

# PSYCHIATRIC NEWS

ISSN 0033-2704

## Be Prepared to Address Technological Addictions in Psychiatric Practice

*In an ever-expanding high-tech environment, some individuals who are overly preoccupied with technology and online activity may need psychiatric help.*

BY PETROS LEVOUNIS, M.D., M.A.

SEE SPECIAL REPORT ON PAGE 23

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## Study Shows Declining Trend In Psychotherapy by Psychiatrists

*The disparity revealed in an AJP study points to a wider public health crisis driven by an insurance industry that disincentivizes treatment aimed at recovery by the most highly trained practitioners.* BY MARK MORAN

More than half of psychiatrists in a nationally representative survey said they do not provide psychotherapy of any kind, and the percentage of visits to a

psychiatrist involving psychotherapy dropped more than 50% between 1996 and 2016, according to a report in the *American Journal of Psychiatry* (AJP).

The findings indicate a growing dis-

parity between patients who receive psychotherapy and those who do not, with psychotherapy by psychiatrists increasingly provided to patients who pay out of pocket.

"Some of the lowest rates in psychotherapy were observed among Black

and Hispanic patients, patients with schizophrenia, those in the Medicaid program, and those receiving care in organized practice settings," study co-author Mark Olfson, M.D., M.P.H., told *Psychiatric News*. "These trends suggest that patients facing socioeconomic disadvantages have the lowest likelihood of receiving psychotherapy from their psychiatrists. Such patterns raise concerns over equitable access to psychotherapy from psychiatrists."

see **Psychotherapy** on page 34

PERIODICALS: TIME SENSITIVE MATERIALS

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## PSYCHIATRIC NEWS

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## FROM THE PRESIDENT

# Don't Look Away

BY VIVIAN B. PENDER, M.D.

In the last month of 2021, the darkly cynical film “Don’t Look Up” was released. The plot revolves around the impending end of the world brought about by a collision with a comet. Despite scientists’ attempts to alert the government, the media, and the public, most people did not focus on this important news from NASA. Their heads filled with inconsequential trivia and the government’s unwillingness to act on the scientists’ advice, they were unable to notice or comprehend their imminent extinction. This farcical allegory points out how the denial of science and truth can be reinforced by destructive aspects of societal structures. When the comet finally becomes visible to the naked eye, people start to recognize the urgency of their dilemma, but by then it is too late.

This doomsday tale may have some cautionary insights for psychiatry. Pre-COVID-19, there was consistent news about the collapsing infrastructure of health care. Two years into the pandemic, it is undeniable that COVID-19 has placed unanticipated and extraordinary demands on our already beleaguered health care system. Psychiatry



the workplace.

Psychiatrists might want to look up, so to speak, and ask what are the plans for the future of psychiatric systems? Are psychiatric services facing this kind of imminent destruction? And if so, what can we do now to change this trajectory? One place to start is the structure and policies of health care workplaces.

For example, in one Connecticut health care system alone, 400 nurses have reportedly resigned or moved. Additionally, nurses who get sick with COVID-19 or test positive must stay home without pay. In part, traveling nurses are filling empty spots; however, these nurses are new to their workplace and its procedures and staff, which is causing turmoil in everyday operations.

In contrast, in another hospital system in Connecticut, 10 surgeons were terminated between 2020 and 2021 because there wasn’t enough work to

in particular has faced an enormous increase in demand for mental health care along with significant changes in the structure of

keep them employed. As one talented working surgeon told me: “I’m at the beginning of my career, and I’m worn out. I was lucky not to be furloughed last year. I don’t want to hear *anything* about COVID anymore. I spent 13 years in training, and I can barely get through the day to use all that experience. I’m worried about patient care. I just started directing a surgical center, but I’m looking forward to an early retirement.”

This surgeon’s story is not an isolated one. The demand for health care varies by specialty because of the pandemic, and the health care system is under enormous strain.

For physicians, looking away is certainly not a solution. We *must look* to secure the future of our health care system and our profession. So, what are the plans for the future of psychiatry? Motivation to become a psychiatrist for many is based on a desire to diagnose, treat, and care for individuals with psychiatric illness. However, the reality is that pre-COVID-19, psychiatry, as a profession, was already wrestling with fundamental problems such as parity and reimbursement, moral injury, medical corporatization, the advent of neuropsychiatry, maintenance

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# No Surprises Act Brings New Billing Rules, Disclosures; Doctors Sue

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*The Biden administration's regulations implementing the No Surprises Act are now in effect. Meanwhile, physician and hospital groups sue over its dispute-resolution process for hospital care.*

**BY LINDA M. RICHMOND**

**K**ey provisions of the No Surprises Act took effect January 1, and with it comes new billing limits for psychiatrists providing emergency and hospital-based care to insured patients at network facilities. The regulations also impose new paperwork rules to clinicians offering office-based care to uninsured or self-pay patients.

The law was intended to protect insured patients from large bills that can arise when they receive care from out-of-network doctors they did not choose, such as in an emergency or for a surgical procedure. Last year, federal agencies published two interim final rules and another proposed rule to implement the law.

First, when patients receive hospital or emergency care at their plans' network facilities, the regulations prohibit plans from charging patients more than in-network rates. In these cases, out-of-network physicians may not bill

patients more than the network cost-sharing amount allowed by their plans. The regulations set a penalty of up to \$10,000 for each violation.

The federal government estimates that patients with private insurance make 40 million emergency visits a year. Prior to this law, 18% involved at least one surprise medical bill.

The regulations establish a process for determining the payment amount for surprise medical bills that starts with negotiations between plans and providers. When parties cannot agree, the regulations create an independent dispute resolution (IDR) process.

Physician and hospital groups filed a lawsuit in federal court last December saying the IDR unfairly benefits insurance companies and gives them incentive to keep payments to network physicians low.

## New Disclosure Rules for All Doctors

When providing office-based care, psychiatrists and other clinicians are excluded from the new rules that govern the amount of the bill. However, the regulations now require them to provide all uninsured or self-pay patients a "good faith estimate" of expected charges. Such estimates must

be provided whenever services are scheduled or whenever a patient requests one. The rule applies to current and future patients alike. For now, the fee disclosure rule does not pertain to patients who intend to submit a claim to their health insurance plan. However, the rule is expected to apply to all patients in the near future as more rules are rolled out.

Physicians' fee estimates must be in a written document that is clear, understandable, and prominently displayed, according to the regulations. Physicians must also post a notice on their website informing patients of their right to a good faith estimate. The Centers for Medicare and Medicaid Services (CMS) has created a template for both disclosures.

The regulations establish a new patient-provider dispute-resolution process for cases in which the billed charges exceed by \$400 or more the good faith estimate. If negotiations don't succeed, a new independent dispute-resolution process may be initiated.

## Details of Lawsuit

What happens when plans and physicians providing emergency or hospital-based care at in-network facilities cannot come to terms on payments? The regulations specify that when disputes arise, the payment should be based on health plans' median rate paid to in-network providers in their geographic area.

Physician and hospital groups say this interpretation of the law upends the careful compromise Congress deliberately chose for resolving billing disputes, according to a statement issued by the AMA and American Hospital Association (AHA). In the lawsuit filed against the federal government

last December, the groups charged that the law unfairly limits consideration of other factors—and benefits commercial health insurance companies.

"The lawsuit argues that the regulations are a clear deviation from the law as written and all but ensure that hospitals, physicians, and other providers will routinely be undercompensated by commercial insurers, and patients will have fewer choices for access to in-network services," according to the joint AMA/AHA statement.

A bipartisan group of 152 lawmakers urged the administration to return to the original language of the No Surprises Act. That law advised arbiters to consider other factors besides median in-network rates, such as provider training, quality of outcomes, complexity of services rendered, as well as hospitals' teaching status, case mix, scope of services, and demonstrations of previous good faith efforts to negotiate in-network rates.

The law's current approach "is contrary to statute and could incentivize insurance companies to set artificially low payment rates, which would narrow provider networks and jeopardize patient access to care—the exact opposite of the goal of the law," lawmakers wrote in the letter. "It could also have a broad impact on reimbursement for in-network services, which could exacerbate existing health disparities and patient access issues in rural and urban underserved communities." **PN**

**APA's guidance for psychiatrists on the No Surprises Act is posted at <https://www.psychiatry.org/psychiatrists/practice/practice-management/no-surprises-act-implementation>. A template for good faith estimates is posted at <https://www.apaservices.org/practice/legal/managed/good-faith-estimate-template.pdf>. The AMA and AHA's press release is posted at <https://www.ama-assn.org/press-center/press-releases/ama-and-aha-file-lawsuit-over-no-surprises-act-final-rule>.**

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nance of certification requirements, emphasis on psychopharmacology, demise of psychotherapy, and exclusion of social determinants of psychiatric illness, just to name a few. The pandemic has only compounded this state of affairs by exponentially increasing the demand for mental health services and expertise.

Structural change in the health care workplace is critical for the future of psychiatry and psychiatrists regardless of the work they do or where they practice. Health care employers need to do the following:

- Provide mental health support to meet the soaring demand for services for their employees.

- Ensure flexible work policies that support and promote the mental health of employees.

- Prioritize workplace policies to benefit the mental health of employees' children and families.

- Promote mental health education, which needs to be provided to all employees.

- Prevent burnout by improving organizational shortfalls.

- Focus on destigmatizing employees' serious psychiatric illnesses such as substance use disorders and suicidal thoughts and create a climate in which employees feel supported to reach out for help.

While genetics, novel treatment approaches, and new investigative targets such as inflammation and the microbiome will give better insights into psychiatric illness and its management, trust in institutional data is decreasing. People live in a wind tunnel of information frequently lacking accuracy and transparency. Discernment of information should not be ceded to another authority lest "fake news" becomes the norm even in matters of life and death. Regarding speaking truth to power, as the Rev. Martin Luther King Jr. so eloquently said, "The day we see the truth and cease to speak is the day we begin to die."

Lastly, physicians must acknowledge that discrimination of all kinds exists in health care systems that must be

addressed by employers. If discrimination continues, innovations in health care may disproportionately reach only a small segment of society. Organizations such as Physician Just Equity are dedicated to improving justice for physicians and surgeons who face discrimination in the workplace. It is focused on building an inclusive work environment at systemic levels.

We can't look away—we *must* look and recognize that the U.S. health care system is in crisis, and psychiatry even more so. Only by acknowledging this can we secure the future of psychiatry and start to reform the psychiatric workplace by demanding that employers must act to ensure equity and make structural changes to support their workers. Lives depend on this. **PN**

# Surgeon General Calls for Action to Address Youth Mental Health Crisis

*One in three high school students reported persistent feelings of sadness or hopelessness, while suicide rates for young people rose 57% in a decade. More child and adolescent psychiatrists are needed. BY LINDA M. RICHMOND*

U.S. Surgeon General Vivek H. Murthy, M.D., M.B.A., issued a rare public health advisory last December, calling on the nation to respond to the growing mental health crisis impacting young people that has worsened with the pandemic.

