitting choice to lead CREST-MST. Blumberger recently oversaw a head-to-head study that ultimately led to the FDA clearance of a new, rapid form of TMS known as theta-burst stimulation.

The CREST-MST trial is enrolling 260 adults with treatment-resistant depression at both the Temerty Centre and UTSW and providing them with either ECT or MST in a random and blinded fashion. (Both procedures are done under anesthesia so patients are not aware of their treatment; the clinicians assessing patient recovery will also be unaware of the treatment patients are receiving.) Blumberger told *Psychiatric News* that the trial has two primary goals. “The intent is to see whether MST is as clinically effective as ECT in terms of depression improvement and whether it has a better cognitive side-effect profile,” he said.

The trial had enrolled about 25% of participants when the COVID-19 pandemic hit last spring. Enrollment had to be put on hold as research activities and patient volumes were limited at both participating centers. Both sites have since reopened, and Blumberger is hopeful that the study can get back to full speed. He is also looking to re-launch another trial with his colleagues in Vancouver and London, Ontario, which is comparing MST and ECT for bipolar depression.

“When all the data are in, I am hopeful MST will meet the bar for regulatory approval and within a few years become

a new option for treatment-resistant depression and potentially other refractory psychiatric disorders,” he said.

‘One Size Does Not Fit All’

If MST does emerge as a safer alternative to ECT, will that spell the end for the original neuromodulation therapy?

Lisanby won’t rule anything out but thinks it’s most likely that MST will become another option for patients with treatment-resistant depression rather than a replacement for ECT. She noted that despite the consensus that unilateral ECT was a tremendous advance over bilateral ECT, some patients still receive the latter procedure. “Patients who qualify for ECT have severe and treatment-resistant depression, so we want as broad a range of options as possible.”

“One size does not fit all,” agreed McClintock, who will also be working on CREST-MST. “As the field advances, we may find that ECT might be better in certain cases, such as patients with psychotic symptoms or suicidal ideation. That’s why we need to find biomarkers that may suggest which treatment would work best for a given patient.”

A key element of personalizing these brain stimulation procedures is to understand how they exert their effects—the mechanisms of ECT and MST are still somewhat of a black box. One of the focuses of McClintock’s research is using neurocognitive and neuroimaging tools to measure the changes in the brain after therapeutic seizures are induced. “We need to know why these treatments are doing what they are doing,” he said. **PN**

2 The details of the first MST trial, “Magnetic Seizure Therapy of Major Depression,” is posted at <https://jamanetwork.com/journals/jama-psychiatry/fullarticle/481724>. More information on CREST-MST is posted at <https://clinicaltrials.gov/ct2/show/NCT03191058>.

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Patients are often not self-referred, and time and skill are needed to engage patients who may not understand the value or necessity of psychiatric consultation. Liaising with the pediatric team, while usually not reimbursed, is also an essential part of the P-CLP role to help develop a referral base and to educate pediatricians about the interaction between physical and psychological factors in their patients’ illness.

In a larger sense, the P-CLP can be seen as the psychiatrist for the hospital in general, providing expert consultation but also support and empathy for pediatricians dealing with the com-

plexity of traumatic medical conditions. As such, practitioners require a wide range of skills that encompass psychopharmacology, individual and family therapy, knowledge of behavioral intervention strategies, and a deep understanding of how systems work. P-CLP is above all a social and team-based specialty that relies upon the three A’s: availability, affability, and ability. These qualities will help maintain the relevance of psychiatry in the medical setting. **PN**

2 References appear in the online version of this article posted at <https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2021.6.22>.

Knee

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justify his actions based on the idea that blocking a fire hydrant is unlawful. He was within his rights to punish us for the infraction without first asking us to move. Nevertheless, we were angry and upset. The officer did not utter a word. The act, done in silence, did not recognize us. He perpetrated an unfriendly deed, and we did not trust him. As Mathew Alemu, a University of Michigan sociologist, explained in an April 21 *Detroit Free Press* column, “It’s hard to find the words to express how it feels, as a Black male, to have to process these events.” Then he talked of being honestly afraid at such moments. The collective fear, my friend’s and mine, was palpable. Alemu asked whether our citizenship must be “contingent on our willingness to accept eternal inequality.” The context framed all one wants to know about a policeman’s power and being treated in an undignified way.