"Recent national surveys of young people have shown alarming increases in the prevalence of certain mental health challenges—in 2019, 1 in 3 high school students and half of female students reported persistent feelings of sadness or hopelessness, an overall increase of 40% from 2009," wrote Murthy in the advisory.

Suicide rates among youth aged 10 to 24 years increased by 57% between 2007 and 2018, and there were more than 6,600 estimated deaths by suicide in 2020 in this age group.

"[T]oo often, young people are bombarded with messages through the media and popular culture that erode their sense of self-worth—telling them they are not good looking enough, popular enough, smart enough, or rich

enough," Murthy wrote. "That comes as progress on legitimate and distressing issues like climate change, income inequality, racial injustice, the opioid epidemic, and gun violence feels too slow."

Various hypotheses have emerged to explain the youth mental health crisis, with researchers pointing to the growing use of digital media; increasing academic pressure; limited access to mental health care; alcohol and drug use; and broader stressors such as rising income inequality, racism, gun violence, and climate change. The pandemic and its disruptions to life at home and school and in the community have exacerbated these effects on youth. Tragically, more than 140,000 U.S. children have lost a parent or grandparent caregiver to COVID-19 as of June 2021.



"[Y]oung people are bombarded with messages through the media and popular culture that erode their sense of self-worth—telling them they are not good looking enough, popular enough, smart enough, or rich enough," says Vivek H. Murthy, M.D., M.B.A.

Gabrielle Shapiro, M.D., chair of APA's Council on Children, Adolescents, and Their Families and a clinical psy-

chiatrist at the Icahn School of Medicine at Mount Sinai, said that the integration of social and emotional development into the school curriculum has helped make today's children and adolescents much more likely than adults to discuss their depression, anxiety, and suicidality and to seek help for it. "We are slowly melting the stigma of mental illness, particularly with the younger generation, and that's a good thing. However, the increases in depression and suicidality among young people should serve as a wake-up call to all of us," she added.

"The level of societal anxiety, conflict, and rage that we have had for the last six years has been much higher than usual, and this has spilled down onto our kids, who've had nearly constant interaction with it on social media. During the pandemic, children have been isolated from their peers and stuck at home, bereft of any structure that is comforting for them. This amplified any existing problems in the family dynamic, such as dysfunction or conflict. At the same time, families experienced serious financial concerns, food insecurity, housing concerns, and fear of death from COVID-19."

Shapiro said that more child and adolescent psychiatrists are needed to ensure that youth with mental health challenges receive the treatment they need. She called for increased government support for those training to

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## APA'S GOVERNMENT, POLICY, AND ADVOCACY UPDATE

### Physician Groups Urge Supreme Court to Uphold Vaccination Requirement

APA joined 15 leading medical organizations in an amicus brief urging the Supreme Court to reject challenges to the Occupational Safety and Health Administration's (OSHA) emergency temporary standard requiring COVID-19 vaccination and testing for large employers. The brief stated that a stay on OSHA's requirement "would cause severe and irreparable harm to the public interest." In mid-January, however, the Supreme Court blocked OSHA's vaccination and testing requirement for large employers but upheld a vaccination mandate for health care workers at facilities that receive funds from the federal government.

The brief outlined the grave danger that COVID-19 poses to workplace health, noting that COVID-19 outbreaks have occurred among workers in numerous industries and citing studies that found, for example, that adults who tested positive for COVID-19 were significantly more likely to report going to an office or school setting than adults who tested negative. No arguments against the need for vaccination are medically valid, the brief stated, other than to accommodate a medical contraindication.

The amicus brief is posted at [https://www.supremecourt.gov/DocketPDF/21/21A244/206954/20211230135726547\\_FOR%20FILING%20SCOTUS%20OSHA%20ETS%20amicus.pdf](https://www.supremecourt.gov/DocketPDF/21/21A244/206954/20211230135726547_FOR%20FILING%20SCOTUS%20OSHA%20ETS%20amicus.pdf).

### DOL Highlights Parity Enforcement in Regulatory Agenda

The U.S. Department of Labor (DOL) included enforcement of the Mental Health Parity and Addiction Equity Act (MHPAEA) as a top priority in its Fall 2021 Statement of Regulatory Priorities.

The statement emphasizes DOL's commitment to ensuring workers "have access to the resources they need to manage their mental health." The work of the Employee Benefits Services Administration (EBSA) to implement MHPAEA "will strengthen health enforcement by clarifying plan and issuer obligations, promote compliance, and address amendments to the Act from the Consolidated Appropriations Act of 2021," according to the statement. The Consolidated Appropriations Act, which included APA's priority legislation—the Strengthening

Behavioral Health Parity Act—gave EBSA new enforcement abilities (*Psychiatric News*, <https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2021.8.19>).

The introduction to the Biden-Harris administration's Fall 2021 Regulatory Plan noted that DOL, as well as the departments of Health and Human Services and Treasury, "are considering changes to clarify health insurance plans' and issuers' obligations to cover mental health and substance use treatment."

DOL's Statement of Regulatory Priorities is posted at [https://www.reginfo.gov/public/jsp/eAgenda/StaticContent/202110/Statement\\_1200\\_DOL.pdf](https://www.reginfo.gov/public/jsp/eAgenda/StaticContent/202110/Statement_1200_DOL.pdf). The administration's regulatory plan is posted at <https://www.reginfo.gov/public/jsp/eAgenda/StaticContent/202110/OIRAIntroduction-202110.pdf>.

### Legislation to Implement VA Zero Suicide Initiative Introduced

In an effort to reduce the rate of suicide among veterans, Reps. Susie Lee (D-Nev.), Tony Gonzales (R-Texas), Colin Allred (D-Texas), and Anthony Gonzalez (R-Ohio) introduced the VA Zero Suicide Demonstration Project Act (HR 6273).

The APA-supported bill would implement the Zero Suicide Initiative at five VA medical centers. The initiative was founded by the Henry Ford Health Care System. According to the Henry Ford website, the goal of zero suicides was implemented in 2001 and led to an 18-month stretch without a suicide death from 2009 to 2010. This was "a statistically relevant decrease in suicide rates within Henry Ford from its inception," the website states.

"By implementing Zero Suicide pilot programs at five VA medical centers across the country, the legislation would increase access to safer and concurrent suicide care," said APA CEO and Medical Director Saul Levin, M.D., M.P.A., in a statement. "Bringing the Zero Suicide model of care to our veterans will help foster a cultural shift toward comprehensive suicide treatment and represents an important step in our ongoing effort to give those who defend our country the support and resources they deserve."

Information about the bill is posted at <https://susielee.house.gov/sites/susielee.house.gov/files/One-pager%20-%20VA%20Zero%20Suicide%20Demonstration%20Project%20Act.pdf>. The legislation is posted at <https://www.congress.gov/bills/117th-congress/house-bill/6273/text>.



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## Cross-State Licensure Laws for Telehealth Evolve During Pandemic

*Physicians practicing telehealth must keep up with a dizzying array of state laws for cross-state licensure during the pandemic. Thirty-three states and D.C. have now joined a multi-state compact to expedite physician licensure.* **BY LINDA M. RICHMOND**

State regulations governing the provision of telehealth across state lines have been in a state of flux during the COVID-19 pandemic. To avoid uncertainty, an increasing number of physicians are obtaining multiple state licenses through an expedited process.

“When it comes to interstate licensure rules as well as reimbursement for physicians using telehealth, the landscape is still shifting, and states

are all on different timetables,” Mei Wa Kwong, J.D., executive director of the Center for Connected Health Policy (CCHP), a federally funded nonprofit providing telehealth policy research, education, and technical assistance, told *Psychiatric News*. “Some states have made permanent changes to their interstate licensure laws; others tied them to declarations of public health emergency, which for some states have expired; and some enacted temporary

changes in procedures during the pandemic. It is very difficult for clinicians to navigate.”

According to CCHP, telehealth services are generally considered to be rendered at the physical location of the patient, so to avoid practicing without a license or jeopardizing malpractice insurance, physicians should verify the location of their patients at the start of each telehealth session. Kwong said complying with the rules can pose challenges when patients become more transient, such as young people moving back in with their parents during the pandemic. “It’s a tricky path for clinicians to navigate, especially if they

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become child and adolescent psychiatrists, including tuition assistance and loan reimbursement, as well as more avenues to train these clinicians to lead mental health teams.


Murthy wrote that most importantly, the mental health challenges of youth are treatable and often preventable. “Ensuring healthy children and families

Shapiro also said that “schools should continue to employ a social and emotional development curriculum for all students, and because of the shortage of mental health professionals, offer group therapy—for students who are deemed stable and not acutely dangerous to themselves or others—with licensed providers who are supervised by child and adolescent psychiatrists.” In addition, Shapiro advised parents to super-

care principles and prevention strategies to improve care for all youth, especially those with a history of adversity.

- Routinely screen children, such as during well-visit appointments, for mental health challenges and risk factors, including adverse childhood experiences.
- Identify and address the mental health needs of parents, caregivers, and other family members.
- Combine the efforts of clinical staff with those of trusted community partners and child-serving systems, such as those in the child welfare system.

- Build multidisciplinary teams to implement services that are tailored to the needs of children and their families and provide culturally appropriate services in multiple languages and delivered by a diverse mental health workforce. **PN**

 **“Protecting Youth Mental Health: The U.S. Surgeon General’s Advisory” is posted at <https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf>.**



**More child and adolescent psychiatrists are needed to ensure youth with mental health challenges receive the treatment they need.**

**—Gabrielle Shapiro, M.D.**

will take an all-of-society effort, including policy, institutional, and individual changes in how we view and prioritize mental health,” Murthy wrote. The advisory provides recommendations for health care professionals and organizations, young people and their families, technology and media companies, schools and community organizations, and government.

vise their children’s use of technology and social media and place limits on the type and duration of use, depending on their developmental stage.

The surgeon general’s advisory gives the following recommendations for physicians and other health care professionals and organizations:

- Implement trauma-informed

suddenly have patients in three states that all do things differently.”

### Many States Retained Licensure Waivers

Although the details vary widely, as of press time, a number of states retained some form of waiver of licensure requirements for out-of-state physicians who are providing telehealth services including Arizona, Colorado, Delaware, Idaho, Indiana, Iowa, Louisiana, Michigan, Minnesota, Mississippi, Nevada, New Mexico, North Carolina, Oregon, Pennsylvania, Texas, Utah, Washington, West Virginia, Wisconsin, and Wyoming, according to the Federation of State Medical Boards (FSMB), which maintains the most detailed database on the subject. Of those, 14 states plus four U.S. territories have opted to allow long-term or permanent cross-state licensure waivers for clinicians engaged in telehealth. Virtually all the waivers require physicians to be licensed in their state of residence and in good standing with no complaints against their medical license.

“It’s imperative that physicians keep up with the status of these rules,” Lisa A. Robin, chief advocacy officer for the FSMB, told *Psychiatric News*. One trend she is seeing is that more states are starting to carve out exceptions to licensure rules only to allow cross-state physicians to treat established patients via telehealth for continuity of care. Ultimately, psychiatrists may be the most impacted by these changes: “It is anticipated that the majority of telehealth is going to be in the field of mental health going forward,” she added.

Arizona’s HB 2454 permanently allows physicians licensed out of state to provide telehealth to Arizona patients, but they must register; Florida has a similar law. Delaware’s HB 348, signed into law last July, permanently allows only those out-of-state physicians who are providing mental health care to serve state residents using telehealth without a Delaware license. Alabama requires out-of-state clinicians to apply for a “special purpose license” to engage in telehealth. Colorado allows out-of-state physicians to provide “occasional” telehealth services to residents.

Meanwhile, Texas allows physicians to apply for a special telemedicine licensure, but it is limited to follow-up care or interpretation of diagnostic testing. Washington permits clinicians licensed out of state to provide telehealth care, but only for “infrequent or episodic” follow up. Connecticut’s changes may be the most confusing: An executive order expired that had temporarily permitted out-of-state physicians to treat Connecticut residents, and while its Public Act 21-9 authorized an extension, no such order

*see Licensure on page 11*

# Board Approves Position Statements, Anticipates In-Person 2022 Annual Meeting

*Trustees dealt with a number of major issues in psychiatry and heard reports on APA's progress on addressing structural racism within APA.*

The APA Board of Trustees approved 14 new or revised position statements during its virtual meeting last December.

New position statements were approved on the following: Civil Commitment of Minors; Medical Supervision of Psychiatry Residents and Fellows; Moral Injury Among Healthcare Workers During a Public Health Crisis; Racism and Racial Discrimination in the Psychiatric Workplace; Mental Health Impact of Public Health Emergencies on Young People; and Immigration, Children, Adolescents, and Their Families.

Revised position statements include Location of Civil Commitment Hearings, Sexual Harassment, Psychiatric Services in Adult Correctional Facilities, Off-Label Treatments, Trial Sentencing of Juveniles in the Criminal Justice System, Telemedicine in Psychiatry, Core Principles for Alternative Payment Models for Behavioral Health, and College and University Mental Health.

Catherine Crone, M.D., chair of APA's Scientific Program Committee, provided a high-level overview of the status of the in-person 2022 Annual Meeting to be held May 21 to 25 in New Orleans. The theme of the meeting is "Social Determinants of Mental Health."

During the meeting's submission

period, 481 general session abstracts, 25 course abstracts, and 745 poster abstracts were received. Of these, the committee selected 119 general sessions, five courses, and 500 posters. New on the submission form this year was a question asking submitters how their proposal incorporates diversity, equity, and inclusion.

Well-known leaders in psychiatry have already been confirmed to present, including Nora Volkow, M.D., director of the National Institute on Drug Abuse; Charles Nemeroff, M.D., Ph.D., the Matthew P. Nemeroff Professor and Chair of the Department of Psychiatry and Behavioral Sciences at the University of Texas at Austin Dell Medical School; and Joshua Morganstein, M.D., an associate professor and assistant chair in the Department of Psychiatry and assistant director at the Center for the Study of Traumatic Stress at the Uniformed Services University.

The program will include a new, 20-session track of clinical updates for clinicians. The sessions will focus on tangible takeaways that attendees can apply to patient care in the domains of anxiety, mood, and personality disorders; schizophrenia; and substance use disorders, among others.

This year's meeting will also be the first hybrid meeting. Select sessions will be recorded at the live meeting. Two weeks later, from June 7 to 10, the recordings will be streamed for virtual attendees, followed by live online Q&A sessions. Additional CME will be available for the online meeting.

## Presidential Theme and Work

APA President Vivian B. Pender, M.D., gave an update on her Presidential Task Force on the Social Determinants of Mental Health (SDoMH).

In November and December 2021, the task force held two virtual town halls for APA members focused on education and awareness of the social determinants of health and mental health, available resources from APA and other organizations and agencies, and the work of the task force. The task force includes clinical, research and education, policy, and public health work groups. Almost 400 people registered for the town halls. The task force will submit a final report with recommendations at the March Board meeting.

## Structural Racism Accountability Report

Mary Hasbah Roessel, M.D., and Felix Torres, M.D., M.B.A., co-chairs of the Board of Trustees Structural Racism Accountability Committee (SRAC), presented an update on the progress APA is making on the implementation of recommendations from the Task Force on Structural Racism Throughout Psychiatry. While there has been progress in some areas, the challenge is how to ingrain that progress for future years and how to measure success. An issue with which the SRAC is struggling is the need for underrepresented members to self-identify so that the success or failure of programs can be evaluated with data. SRAC will be spearheading a campaign along with Communica-

tions and the Division of Diversity and Health Equity (DDHE) to encourage members to self-identify.

Bob Ensinger, chief communications officer, and Ryan Vanderbilt, membership and marketing officer, presented a communications and marketing plan to ensure that members are aware of SRAC, its charge, and APA's progress in implementing the task force's recommendations.

## APA Supports ABPN Proposals

To support the growth of the PsychPRO registry and continued access to high-quality and innovative continuing medical education (CME) products that participating members can use to satisfy Maintenance of Certification (MOC) requirements, the Board voted at a subsequent meeting to approve two contract funding proposals from the ABPN. The first contract will provide \$1 million to help establish the PsychPRO registry by funding part of the cost of joining for institutions and individuals and help APA reach its goals of 1 million unique patients and 10 million patient encounters by 2025. The second contract provides \$1 million to develop CME consisting of 36 hours, 16 of which can be used to satisfy MOC self-assessment requirements in 2022. These CME and MOC activities will be provided free to APA members and ABPN diplomates through the APA Learning Management System. More information on ABPN-funded activities is posted in the 2022 APA CME and MOC guide at <https://www.psychiatry.org/psychiatrists/education/certification-and-licensure>. **PN**

**APA position statements are posted at <https://www.psychiatry.org/psychiatrists/search-directories-databases/policy-finder>.**

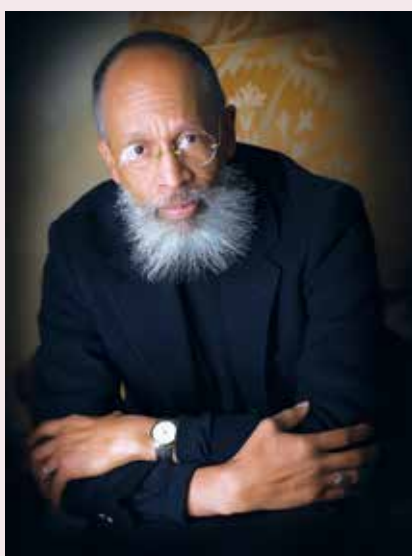
## Special Exhibit, Town Hall by APA Library to Mark Black History Month

The Melvin Sabshin, M.D. Library and Archives, under the direction of Deena Gorland, M.S.L.I.S., is sponsoring a series of events on the history of the Central Lunatic Asylum for Colored Insane to mark Black History Month.

Central Lunatic Asylum for Colored Insane, now Central State Hospital, opened in 1870 in Petersburg, Va., and was the first state hospital in the United States exclusively for African Americans. Rather than integrate its two existing asylums, Virginia's governor signed legislation to house all "insane" Black people in a former Confederate hospital. The governor alleged that the two other Virginia asylums lacked sufficient space.

The Black History Month commemoration includes a live exhibition at APA's headquarters and a virtual exhibition posted at <https://legacy.psychiatry.org/Historic-Highlights/Exhibitions>. The exhibition includes primary

source documents, photographs, public laws, news articles, and admission and treatment data from Central State Hospital's records. A virtual town hall with historian and Central State Hospital expert King Davis, Ph.D., will be held on Tuesday, February 22, at 7:30 p.m.



Analysis of these primary source documents confirms that at the conclusion of the Civil War, strict racial separation and medical disparities were ubiquitous throughout Virginia. APA's forerunner, the Association of Medical Superintendents of American Institutions for the Insane, played a central role in setting segregation policies in asylums. Integrating insane asylums would have established a new racial covenant consistent with the aims of Reconstruction but contrary to the recommendations of asylum directors and the state's asylum commission. The trove of historical doc-

uments in the exhibition reveals that the decision to open a separate institution for Blacks was based on a series of hypotheses that created a false connection between Blackness, freedom from enslavement, and the risk of psychiatric illness. Contemporary research by Jonathan Metzler, M.D., Ph.D., found that these historical faux assumptions resulted in disproportionate diagnoses of severe mental illness as Blacks sought equitable access to civil rights well into the 21st century.

"The history of Central State Hospital is part of the untold history of America, APA, and the field of psychiatry," said Rawle Andrews Jr., executive director of the APA Foundation. "Taking ownership of this history is an important step toward atoning for the harm to Black patients and their families who did not get the care or compassion they deserved."

**Register for the town hall at [https://zoom.us/webinar/register/WN\\_qaCzzYqjQaqP0G-oQn29Yw](https://zoom.us/webinar/register/WN_qaCzzYqjQaqP0G-oQn29Yw). An article by Davis on the history of the asylum is posted at <https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2018.5a18>. More information on efforts to save Central State Hospital's archives is posted at <https://www.coloredinsaneasylums.org/>. To visit the live exhibit, email [library@psych.org](mailto:library@psych.org).**



# Past APA President Harold Eist, M.D., Dies

*Eist was also president of the Washington Psychiatric Society for three terms and was active in the World Psychiatric Association. BY MARK MORAN*

**P**ast APA President Harold Eist, M.D., died December 16, 2021. He was 84. The cause of death was complications related to surgery, according to Ann Eist, his wife of 61 years.

Eist, who served as APA president for the 1996-1997 term, was elected on a wave of membership anger with managed care, which Eist castigated as destructive of patient care. Introducing Eist at the 1997 APA Annual Meeting in San Diego, then Medical Director Melvin Sabshin, M.D., described Eist as a “populist president whose intensity of care for our profession and for our individual members has never been exceeded; a president whose assertive passion about the threats to the practice of psychiatry has never been surpassed; and a president who has mobilized us, individually and collectively, to combat those threats with all the force we can muster.”