It is a natural first step to hope that proper training of police will improve things. However, those of us interested in these phenomena know that one-sided training exercises are rarely enough. In that case, I turn to other explanatory mechanisms I have discussed elsewhere before. That officer and we needed a sustained interactive experience so we could tell him about our fear of his power and his weapon. He could, in turn, recount his feelings toward Black men who put their cars next to fire hydrants in the middle of the day and chat as though they have no pressing cares. However, in truth, I know nothing about what undergirded his decisions concerning lawbreakers. I never met him again. Perhaps he too was afraid.

I have occasionally discussed this incident with White and Black police officers. They said consistently that my friend and I did the wise thing. They advised walking away and celebrating life with our families. I have even questioned them about the cowardice in our defensive behavior. They smiled and said calmly that avoiding conflict with an officer beats a hospital stay and an arrest. Still, none of this gets at understanding why my officer did not at first strike a position of reasonable neutrality and ask me to move the vehicle. The psychoanalyst Anton Hart, writing about what he calls diversity-related pedagogy, advocates cultivation of curiosity about the “other.” I presume this invitation mandates taking this stance toward all officers. However, the tableau of the knee on the neck gets in the way. It demands hostility toward the knee’s owner and blunts our potential interest in and cultivation of a generous spirit toward those who pos-

sess the power to hurt us. When the hurt is aimed at our dignity, our anger can be unforgiving.

There is an important lesson here. The officer in my vignette did not put a Chauvin-type knee on my neck. His act was not so baldly violent. It was, nevertheless, oppressive. It troubled my composure and evoked fear; it lowered my dignity and disrupted my confidence as a productive citizen. My officer’s behavior borrows its power from a tradition of pervasive police supremacy. Sometimes it borders on the criminal, as we know well. That is the way it is in many democratic societies, especially where racialized thinking operates. The trouble is that little attention is paid to what the policeman is thinking when he deploys his power. I am also concerned that the sense of supremacy is visible in other systems besides law enforcement. That leads to the unavoidable conclusion that while Derek Chauvin’s behavior may be aberrant because of its duration, outcome, and public nature, it should not be considered a rare exemplar of interpersonal violence. I admit, too, that my personal experience has encouraged a more empathic curiosity and view of Chauvin. I understand that there are obscure structural factors that confirm the reality of the officer’s power and my fear of it and of him.

Yale President Peter Salovey issued a letter to members of the university community on the evening of April 20. In the letter, titled “Today’s Verdict on the Murder of George Floyd,” Salovey termed Floyd’s death an “indictment of our nation’s failure to address anti-Black violence and racism.” He demonstrated cogently and passionately in his public missive that he and his cadre of university officers have developed a thoughtful response to these race matters. However, he did not explain why the university took so long to enter the fray. I remember delivering a public lecture at Yale Medical School in January 1990 on the subject of “Belonging at Yale.” Few others were concerned then about such matters.

I used another presentation around 2006 to recommend steps I thought the leader of the medical school should take to improve the climate of equity and belonging. Afterward, a few full professors chastised me for giving my advice for all to hear. They were not polite in making clear that I had no right to say anything so pointedly to the dean at the time. Talking about knees and necks in an academic institution!

More recently, the university finally became interested in what it meant for minority groups to belong to this academic community and set up a Committee on Diversity, Inclusion, and Belonging. I wonder what elements would have been needed to foment this interest sooner: fiercer political activ-

ism, more intensive questioning about the university’s intentions, cultural humility? Now that the university leadership is keen on utilizing its human, sociopolitical, and economic resources in the broad struggle for social justice, the potential impact is breathtaking, especially if sustained.

Charles Blow, *The New York Times* columnist, recently noted that even in celebrating victories like the *Chauvin* verdict, sadness accompanies the joy. He explained that between the discernible poles that mark progress, minorities develop “hostility, resentment, and contempt.” Blow sees value in ritualizing the outcome, as such positive results can be “recharging and restorative.” Nevertheless, we must not confuse “the war that still rages for the battle in which we were victorious.” The crusade must continue, Blow argued, if change is to emerge from the verdict. Blow emphasized keeping one’s eyes on the prize, advancing the struggle for human rights.

In the April 21 issue of *The Harvard Gazette*, Professor Cornell Brooks of the Harvard Kennedy School asserted that *Chauvin* “is by no means a congratulatory moment or a moment of commendation for either the judiciary or policing. It is a moment of challenge, and it’s a moment of resolve.” Brooks sees the need for multiethnic, multiracial, and multisectoral coalitions to “face down” this problem of racism and police violence. The activism must take place at and on different levels simultaneously. There are roles for all of us. He demands the passage of the George Floyd Justice in Policing Act (HR 7120). He assigns to media the task of defining a justice narrative that must be heard everywhere. Only then will it penetrate the courts.