“The suffering of the mentally ill is being ignored, denied, and made invisible on the altar of managed care’s bottom line, and our patients know this,” wrote Eist in his February 7, 1997, pres-

idential column in *Psychiatric News*. “This dehumanization is intolerable, and regardless of ‘contracts,’ we have to ask how physicians can participate in it?”

In addition to being president of APA, Eist served three separate terms (1981-1982, 1990-1991, and 2008-2009) as president of the Washington Psychiatric Society and a term as president of the Suburban Maryland Psychiatric Society. Always active in the World Psychiatric Association (WPA), Eist was a chair of the WPA Standing Committee to Review the Abuse and Misuse of Psychiatry. In that role, he was part of a delegation that met in 2004 with the Chinese Minister of Health and other Chinese officials around allegations that the Chinese used psychiatric hospitalization to punish members of the Falun Gong for their religious and cultural beliefs (*Psychiatric News*, <https://psychnews.psychiatryonline.org/doi/full/10.1176/pn.39.15.0390002>).

Eist completed his undergraduate and medical school training at the University of Alberta. He was trained in



Past APA President Harold Eist, M.D., died December 16. He was 84.

psychiatry at the University of Minnesota and completed his residency in 1967. It was at the University of Alberta that he met his future wife, who was getting a degree in social work. They married in 1960 while Eist was still in medical school.

At APA meetings and elsewhere, the two were inseparable. “They are a true partnership, supporting each other in all areas of their lives, personal and professional,” Sabshin said in his 1997

speech. “Even his presidency has been a partnership effort.”

The Eists moved to Washington, D.C., in 1967 when he was hired by the legendary Chestnut Lodge in Rockville, Md. He was trained in psychoanalysis at the Washington Psychoanalytic Institute. He was also hired as medical director of the fledgling District of Columbia Institute of Mental Hygiene. That clinic—with a staff of five and 18 patients—grew under his leadership to a staff of 150 professionals treating more than 2,500 patients a year at three sites. The clinic was a major part of Eist’s life for 22 years.

In addition to his work at the clinic, Eist maintained a private practice in Bethesda, Md., and was a professor of psychiatry at Howard University School of Medicine and clinical professor of psychiatry and behavioral sciences at the George Washington University School of Medicine and Health Sciences. Mrs. Eist recalled telling her husband once that maybe he should cut back on working six days a week. He responded, “This is what keeps me going, working for my patients.”

He was recipient of the NAMI Exemplary Psychiatrist Award and the WPA’s Leader in World Psychiatry Award. He was also awarded the Frieda Fromm-Re-

see **Harold Eist** on page 9

Advertisement

# Best Health Care App for 2021 Helps Patients Complete Crisis Care Plans

*SMI Adviser's app named My Mental Health Crisis Plan is designed to advance patient-centered care by ensuring that a patient's voice is heard, even during times when the patient may not be able to clearly express his or her wishes.* **BY LINDA M. RICHMOND**

There is increasing interest in helping individuals with serious mental illness (SMI) create a crisis plan: As of press time, My Mental Health Crisis Plan app has been downloaded more than 7,625 times and just racked up its second award, "Best Health Care Mobile Application" for 2021 in the MobileWebAwards.

"When a crisis occurs, some people with mental illness lose control of their treatment and their treatment choices. Due to an inability to make and communicate treatment decisions, they are unable to give valid, informed consent to a treatment plan," said Marvin Swartz, M.D., professor and head of the Division of Social and Community Psychiatry at the Duke University School of Medicine, who consulted on the app's design. "The default may be involuntary commitment, which many patients later regret. Such patients

may not have their choice of hospital, and they are most often transported by police, which can give them the feeling of being arrested. It's an intimidating process."

The app was developed and released in October 2020 by SMI Adviser, which is funded by the Substance Abuse and Mental Health Services Administration and administered by APA. SMI Adviser provides a variety of free resources and consultations with clinical experts to provide the best possible care for people with serious mental illness.

The My Mental Health Crisis Plan app walks people through the process of creating a crisis plan by letting them specify their preferences for facilities, emergency treatments, clinicians, and medications.

Individuals who create a crisis plan using the app can also list the names of their proxy (decision-maker); psy-

chiatrist, therapist, and other clinicians; emergency contacts and others to be notified; and whom they prefer to watch their children.

My Mental Health Crisis Plan allows individuals to easily share their crisis plan via text, email, PDF, or even QR code—the app also won an award in 2020 for best use of a QR code. "For privacy reasons, none of the data that someone inputs is stored to the cloud; it is saved only on the user's phone," explained Amy Cohen, Ph.D., director of SMI Adviser. "Ultimately, the goal is the advancement of patient-centered care by ensuring that an individual's voice is heard, even during times when the individual may not be able to clearly express his or her wishes," she said.

The app also helps users take a few extra steps to turn their crisis plan into a psychiatric advance directive (PAD), a legal instrument that allows individuals to plan for their own care in the event of decisional incapacity. According to the National Resource Center on Psychiatric Advance Directives, at least 27

see **Best App** on page 28



The free My Mental Health Crisis Plan app walks users through the process of creating a crisis plan by letting them specify their treatment preferences, name a trusted decisionmaker, and provide emergency contacts.

Advertisement



# Community Psychiatrist Brings Awareness Of Inequity to Work as White House Fellow

Sunny Patel, M.D., M.P.H., credits APA for helping to shape his career trajectory through a number of its programs. **BY MARK MORAN**

When psychiatrist Sunny Patel, M.D., M.P.H., was growing up as a child in Maharashtra, a state in the western region of India, he lived in a building that abutted a slum.

"On one side we were pretty middle class, but on the other side of the wall was a slum," he recalled. "If I made a left, I was in the slum. If I made a right, it went to the elementary school I attended with the other middle-class kids."

It was a stark division that has stayed with him. "I remember thinking even then as a child—why do I go to school but the kids on the other side of the wall, in the slum, play in the streets?"

That same acute awareness of haves and have-nots followed him to the United States, when he and his family emigrated to a middle-class suburb of Chicago. He brought with him the idealized vision of a country where opportunity is open to all.

"I had a fantasy of America as a place of walking escalators"—everyone on the move and moving up. And sure enough, when he landed at O'Hare air-

port, there he was on the airport's walking escalator, with the flashing lights overhead, moving from the arrival gates to the terminal.

"I thought, I've arrived."

Reality intruded upon the fantasy. "The complexity of the American experience struck me pretty early on," Patel said. "The America I saw didn't match the fantasy. I kept grappling with the question, Why does inequality and inequity exist? Why do I have, and others don't have?"

Today, Patel is bringing that formative awareness to the federal Department of Homeland Security (DHS), where he is working as a White House fellow with DHS Secretary Alejandro Mayorkas on immigration issues. He was appointed to the fellowship by President Joseph Biden last October.

The prestigious White House Fellowship embeds professionals from diverse



"This is a unique opportunity to work with the federal government at the highest level with senior White House officials and learn how policymaking works and how the federal government impacts the lives of people," says Sunny Patel, M.D., M.P.H.

backgrounds for a year as a full-time, paid fellow for White House staff, cabinet secretaries, and other senior government officials. (One notable graduate of the fellowship program is the late Colin Powell.)

President Lyndon B. Johnson created the White House Fellowship in 1964. The mission of the fellowship is to encourage active citizenship and service to the country. Throughout the year, fellows participate in an education program that expands their knowledge of leadership, policymaking, and contemporary issues. The fellowship is a nonpartisan program that has been maintained throughout Republican and Democratic administrations.

To his work at DHS, Patel carries with him an impressive background in general medicine, child and adolescent psychiatry, community psychiatry, and global health. He graduated from the University of California, Los Angeles, at age 19 and entered medical school at the Mayo Clinic thinking he would become a cardiac electrophysiologist.

But at Mayo, he met three psychiatrists whom he credits as mentors—

Michael Bostwick, M.D., Cosima Swintak, M.D., and Brian Palmer, M.D., M.P.H.

"I really liked the way they interacted with patients," Patel said. Together they convinced him that psychiatry was where he could find a home for working with patients and communities and for his interest in public health and health disparities.

He completed his residency at Cambridge Health Alliance (CHA) at Harvard Medical School and a fellowship in child and adolescent psychiatry at New York University (NYU), where he created a model embedding mental health services in the pediatric oncology clinic. He spent the past decade working with refugee populations and has conducted forensic psychological examinations for asylum seekers with NYU and Physicians for Human Rights. During the COVID-19 pandemic, he launched a comprehensive mental health response for thousands of frontline workers and volunteered as a palliative care physician at Bellevue Hospital.

Mentors included J. Wesley Boyd, M.D., Ph.D., and Amber Frank, M.D., at CHA; and K. Ron-Li Liaw, M.D., and Jenny Havens, M.D., at NYU.

Patel also credits APA for shaping his career trajectory through several travel grants to attend the Annual Meeting and his participation in the APA Medical Student Elective in HIV Psychiatry. The program was established in 2004 to foster the participation of fourth-year medical students (particularly students from racial and ethnic minorities) in HIV-related care and research and provide them with essential HIV-related mental health training through an integrated approach to patient care. He was also an APA Diversity Leadership Fellow and served for a term on the APA Council on International Psychiatry.

Patel noted that the White House Fellowship was designed from the beginning as a way to open the mysteries of federal policymaking to leaders in diverse fields who can bring that knowledge back to their own communities.

He said, "This is a unique opportunity to work with the federal government at the highest level with senior White House officials and learn how policymaking works and how the federal government impacts the lives of people. It creates a community of people who are like-minded in their devotion to their communities and to public service." **PN**

## See You in the Big Easy!

APA's 2022 Annual Meeting will be held for the first time in person since 2019, and it's in a city that has proven popular with APA members over the years—New Orleans, the birthplace of jazz and home to the most distinctively recognized regional cuisine in this country. Register now at the meeting's lowest rates and learn about virtual options at [psychiatry.org/annualmeeting](https://www.psychiatry.org/annualmeeting). Book your hotel at conference rates through the secure portal at <https://www.psychiatry.org/psychiatrists/meetings/annual-meeting/hotel-information>.

### Why Attend?

In addition to reconnecting with colleagues after a stress-filled two-year break due to the pandemic, earning CME, and interacting with psychiatrists from around the world, you'll hear from experts on emerging trends and research that will impact your practice. The theme of the meeting, chosen by APA President Vivian B. Pender, M.D., is "Social Determinants of Mental Health." New this year is the Clinical Updates Track, which will focus on practical, clinical information that can be immediately applied to patient care. Look for more information on the program in future issues of *Psychiatric News*.

APA is keeping a close watch on the evolving COVID-19 situation, and protecting the health and safety of attendees is paramount. All attendees and contractors must be fully vaccinated and wear a face mask during all indoor activities. More information is posted at <https://www.psychiatry.org/psychiatrists/meetings/annual-meeting/safety-considerations>.

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## Harold Eist

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ichmann Award of the Washington School of Psychiatry for his efforts to bring psychotherapy and psychoanalytic treatment to poor and underserved individuals. And he received the Jack Greenspan Award from the Phil-

adelphia Psychiatric Society for "his efforts to preserve, protect, and defend the practice and profession of psychiatry." In 2015, the University of Alberta honored Eist with its Distinguished Alumni Award.

In addition to Mrs. Eist, Eist is survived by their three children and four grandchildren. **PN**

# Minority Students Lead Surge In Medical School Applicants

After a study last year highlighted the lack of diversity among medical students, experts emphasized the importance of pipeline programs and holistic admissions practices to encourage students from underrepresented groups to continue applying to medical school. **BY KATIE O'CONNOR**

The number of medical school applicants for the 2021-2022 school year set records, increasing 17.8% over 2020. The swell was driven by students from underrepresented groups: For the first time since the Association of American Medical Colleges (AAMC) began tracking the figure, most of the 2021-2022 applicants were not White.

The 2021 matriculants reflected greater diversity, as well. The rate of matriculants who were Black rose from 9.5% in 2020 to 11.3% last year, while matriculants of Hispanic, Latino, or Spanish origin rose from 12% to 12.7%.

"This is really encouraging news," said Walter E. Wilson Jr., M.D., M.H.A., chair of APA's Council on Minority Mental Health and Health Disparities. "This suggests we're on the right track to making sure our medical workforce reflects the populations we serve."

Last year, a study published in the *New England Journal of Medicine (NEJM)* found that from 1978 to 2019, the percentage of medical students from Black, Hispanic, and other underrepresented racial and ethnic groups remained well below their corresponding percentages in the U.S. census.

This year's upswell in applications from students belonging to minority groups is a welcome sign, but one question looms: Will it last?

## Reaching Students Earlier in Their Educations

When Devin Morris, B.A., started medical school, she made a quick observation: It was clear that the races and ethnicities of the students and teachers with whom she worked were not reflective of the patient population. Morris, a fourth-year medical student at Brown University's Warren Alpert Medical School, initiated the *NEJM* study.

She said she and other students of color experienced the effects of the lack of diversity in medicine. She believed that Brown University was working to increase the population of underrepresented racial and ethnic students, but she wondered how others felt about it and to what extent some individuals were deterred from applying to medical school due to a perceived lack of diversity and support.

"A key principle of medicine is beneficence and providing the best patient care possible," she said. "I have thought

a lot about how difficult that is when the provider population is so different from the patient population."

The study investigated four decades of data on medical school enrollment. While gender parity was achieved as early as 2005, there has been limited progress by members of racial and ethnic groups that are underrepresented in medicine. In 1978, Black men accounted for 3.1% of the national medical student body, according to the study. In 2019, that figure had dropped to 2.9%. The study also



Even beyond improving student diversity in medical schools, more work needs to be done to ensure diversity within medical leadership as well, says Francis Lu, M.D.

noted the importance of historically Black medical schools: "Without these schools, the percentage of enrollees who are Black men would have remained a constant 2.4% for the duration of the study period."

(There was a modest increase in the rate of Black women in medical school, from 3.6% to 4.4%.)

Francis Lu, M.D., consultant to the Committee on Diversity, Equity, Inclusion, and Anti-Racism of the Association of Directors of Medical Student Education in Psychiatry, said the study offers a comprehensive, 40-year summary of a disturbing reality: Despite efforts on the part of medical schools, true diversity within the student body has not yet been reached. Lu is the Luke and Grace Kim Endowed Professor in



"We have a lot of work to do around improving K-12 education, and that could really help to minimize the barriers that exist for underrepresented communities," says Norma Poll-Hunter, Ph.D.

Cultural Psychiatry, Emeritus at UC Davis and a member of APA's Presidential Task Force on Social Determinants of Mental Health.

Philip Gruppuso, M.D., another author of the *NEJM* study and a professor of pediatrics and medical science at Brown University, explained that he and his colleagues' work emphasized a fundamental problem: There were not nearly enough applicants from underrepresented groups to drive improvements in the diversity of the medical student population. The percentage of applicants who were men from underrepresented racial and ethnic groups remained stationary, as it did among women who

identified as American Indian, Alaska Native, Native Hawaiian, or Pacific Islander (the percentages of female applicants who identified as Asian, Black, and Hispanic increased over the study period).

"This is a problem that extends all the way back to the earliest stages of people's educations," Gruppuso said. "It's a reflection of racial and ethnic disparities throughout our educational system."

There have been many efforts in medicine to improve diversity, but studies such as Morris and Gruppuso's show there is still work to be done, said Norma Poll-Hunter, Ph.D., senior director of workforce diversity at the AAMC. For example, more medical schools have instituted "holistic reviews" when

considering applicants, evaluating students on broad-based, mission-driven criteria, rather than focusing solely on MCAT scores or GPAs.

Many medical schools also have pipeline programs that attempt to prepare college students of underrepresented backgrounds for medical school. APA's Workforce Inclusion Pipeline Program allows undergraduates to learn about the field of psychiatry while receiving mentorship from psychiatrists. The program also provides resources to prepare for medical school, as well as other learning and development opportunities. It is open to students who are underrepresented in medicine.

"But what's become clear is that the pipelines need to go back further, all the way to elementary school," Lu said. "Really, this is a society-wide issue, and medical schools can't fix these trends on their own. We need structural and infrastructure changes earlier in education."

"We can't work in silos," Poll-Hunter said. "There must be connections between various systems in order to make long-lasting improvements."

## A Changing Tide?

The increase in diversity among medical school applicants and matriculants for the 2021-2022 school year is very positive, but should be watched closely to determine if it continues or not, Lu said in an email. A perfect storm of factors may have been at work, including the COVID-19 pandemic.

"During the pandemic, the general public has witnessed physicians in multiple roles, whether they're at the forefront of clinical care, research, public health, or advocacy," Poll-Hunter said. "Health careers are part of the daily news that everyone is exposed to, and that may be why we've seen so many more applicants."

Wilson pointed out that the pandemic placed existing health disparities in a stark light, highlighting the need for social justice within medicine that may have encouraged students of color to apply. "Many medical schools also allowed applicants to interview virtually, which dramatically improved access for some of our talented, underrepresented applicants who may not have the financial means to travel for interviews," he said.

There is still a lot of work to be done. Wilson pointed to the importance of ensuring there is a representative number of men of color within medicine, and particularly within psychiatry. The rate of males who were accepted for the 2021-2022 school year decreased by 1%, while the rate of male matriculants fell by 2.1%. "When it comes to [people] of color, particularly Black males and Latino/Hispanic males, access to care is often an issue," Wilson said. "We don't

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# Clerkship for Personal Growth: Teaching Psychiatry to Medical Students

*Psychiatry teachers should use multiple communication skills to stimulate curiosity, creativity, and compassion to maximize medical students' experience in their psychiatry rotation. BY FERNANDO ESPI FORCEN, M.D., PH.D.*

A psychiatry clerkship offers the distinctive opportunity to study not just the human brain, but the human mind. Critically, it is not just the minds of patients but also those of students and teachers who are impacted; done right, a psychiatry clerkship leaves no one untouched.

Before students are exposed to the field of psychiatry, all kinds of ideas may cross their minds. People have different thoughts and feelings about what mental illness is and how it should be handled. At the same time, psychiatry, our beloved field, has been affected by its troubled past and attempts to devise treatments that seem barbaric today. Nonetheless, a day or two into medical students' psychiatry clerkship rotation, prior conceptions about psychiatry rapidly fade away. They are pleased to discover that psychiatry can be joyful, approachable, and helpful not only in the treatment of individuals with mental illness but also in understanding the psychology of our daily lives.

Though most students are excited for their psychiatry clerkship, they start

with some trepidation. After being assigned to a new team and given a brief orientation, they have to figure out the culture of their new rotation quickly. Sometimes they get to work with a team for a few weeks, other times just one afternoon. While there are overall goals, every supervisor they encounter may have particular expectations for them. Whatever happens is no longer completely up to them. Treatment may not go well even if they are trying hard. Being intelligent or a hard worker is no longer the key. Now they must also demonstrate interpersonal skills and the ability to cope with the uncertainty of not having absolute control of the patient's outcome. These are new and difficult lessons to master, but ones that will help students in their future careers.

Like most human beings, medical students are auditory, visual, and kinesthetic learners. In school, we are well taught how to master auditory communication, but we at times neglect the latter two communication skills. We do a good job of reporting and sharing clinical data, but sometimes we dismiss other ways to bring a message



Fernando Espi Forcen, M.D., Ph.D., is faculty for the students' core clinical experience at Massachusetts General Hospital.

home. It is important to explain and review complex concepts about psychiatry and to stimulate students' curiosity about the field, which will help them academically. Perhaps even more important, however, is to stimulate students' creativity and compassion—these are not characteristics one can learn from a book.

As teachers, we will have a greater chance of communicating effectively with our medical students if we consider all three facets of learning. For example, if I say, "This is a patient with a history of schizophrenia presenting with delusions," I may not be as effective a communicator as if I say instead something visual like, "This woman was found under a bench at the park freezing in the cold and talking loudly about the end of the world." With the second description, medical students can better visualize that person who has schizophrenia in a way that they will remember. Kinesthetically, I may

add an emotional component and say, "This is a woman found under the bench at the park, alone and crying out loud about the end of the world after losing the custody of her daughter."

In teaching, positive reinforcement is effective, but more powerful, and more difficult, is social modeling. Medical students are still evolving into independent physicians, and clerkships represent perhaps the most vulnerable period of their careers. As supervisors, we need to enable students to navigate their anxieties about their performance on their own. At the same time, we can provide support and help them view their obstacles with perspective. Struggling can become a great teacher, and the experience of overcoming obstacles can foster growth. Hence, adversity in medical school can turn into one of the most meaningful experiences for their future careers.

Therefore, as models, we teachers must first work on ourselves. Before we teach, we must be aware of our own affects. We are responsible for creating a healthy environment that supports learning. For me, teaching medical students has been an opportunity to create a mutually enriching experience. To learn about their unique backgrounds, interests, and personal circumstances has helped me grow as a teacher and a human being. Through helping other people, we help ourselves. **PN**

*The author acknowledges Deirdre Gorman and Nick Zagorski for help in developing this manuscript.*

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always feel welcome in mental health care especially."