Brooks also wants “a sustained presence of protesters and demonstrators in the streets.” Hopefully, that movement will attract participation of the business community and politicians. He thinks that “our confidence, our hopefulness, our sense of optimism” can be found in the “commitment and courage of those around us.” Once again, passing laws will not bring total satisfaction. Statutes cannot mandate the earnest curiosity that Anton Hart suggests we display toward each other. Neither can we forcefully implement that intersubjective recognition of the other’s inherent dignity. Brooks essentially broadens Charles Blow’s program of making things better through a multipronged approach that relies on a coalition of interdisciplinary participation harnessed by deep commitment from authentic citizenship.

The Rev. Phillip Jackson, priest-in-charge of New York’s famous Trinity Church Wall Street, sent a brief public letter of reflection to his church community on April 20. Father Phil, as parishioners know him, described bear-

ing witness with “teary eyes” as he listened to the judge meting out justice to Derek Chauvin. It was not lost on the priest that the “undercurrent of the trial was quite literally centuries of trauma and injustice inflicted upon Black people in these United States.” He asked whether people might look away as had happened so many times in the past? In the present instance, the people did not look away. They held vigil, “recalled, remembered, and resisted” and “were not afraid.” Coming from a man of the cloth, this is a reminder of the utmost significance. It is reinforced by the call to advocacy issued by Professor Brooks. Someone must stand watch to monitor things and make sure the moral base of our institutions is not eroded.

New York County District Attorney Cyrus Vance Jr. stated on April 20 that “while this conviction brings a modicum of much-needed justice to the family of George Floyd, it does not, of course, bring him back nor does it deliver justice to the families of the numerous Black men ... whose needless deaths at the hands of police resulted in no criminal accountability.” Vance recommended that “the only way to meet the moral imperative of this moment is to enact policies which move our justice system forward ... and show every citizen in every community that Black lives matter and police violence is a crime.” This is the pragmatic statement of a lawyer who recognizes the advantages and shortcomings of the legal arena. He also sees that George Floyd and his family are the victims of this terrible episode of violence. Nothing can erase that fact. We must bear witness to that reality and hope that its memory will sustain efforts to make things better for all of us who remain.

Seeking justice is hard work. It requires us, on encountering injustice, to accept responsibility for finding a role to change things and make progress. The knee-on-the-neck tableau is not a problem merely for the justice system and police officers. We must think about violence in other contexts, such as in faith communities, universities, workplaces, political systems. Violence resides in the demeaning behavior of those who oversee others and treat them with scant respect. Paraphrasing James Baldwin, it demands great resilience not to hate the one whose knee is on your neck. Recognizing this demands a level of spiritual humility that unsettles many of us. Still, it is at the core of working together to make change. Standing arrogantly to the side and demanding that my police officer abase himself and take his traffic ticket back will not achieve lasting change. He and I must chat and figure out why we are so estranged one from the other. **PN**

Older People

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She added that creating and promoting supportive environments are necessary to protect older people from abuse during the pandemic and beyond. This includes social support from neighbors, friends, and family either in person or online; financial support such as programs or policies that enhance family financial resilience; and interventions that target community-level support, such as advocacy programs that involve community members.

Such programs should keep older people on the radar long term, said Elizabeth Santos, M.D., M.P.H., an associate professor of psychiatry, neurology, and medicine at the University of Rochester Medical Center and the clinical chief of the Division of Geriatric Mental Health and Memory Care.

“When we are attempting to increase social connectedness, sometimes people will reject it right away, but we should still have the ways and means to reach out and let them know we’re still here for them six months from now,” said Santos, who is also the secretary and treasurer of AAGP. “Often we just walk away and it’s not until there is crisis of some sort that we reach out again.”

Physical distancing also conferred some protection from elder abuse, Chang and Levy found. While physical distance from abusers inherently lowers risk, there may be more to it than that, said Chang. She speculated that physical



Abuse may occur when older adults are living either with spouses who are impaired or with adult children who are stuck in the middle caring for their children and their aging parents, says Brent Forester, M.D., M.Sc.

distancing may also be a reflection of older adults’ problem-solving abilities.

“We think that older persons who adhere to public health guidelines are likely those who are more attuned to their surroundings and able to find solutions to ongoing problems [such as] preventing widespread infection. Thus, they may be more likely to resolve conflicts ... at home before they escalate into abuse and mistreatment,” Chang explained. She added that these

adults may also have the ability and resources to fend for themselves in the face of danger.