The upswell in applicants for the 2021-2022 academic year may be an aberration. According to the AAMC, medical schools report that applications for the 2022-2023 school year have been closer to the levels seen prior to the pandemic. Wilson pointed out that steps must be taken to ensure greater diversity among applicants and matriculants continues, such as by continuing to allow virtual interviews.

"We must continue to be intentional about diversity and inclusion," he said. **PN**

**■** "Diversity of the National Medical Student Body—Four Decades of Inequities" is posted at <https://www.nejm.org/doi/full/10.1056/NEJMSr2028487>. "Medical School Applicants and Enrollments Hit Record Highs; Underrepresented Minorities Lead the Surge" is posted at [http://apapsy.ch/Medical\\_School\\_Diversity](http://apapsy.ch/Medical_School_Diversity). More information on APA's Workforce Inclusion Pipeline Program is posted at <https://www.psychiatry.org/residents-medical-students/medical-students/medical-student-programs/workforce-inclusion-pipeline>.

## Licensure

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was put in place.

Ultimately, Kwong recommends that clinicians who are frustrated with the complexity of current telehealth rules consider contacting officials. "Speak to your representatives at the state and federal levels because they are the ones who really hold the keys to all of this. [Clinicians] are the folks they want to hear from, if you want to move the needle on this."

### Route to Multistate Licensure

An increasing number of physicians are bypassing the uncertainty of shifting state regulations by obtaining licenses through the Interstate Medical Licensure Compact Commission (IMLCC), which issued nearly 27,000 licenses through 2021, more than triple the 8,200 through pre-pandemic 2019.

"Physicians who use telehealth as their delivery model of care find this to be a much easier way to obtain licensure in multiple states," Marschall Smith, the IMLCC's executive director, told *Psychiatric News*. The goal of the IMLCC is to increase access to health

care, particularly for patients in underserved and rural areas.

Regionalism is another reason for obtaining licenses through the IMLCC—for example, physicians who live close to a state border, want to maintain a practice in more than one state, or have patients who move between states. It is also popular among locum tenens physicians, or physicians working in short-term positions.

While it can take up to three to four months to obtain a state medical license using the traditional route, Smith said that physicians in good standing who hold a license from an IMLCC member state can obtain additional licenses in seven to 10 days. The licenses are full and unrestricted; on average, physicians obtain licenses from three states. Physicians must meet a list of criteria, for which about 80% of physicians qualify, Smith said.

"The reason we're able to obtain licenses so quickly is we leverage a physician's existing license from the physician's home state. Those states verify from primary sources all the information on the application, including a fingerprint-based background check, the medical school transcripts, all the national

practitioner databank information, the DEA web page entries. ... So there's a lot of vetting that goes on by that one state, which then issues a letter of qualification, allowing all the other IMLCC member states, in turn, to issue a medical license without doing the vetting."

The IMLCC is controlled and governed by member states; each state's legislature must pass legislation for a state to join. There are now 29 member states that can issue licenses; physicians who join can also obtain a license to practice in Vermont and Oklahoma through the compact. Another four states (Delaware, Ohio, Pennsylvania, and Texas) and Washington, D.C., are in the process of joining. Physicians using the compact pay the IMLCC \$700 for the first year and \$25 for annual renewals (in addition to the typical state licensing fees). **PN**

**■** FSMB's "U.S. States and Territories Modifying Requirements for Telehealth in Response to COVID-19" is posted at <https://www.fsmb.org/siteassets/advocacy/pdf/states-waiving-licensure-requirements-for-telehealth-in-response-to-covid-19.pdf>. CCHP's cross-state licensing information is posted at <https://www.cchpca.org/topic/cross-state-licensing-covid-19>.

# What Is Effective Patient Education?

Understanding patients' learning styles will help you explain health information in a way they can understand and integrate it. **BY GLORIA UMALI, R.N., M.S., C.P.H.R.M.**

The goal of patient education is to improve outcomes. Physicians, including psychiatrists, must be effective educators to promote understanding, adherence, and motivation for self-management among patients. Yet, how do physicians become effective patient educators and make a positive impact on patients' behavior? According to a study by Katey Savage, R.T.T., B.M.R.Sc., B.Sc., et al. published in the *Journal of Medicine Imaging and Radiation Sciences*, how information is received depends on the individual's learning style. Therefore, understanding those different learning styles can help a physician identify how patients learn best. By assessing each patient's learning style, health care professionals can find innovative ways to educate patients about the disease process and self-management.

## What Are Learning Styles?

According to the VARK Model, as described by Kendra Cherry on the Verywellmind website, learning styles are categorized into visual, auditory, reading/writing, and kinesthetic.

- Visual learners understand best by seeing information presented in a visual rather than written form.
- Auditory learners process new information by hearing and repeating back the explanation for validation.
- Reading/writing learners understand information by writing it down as words and text.
- Kinesthetic learners absorb information by touching and by active participation through demonstration.

While determining learning styles helps with education strategies, Cara Marcus, director of library services at Brigham and Women's Faulkner Hospital, suggests in her research study published in *Health Psychology and Behavioral Medicine* that an accurate health literacy assessment and determination are key elements to successful learning and comprehension. In other words, to apply methods for an effective assessment of learning, edu-

cators must consider not only the learning styles but also the health literacy of patients.

## What Is Health Literacy and Why Is It Important?

The Department of Health and Human Services (HHS) defines personal health literacy as "the degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others." HHS's Healthy People 2030 initiative believes personal health literacy supports the goal of enabling people to move from understanding to action and thereby from improving their own health to the health of others.

## How Do You Assess for Health Literacy and Low Health Literacy Skills?

In her article "Assessing and Addressing Health Literacy," Sandy Cornett, Ph.D., R.N., provides practical tips that can be applied in your practice:

- Do not ask patients about their education level as this is not an indicator of reading ability.
- Ask targeted questions. For example: Do you need help with forms, reading prescription bottles,



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or health education sheets? Do you have any difficulty reading and remembering health information?

- Administer a screening test such as the Newest Vital Sign whereby patients are asked to read a nutritional label while the health care professional asks questions to assess their ability to read and apply information.
- Ask patients to read prescription bottles and have them explain how to take their medication.
- Observe and look for clues that indicate problems with reading and comprehension including incomplete medical history, checking items as "no" to avoid follow-up questions, making excuses when asked to read or fill out forms, and errors regarding their medication.

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## ETHICS CORNER

# Ethics Committees Reimagined

**BY CLAIRE ZILBER, M.D.**

The APA and district branch (DB) ethics committees used to stay busy processing complaints from patients, their family members, and colleagues about members who allegedly engaged in ethically compromised behavior. Most complaints now are directed to state licensing boards, giving ethics committees more time to engage in proactive contemplation of emerging ethical dilemmas as our field adapts to changes in practice such as physician aid in dying and psychedelic-assisted psychotherapy.

APA has gradually shifted its ethics focus away from adjudication of ethics complaints and enforcement of sanctions for violations of APA's *Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry* toward educating members about the *Principles* and how to think ethically about dilemmas that arise in psychiatric practice. The goal is to help psychiatrists recognize and deliberate about dilemmas before they act, support ethical decision-making, and prevent



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ethics infractions. The APA Ethics Committee regularly issues and updates "The Opinions of the Ethics Committee on the Principles of Medical Ethics," a compilation of responses to questions posed by psychiatrists about dilemmas that arise in education, research, clinical practice, and the business of psychiatry. The committee also issues opinions and prepares resource materials for members discussing the ethical implications of current issues in medicine. At every Annual Meeting, the committee hosts a forum during which panelists

respond to questions submitted in advance at [apaethics@psych.org](mailto:apaethics@psych.org) as well as from psychiatrists in the audience to receive on-the-spot guidance.

District branch ethics committees have also experienced a shift in focus over the last two decades. A question that a number of DBs are contemplating is what their role should be going forward. The Ethics Committee of the Colorado Psychiatric Society (CPS) has occasionally met to discuss dilemmas arising as a result of changing laws. For example, when Colorado's legislature considered physician aid in dying in 2015, our ethics committee met to discuss what guidance to offer members should the legislation pass. Although the bill died in the legislature, in 2016 a similar law was approved by voters. The CPS Ethics Committee wrote a newsletter article to educate members about the nuances of participation in a patient's request for aid in dying, offering guidance to avoid an ethical misstep. CPS devoted its Spring Dinner Meeting that year to a panel discussion on the topic, deepening members' understanding about the law, the ways in which psychiatrists might be asked to participate, and alternatives to physician aid in dying such as palliative

care. This issue invigorated the committee toward its new role as an educational resource.

Ethics columns in *Psychiatric News* and DB newsletters are important, but we shouldn't stop there. Ethics committees can become more proactive, responding to legislative and emerging practice issues with guidance for psychiatrists. For example, there has been a wealth of professional and lay literature in the last few years about psilocybin, LSD, and ayahuasca in mental health treatment, which raises intriguing ethical questions surrounding psychiatrists' participation in this new practice. Several scholarly articles have wrestled with this topic, and ethics committees need to provide guidance. Dr. Charles Grob has called for the establishment of ethical structures around this new psychiatric practice, and Dr. Brian Holodya advocates for psychiatrist involvement in informed consent discussions about the risks and potential benefits of psychedelic treatments. APA is now working on a resource document that will be released in the near future.

The APA and DB ethics committees collectively comprise a remarkable resource for ethical deliberation. If you have not done so recently, take time to



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Effective patient education in which there is evidence of increased understanding of illness and conditions and improvement in health-promoting behavior hinges upon adequate and accurate assessment of the patient's learning style and health literacy. **PN**

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➤ "Preferences in Learning Styles and Modes of Information Delivery in Patients Receiving First-Day Education for Radiation Therapy" is posted at [https://www.jmirs.org/article/S1939-8654\(16\)30129-1/fulltext](https://www.jmirs.org/article/S1939-8654(16)30129-1/fulltext). "Learning Style Inventory Types and Their Uses" is posted at <https://www.verywellmind.com/what-is-a-learning-style-inventory-2795159>. "Assessing and Addressing Health Literacy" is posted at <http://apapsy.ch/health-literacy>. Information on the Newest Vital Sign is posted at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1466931/>.



Margie Balfour, M.D., Ph.D., says that three critical features of a crisis delivery system are accountability, collaboration, and continuous improvement.

review ethics opinions that have been issued by APA's committee in the last few years and to submit any questions you might have to [apaethics@psych.org](mailto:apaethics@psych.org). Our ethics committees represent collectives of psychiatric ethical wisdom that can proactively issue guidance to members about how to best navigate the dilemmas encountered in new areas of psychiatric research and practice.

On a personal note, this is my last column for *Psychiatric News*. I have enjoyed communicating with you these last five years and pondering the ethics issues we all face, big and small, as we meet our professional and ethical obligations with the utmost respect for our patients, colleagues, and communities. It is in so doing that we are not only helping people heal, but also decreasing stigma and instilling confidence in our profession. **PN**

➤ "APA Commentary on Ethics in Practice" is posted at <https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/Ethics/APA-Commentary-on-Ethics-in-Practice.pdf>. "The Opinions of the Ethics Committee on the Principles of Medical Ethics" is posted at <https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/Ethics/Opinions-of-the-Ethics-Committee.pdf>.

## Tucson Shares Blueprint For Crisis System Success

*The comprehensive crisis services offered by the city of Tucson reach 10,000 individuals a year, with the goal of providing patient care in the least restrictive, least expensive way.*

BY LINDA M. RICHMOND

The city of Tucson's crisis response system, which was built in stages over the past 20 years, provides a continuum of care to individuals at any stage of a mental health crisis, from early intervention to acute stabilization and aftercare, explained Margie Balfour, M.D., Ph.D., chief of quality and clinical innovation at Connections Health Solutions and an associate professor of psychiatry at the University of Arizona. She spoke at the recent conference "REIMAGINE: A Week of Action to Reimagine Our National Response to People in Crisis," sponsored by the National Alliance on Mental Illness.

The crisis hotline for the southern Arizona region receives about 10,000 calls a month involving individuals

with mental health, suicidal, or substance use crises, 80% of which are resolved through telephonic counseling. That's because the Regional Behavioral Health Authority overseeing the program contractually requires area mental health clinics to enter available appointment slots in the hotline's computer system to serve callers in need.

"Part of what it takes to resolve someone's crisis at 2 a.m. is being able to say 'We can get you an appointment for that at 11:30 this morning,'" Balfour said. To help keep people in crisis out of jail, hotline staffers are co-located with 911 dispatchers, so they can intercept crisis calls that the police would have otherwise handled.

For situations that cannot be resolved by phone, hotline staff can dispatch one of 16 mobile crisis teams with specially trained clinicians. The teams resolve the crises of 70% of callers in the field, and the rest are transported for immediate care to one of several crisis stabilization centers. The largest of these is the Crisis Response

Center (CRC), which is the heart of the crisis system in the Tucson area.

The CRC serves 12,000 adults and 2,400 youth a year, Balfour said. It offers a variety of services, including a 24/7 mental health urgent care and a 23-hour observation unit for patients who would otherwise be "boarded" in the emergency room. Staff can also initiate medication-assisted treatment (MAT) for individuals experiencing opioid withdrawal. The CRC was built with Pima County bond funds, with Medicaid payments funding the patient care.

It has been run by ConnectionsAZ since 2014 and staffs an interdisciplinary team, including psychiatrists, social workers, nurses, and peers. Balfour said many patients treated by the CRC are a danger to themselves or others, acutely psychotic, intoxicated, or experiencing withdrawal. "Our philosophy is that a lot of these people don't need to be hospitalized if we start treatment early and very aggressively," she said.

The facility is adjacent to an emergency department, inpatient psychiatric facility, and a mental health court, providing easy access to additional services for those who need them. Also, there are various post-crisis wrap-around services that provide ongoing treatment, so that most people can remain in the community.

### Tucson's Crisis System Structure

The state's Medicaid program—Arizona Health Care Cost Containment System (AHCCCS)—handles all of Tucson's crisis services funds, pooling together funding from a variety of sources, including federal block grants and state and local crisis funds. Because of this braided funding model, service providers can accept any individual in crisis regardless of health insurance status or type, Balfour said.

The various components of the crisis response system are designed to work together seamlessly, Balfour explained. Three critical features are accountability, collaboration, and continuous improvement through collection of outcome data that drive decision-making. "Arizona has a lot of these features baked into how our crisis system is financed, so many communities are looking to our state as a model for how to set up their own crisis systems."

For each part of the state, AHCCCS contracts with its Regional Behavioral Health Authority, which in turn contracts with various crisis services providers. It keeps them aligned on one simple clinical and financial goal: providing patient care in the least restrictive and least expensive setting possible.

### Diverting Patients From Jail

Tucson's CRC is set up to make it easier for law enforcement officers to bring people for treatment rather than

see **Tucson** on page 14



# Use of Emotion Recognition Tools in Psychiatry Said to Be Premature

BY JACOB LEE, M.D.

The extended COVID-19 pandemic has brought about untold changes across nearly every facet of life in the United States. As society looks to transition from the crisis phase toward a so-called “new normal,” many industries are making greater use of tools that enable productivity at a distance. In many cases, artificial intelligence (AI) has provided the foundation upon which these tools are developed. Emotion recognition tools (ERTs) are one example. These AI-powered technologies are alleged to be able to evaluate facial micro-expressions based on camera data, from which an emotional state is reported. Is your co-worker happy? Is this second grader angry? The potential benefits of these technologies are obvious, but the many pitfalls may not be.

As this new field explodes onto the scene and is poised to reach a value of \$20 billion to \$60 billion by mid-decade, the stakes for an industry rightfully



Jacob Lee, M.D., is a PGY-4 child/adolescent psychiatry fellow at the University of Hawaii and a member of the APA Committee on Climate Change and Mental Health.

already under ethical scrutiny have been heightened. The central questions for these technologies regard how accurately software can identify facial expressions, and whether facial expressions are a reliable indicator of underlying emotion. The technology companies confidently assert that these questions are answered and have introduced their new technologies into diverse and ethically complex settings including private and national security, criminal justice, and health care. Already, software programs such as Woebot have introduced mental health-specific ERT applications to monitor depression, anxiety, and sub-

stance use. This program received FDA Breakthrough Device designation to monitor women for postpartum depression. While Woebot was designed and validated by Stanford-trained computer scientists and psychologists, many other programs have not been developed with such scientific rigor.

Built upon models by Paul Ekman, Ph.D., to categorize facial movements into emotional taxonomies, current ERT technologies largely tout the ability to recognize “the six universal human emotions”: anger, disgust, fear, happiness, sadness, and surprise. Technologies such as the Enablex or Emotient software also claim to detect attention and arousal. Psychiatrists utilize facial expressions as part of a complex, multifactorial formulation of a patient, whereas these software programs rely primarily on graphical information captured by a webcam. For the same reasons Ekman’s ideas have been subject to increasing scrutiny by contemporary psychologists and psychiatrists, technologies built upon these models often fail to consider cultural differences and cultural factors.

A landmark 2019 review in the journal *Psychological Science in the Public Interest* by Lisa Feldman Barrett, Ph.D., et al. found weak correlation between

facial expressions and emotions. In short, while people do smile when happy, there are substantial differences across cultures, situations, and even individuals. Many female-presenting individuals are socialized to smile politely, which might not confer happiness or agreement. As these technologies are largely being developed by a small, homogenous group of programmers, particular caution is needed.

Anticipating the dangers of this understudied technology, legislators within the European Union have already drafted an omnibus proposal to regulate AI in this and similar applications. The American think tank Brookings Institution called for a total ban of ERTs in law enforcement, citing civil liberty concerns.

Just as medications and therapies are subject to intensive study prior to use on humans, psychiatrists should lobby for greater study of emotion analysis technologies prior to their further deployment. Child psychiatrists, in particular, should object to the use of these understudied technologies to analyze minors in ways that might have lasting negative consequences. Until these software programs are validated, we should approach their analyses with caution and skepticism. **PN**

**“Emotional Expressions Reconsidered: Challenges to Inferring Emotion From Human Facial Movements” is posted at <https://journals.sagepub.com/doi/full/10.1177/1529100619832930>.**

## Advertisement

## Tucson

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to jail. “The whole crisis system treats officers as preferred customers,” Balfour said. With that goal in mind, staff process new patients in 10 minutes or less, a fraction of the time it would take officers to drop people off at the Pima County jail. Mobile crisis teams are contractually obligated to give officers its fastest response time—less than 30 minutes. Officers are given a secure, dedicated entrance for which they are not required to remove their weapons, thus removing an obstacle that might otherwise deter police.

The CRC has adopted a “no wrong door” approach, so it never turns away a person in crisis brought in by law enforcement officers. “We’ll work on getting patients stabilized and sent to where they need to go,” she said. “We take everybody. . . . We don’t use security but have highly trained behavioral health care staff. We feel that if we turn people away because they’re too acute, or too violent, or too agitated, they’re going to be taken to an emergency room and restrained on a gurney or

they’re going to end up in jail. We feel that these people have the highest needs, and they belong in a specialized facility like ours.”

The city also has several dedicated “co-responder teams,” in which peers and plainclothes detectives or police officers work in tandem on homeless outreach, substance use response, and follow up on high-risk individuals with mental illness, all with the goal of connecting people with treatment before a situation escalates to crisis.

“A large part of the reason this all works is because the Tucson police department has really bought into this idea of being able to serve people with mental health and substance use issues, and it starts with the department’s leadership,” Balfour said. All officers receive basic Mental Health First Aid training. Officers receive incentives for completing more advanced voluntary training, and most of its officers (70%) have also completed the 40-hour Crisis Intervention Training course.

The program has grown every year: In 2013, officers transported fewer than 2,000 individuals for mental health

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# Article on Dismantling Racism in Psychiatry Among 2021 *AJP* Editor's Picks

*The editors of the American Journal of Psychiatry (AJP) have vowed to use the journal to combat structural racism and health care inequities.*  
**BY NICK ZAGORSKI**

It has been a longstanding tradition for the editors of the *American Journal of Psychiatry* to close out each year with a selection of articles from the previous year that rose above the rest.

"One of the most important and relevant articles that we published [in 2021] in the *Journal* is a call to action for psychiatry to confront and change the structural racism framework that significantly contributes to mental health care inequities," wrote *AJP* Editor-in-Chief Ned Kalin, M.D., in the editorial "2021 Articles of Import and Impact" in the January issue.

The article Kalin was referring to was titled "Dismantling Structural Racism in Psychiatry: A Path to Mental Health Equity" by Ruth S. Shim, M.D., M.P.H. Shim is the Luke & Grace Kim Professor in Cultural Psychiatry at the University of California, Davis.


Shim opened the review with an examination of the meaning of the terms race, structural racism, social injustice, health disparities, and health inequities.