However, this may not apply to all older people. One of the study’s limitations is that the participants tended to be relatively young, with a mean age of about 69 years, and they had both access to the technology necessary for taking an online survey and the skills to use it. The study also did not specifically include people who have dementia, who may be at higher risk of elder abuse. Chang and colleagues wrote that because their study was less likely to capture those in poorer health and those with fewer resources, their results likely present a conservative estimate of elder abuse during the pandemic.

Safety in Screening

Forester said the results are testimony to the long-standing challenge of detecting elder abuse.

“Even in specialty areas like geriatric health, we’re not routinely screening for elder abuse. When you systematically screen for this, it’s not surprising that rates have gone up as much as they have,” he said. “Like other kinds of abuse, elder abuse is hidden. People are reluctant to talk about it.

It’s not always obvious and it can be very subtle, like financial pressure from family members.”

Forester noted several advantages and disadvantages of telehealth with respect to screening.

“The opportunity with telehealth treatment of older adults is that you can see people in their own environment. It’s also much more convenient for older adults because they don’t have to worry about traveling to appointments,” he said. “But the downside is that the abusers may also be in the house and the older person may not be able to speak freely. You need to pay attention to non-verbal cues for anxiety or distress.”

Santos has a few tips for screening during virtual appointments.

“If patients have a portable device, have them show you where they sleep. Do they have a private room or are they sleeping on a recliner in the living room where everyone is coming in and watching TV and playing games so the person cannot get any sleep?” Santos said.

“Have them read the names of their medications to you,” she added. “Do they know where to get them and what they’re for? Are their medications right there and easy for them to get or do they have to look around for them? You can see how well someone is being cared for that way.”

Santos encourages in-person visits whenever possible to allow for private discussions between the patient and health professional.

“You always need to see the patient alone. You can tell a lot about the relationship between patients and their caregivers by how their caregivers react to you asking to see patients by themselves. Are the caregivers suspicious? Do they discount the patient’s complaints or talk over them?” Santos said.

Chang said that screening for elder abuse should be universal and a permanent part of caring for older people across health professions.

“Most people who experience elder abuse will not seek help or recognize that they are dealing with an abusive situation. I think it is important to incorporate screening of elder abuse into every health professional’s clinical routine,” she said. “The fight against elder abuse will be ongoing even after COVID-19 gets under control with vaccinations.”

This study was supported by the National Institute on Aging and the Samuel and Liselotte Herman Fellowship at Yale School of Public Health. **PN**

Ezogabine

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Lead study investigator James Murrough, M.D., Ph.D., an associate professor of psychiatry and neuroscience at Mount Sinai, told *Psychiatric News* that the neuroimaging data were included to follow the National Institute of Mental Health’s (NIMH) vision for mechanism-based clinical trials—that is, trials that not only demonstrate a medication is effective, but also can explain why it is effective.

“It is also an attempt at finding a transdiagnostic intervention,” Murrough said. “Focusing on a core symptom of mental illness like anhedonia that is found in many disorders opens up more clinical opportunities than focusing on a discrete diagnostic condition.”

The patients who received ezogabine reported significantly lower scores on both the depression and anhedonia scales relative to placebo users after five weeks, with a clear difference between the two groups emerging after just two weeks. The patients rapidly improved even though the ezogabine dose was raised slowly to minimize the risk of dizziness. (Participants did not reach the

target 900 mg/day dose until week 4.)

“Based on the standard clinical trial metrics like symptom severity, this medication did great,” Murrough said. “There are even some signs that ezogabine might have rapid antidepressant and anti-anhedonia effects. If we could titrate the dose more rapidly, we might be able to see improvements in one week or even less.”

The objective MRI data were not as clear-cut as the clinical findings, Murrough said. Though the participants taking ezogabine showed elevated activity in the ventral striatum after five weeks compared with participants taking placebo, the differences were not statistically significant.

“The data indicate that there is very likely something going on in this region following ezogabine exposure. We might have been able to show it definitively with a different tool or even with just a few more participants,” Murrough said. “But based on the parameters we set at the onset of the trial, ezogabine did not meet our primary goal.”

Alan Schatzberg, M.D., the Kenneth Norris Professor of Psychiatry at Stanford University and former APA presi-

dent, said that the disparate clinical and imaging data from this study highlight the challenges of designing drug studies that need to prove that the drugs engage specific biological targets and provide clinical benefit. He noted that NIMH’s motivations to include “target engagement” in smaller studies are valid given that so many drugs that show promise at first then fizzle out in larger and more expensive trials. But as he explained in an editorial accompanying this study, “Undue emphasis on the target validation rather than on determining clinical effects is perhaps as likely to delay drug development as it is to facilitate it.”

This study was supported by grants from NIMH and the National Center for Advancing Translational Sciences, with additional support from the Ehrenkranz Laboratory for Human Resilience at the Icahn School of Medicine at Mount Sinai. **PN**

“Impact of the KCNQ2/3 Channel Opener Ezogabine on Reward Circuit Activity and Clinical Symptoms in Depression: Results From a Randomized Controlled Trial” is posted at <https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.2020.20050653>.

“High Prevalence of Elder Abuse During the COVID-19 Pandemic: Risk and Resilience Factors” is posted at [https://www.ajgonline.org/article/S1064-7481\(21\)00018-X/fulltext](https://www.ajgonline.org/article/S1064-7481(21)00018-X/fulltext). “Elder Abuse in the Time of COVID-10—Increased Risks for Older Adults and Their Caregivers” is posted at [https://www.ajgonline.org/article/S1064-7481\(20\)30346-8/fulltext](https://www.ajgonline.org/article/S1064-7481(20)30346-8/fulltext).

Assisted Suicide

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Inducing death as a means of coping with emotional pain is suicide, he said. Evidence from his work shows that a public emphasis on death as a useful coping strategy for emotional suffering often increases the incidence of suicide, while an emphasis on hope, survival, and resilience may lower suicide.

Psychiatrist Sephora Tang, M.D., told the Senate committee that patients could be approved for MAID without assurance that they have received adequate support or care. The absence of appropriate care and support in many cases amplifies suicidal thinking, she noted. Tang is a co-author of the “MAID to MAD” declaration—“Medical Assistance in Dying becomes Medically Assisted Death” (see <https://maid2mad.ca/#DeclarationEnglish>). It was signed by more than 1,000 Canadian physicians.

Tang said that the bill as initially drafted would not have protected physicians who refused to make referrals for MAID. The final version, however, protects physicians from being coerced into providing MAID, according to the official statement provided by the Canadian government.

Psychiatric News spoke with Elaine Yingcheng Xu, M.D., who at the time of the interview was completing her psychiatry residency at the University of Pennsylvania Perelman School of Medicine. Prior to studying medicine, Xu studied philosophy and neuroscience, and in 2019 co-wrote an article in the *American Journal of Bioethics* titled “Physician Aid-in-Dying for Individuals With Serious Mental Illness: Clarifying Decision-Making Capacity and Psychiatric Futility.” She was also a presenter at APA’s online 2021 Annual Meeting on the ethics and framework for considering medically assisted suicide for people with serious mental illness.

“The most important thing in my perspective is that MAID is spreading across the globe, and it’s a really important issue for all psychiatrists to be thinking about” since psychiatrists may eventually confront patients asking why it is not available for them, said Xu. “In order for us to be ready for that ... and be responsible advocates for our patients, we need to be thinking really deeply and clearly about when we can appropriately make such a recommendation.”

How “terminal” mental illness is



As medical assistance in dying spreads across the globe, all psychiatrists “may eventually confront patients asking why it is not available for them,” says Elaine Xu, M.D.

defined and what constitutes “futility” in psychiatry are central to this conversation, said Xu—and psychiatry has not been able to do so up to now. Also, how to establish whether or not a mentally ill patient is competent to make a life-ending decision also has yet to be determined, Xu commented. In addition, she said, the United States lacks universal access to high-quality health care—a similar point made repeatedly by Canadian psychiatrists

who live in a country where there is universal health care but an absence of adequate, intensive care for people with serious mental illness. Such inequities in health care add “another layer to this already very complex question,” said Xu.

If, however, psychiatric illness is seen as comparable to any other medical illness, then psychiatric patients should eventually be eligible for the same considerations as other patients asking for medical assistance in dying, she said. Given the current limitations in defining terminality and futility in psychiatry, however, it is essential that the profession ponder more clearly how we care for chronically mentally ill patients and how we can better provide comprehensive palliative care, said Xu. **PN**

“Current Death With Dignity Laws” is posted at <https://www.deathwithdignity.org/learn/death-with-dignity-acts/>. “Psychiatric Euthanasia and the Ontology of Mental Disorder” is posted at <https://onlinelibrary.wiley.com/doi/full/10.1111/japp.12462>. “Government Agrees Mentally Ill Should Have Access to Assisted Dying—in 2 years” is posted at <https://www.cbc.ca/news/politics/maid-bill-senate-amendments-1.5924163>. “Physician Aid-in-Dying for Individuals With Serious Mental Illness: Clarifying Decision-Making Capacity and Psychiatric Futility” is posted at <https://doi.org/10.1080/15265161.2019.1654018>.

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