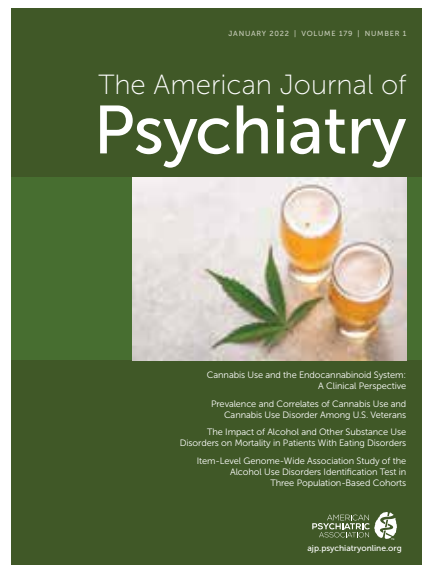
"While health disparities are differ-

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treatment to the CRC, and by 2020, they had brought in nearly 6,000. The success of the crisis system can also be seen in the dramatic decline in the annual SWAT team calls and arrests for vagrancy, civil disturbance, and drinking in public. "From an advocacy standpoint, this is a really good argument for funding these types of programs because look at how much they save," she said.

Studies of similar crisis services operating in Phoenix were found to save \$37 million in emergency department spending in 2012. Phoenix police transported 22,000 patients to crisis service facilities in 2016, cutting \$260 million in psychiatric inpatient costs that year. "This is how you can make an argument for communities to invest in these kinds of services," Balfour said. **PN**

 **The National Council's Roadmap to the Ideal Crisis System is posted at <https://www.thenationalcouncil.org/roadmap-to-the-ideal-crisis-system>. Archived sessions of the "REIMAGINE" conference can be accessed at <http://apapsy.ch/REIMAGINE>.**



ences in health status among distinct segments of the population, health inequities are defined as disparities in health that are a result of systemic, avoidable, and unjust policies and practices that create barriers to opportunity," she wrote. "By describing the *cause* or *origin* of these differences in health, the definition of inequities is more precise. Because the term *disparities* does not identify the cause of the difference, there is a tendency to default to traditional and historical explanations for difference, which include seating the pathology with an individual or a population."

Also captured in Shim's article are the ways that policies that led to residential segregation beginning in the 1930s, and the War on Drugs in the 1980s have impacted and continue to impact the mental health of people of color.

"[A]s a result of residential segregation, psychiatrists and therapists were (and are) less likely to be located in low-income neighborhoods with greater percentages of Black and Latinx residents (when compared with high-income neighborhoods with less than 1% of Black or Latinx residents)," Shim wrote. "The structurally racist policies of the War on Drugs have led to the mass incarceration of people of color for substance use disorders."


Shim concluded her piece with suggestions for how psychiatry can begin to dismantle the legacy of structural racism and advance mental health equity for all. There are immediate actions that mental health professionals can take, she noted, such as observing and challenging their own biases, enforcing social norms of inclusion and equity in personal and professional settings, and advocating for policies that may appear to not be directly related to mental health but are critical for it to succeed: stable housing, unem-

ployment benefits, and access to healthy food.

"Because psychiatrists and other mental health professionals desire to promote the mental health and well-being of all people, we all have a moral responsibility to speak out against racial injustice wherever we encounter it, recognizing, in the words of Frederick Douglass, that 'power concedes nothing without a demand,'" Shim concluded.

Also recognized in the editor's picks for 2021 were studies that highlighted potential new treatments for depression and compulsive behaviors, called attention to medication-related cognitive impairments in schizophrenia, and provided insight into brain development in girls who were abused (see box). But the promise offered by such research cannot be truly fulfilled unless everyone can benefit equally, Kalin noted.

"As we avowed earlier in the *Journal*, the deputy editors and I have made the commitment to use the *American Journal of Psychiatry* as a means to combat structural racism and health care inequities," Kalin wrote in his summary of Shim's article. "We are specifically focused on improving mental health care for individuals of color and more broadly for individuals from underprivileged and discriminated communities. We thank Dr. Shim for moving us forward in this direction, as we enthusiastically continue in our pursuit of this critical goal." **PN**

 "Dismantling Structural Racism in Psychiatry: A Path to Mental Health Equity" is posted at <https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.2021.21060558>.

## Four *AJP* Studies Recognized by BBRF

*AJP*'s commitment to publishing cutting-edge and clinically relevant research was recognized by the Brain & Behavior Research Foundation (BBRF) this past year. (BBRF President and CEO Jeffrey Borenstein, M.D., is the editor in chief of *Psychiatric News*.) Four *AJP* studies were cited among BBRF's leading research achievements in 2021 (the most of any journal). These include the following:

- A Randomized Controlled Trial of Repeated Ketamine Administration for Chronic Posttraumatic Stress Disorder. Adriana Feder et al.
- Anticholinergic Medication Burden–Associated Cognitive Impairment in Schizophrenia. Yash B. Joshi et al.
- Neonatal Brain Response to Deviant Auditory Stimuli and Relation to Maternal Trait Anxiety. Chad M. Sylvester et al.
- Stanford Neuromodulation Therapy (SNT): A Double-Blind Randomized Controlled Trial. Eleanor J. Cole et al.

*A list of BBRF's 2021 Leading Research Achievements is posted at <https://www.bbrfoundation.org/blog/2021-leading-research-achievements>.*

## *AJP* Editor's Picks for 2021

- Dismantling Structural Racism in Psychiatry: A Path to Mental Health Equity. Ruth S. Shim.
- Impact of the KCNQ2/3 Channel Opener Ezogabine on Reward Circuit Activity and Clinical Symptoms in Depression: Results From a Randomized Controlled Trial. Sarah Costi et al.
- Efficacy of Combining Varenicline and Naltrexone for Smoking Cessation and Drinking Reduction: A Randomized Clinical Trial. Lara A. Ray et al.
- Anticholinergic Medication Burden–Associated Cognitive Impairment in Schizophrenia. Yash B. Joshi et al.
- A Longitudinal Study of Resting-State Connectivity and Response to Psychostimulant Treatment in ADHD. Luke J. Norman et al.
- Effect of Experimental Manipulation of the Orbitofrontal Cortex on Short-Term Markers of Compulsive Behavior: A Theta Burst Stimulation Study. Rebecca B. Price et al.
- Differential Patterns of Delayed Emotion Circuit Maturation in Abused Girls With and Without Internalizing Psychopathology. Taylor J. Keding et al.
- Adrafinil: Psychostimulant and Purported Nootropic? Danielle W. Lowe et al.

*Editor summaries for all "2021 Articles of Import and Impact" are posted at <https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.2022.21111087>.*

# Caplyta Now Approved for Bipolar Depression

*With the FDA's expanded indication, Caplyta (lumateperone) becomes just the second medication for both bipolar I and bipolar II depression. It is also the first approved for use in combination with lithium or valproate for bipolar II depression. BY NICK ZAGORSKI*

Last December, the U.S. Food and Drug Administration (FDA) approved an expanded indication for the antipsychotic Caplyta (lumateperone) for the treatment of bipolar I and II depression in adults. Caplyta, marketed by Intra-Cellular Therapies Inc., was already approved for the treatment of schizophrenia in adults.

People with bipolar I disorder cycle between episodes of mania and depression, whereas those with bipolar II experience hypomania between more severe and longer-lasting depressive episodes.

"Bipolar disorder is a complex illness that has few treatment options for the depressive side of the cycle," Suresh Durgam, M.D., chief medical officer of Intra-Cellular Therapies, told *Psychiatric News*. "Caplyta will be an important addition to therapy given the broad label of the new indication." Caplyta was approved both as a monotherapy and as adjunct therapy with the mood stabilizers lithium or valproate for patients with bipolar I and bipolar II depression.

Chris Aiken, M.D., director of the Mood Treatment Center in Winston-Salem and an adjunct professor of psychiatry at Wake Forest University

in North Carolina, noted that people with bipolar II might particularly benefit from the medication's approval. Aiken has no financial ties to Intra-Cellular Therapies.

Prior to Caplyta, the only authorized medication shown to be effective for bipolar II depression was the antipsychotic quetiapine, which is only

The FDA approval of Caplyta was based on positive findings from two six-week, phase 3 trials. The first trial evaluated the effects of 42 mg/day lumateperone monotherapy versus placebo in 381 adults aged 18 to 75 with bipolar I or II depression. The second trial evaluated 28 mg/day or 42 mg/day lumateperone versus placebo in 529 adults with bipolar I or II depression who were also taking lithium or valproate.

In both studies, participants taking 42 mg/day lumateperone showed statistically stronger improvements in their depression symptoms after six

weeks compared with those taking placebo. In the monotherapy study, which was published in the *American Journal of Psychiatry*, Montgomery-Åsberg Depression Rating Scale (MADRS) scores dropped by an average of 16.7 points after six weeks in the lumateperone group compared with 12.1 points in the placebo group.

The drug was also superior to placebo in the secondary outcome—change in the Clinical Global Impressions scale, which assesses the overall severity of patients' illness.

These improvements align with what has been found for other antipsychotics approved for bipolar depression, but where Caplyta shined was in its tolerability profile, Durgam noted. "The rates of weight gain or EPS [extrapyramidal symptoms] for Caplyta were almost at placebo levels, which is very favorable," he said. Durgam added that a six-month, open-label safety study did not reveal additional health risks.

In an editorial that accompanied the *AJP* monotherapy study, Michael Ostacher, M.D., M.P.H., a professor of psychiatry at Stanford Medical School, noted some concerns about the findings. For one, only 20% of the participants were categorized as having bipolar II disorder and in many cases were categorized retrospectively. "Even as bipolar I disorder is difficult to diagnose retrospectively without the presence of a clear index manic episode (requiring hospitalization, for example, or present with psychotic symptoms), it is even more difficult to accurately diagnose the hypomanic episodes required for the diagnosis of bipolar II disorder," he wrote. As such, the true efficacy of this medication for patients

**"As a field, ... we need to focus not just on acute symptoms, but also on treatments that improve long-term functioning in patients."**

**—Chris Aiken, M.D.**

approved as a monotherapy and has some adverse side effects including weight gain and abnormal heart rhythms. Vraylar (cariprazine), which was approved for bipolar I depression in 2019, failed to show any clinical effect in patients with bipolar II.

The approval of Caplyta may help to raise awareness about bipolar II, which is still frequently misdiagnosed as either bipolar I disorder or unipolar depression, Aiken said.

weeks compared with those taking placebo. In the monotherapy study, which was published in the *American Journal of Psychiatry*, Montgomery-Åsberg Depression Rating Scale (MADRS) scores dropped by an average of 16.7 points after six weeks in the lumateperone group compared with 12.1 points in the placebo group. In the adjunct therapy study, MADRS scores dropped by an average of 16.9 points after six weeks in the lumate-



## ON MENTAL HEALTH, PEOPLE, AND PLACES

### Identity and Political Independence

BY EZRA E. H. GRIFFITH, M.D.

On November 30, 2021, my 166 square miles of island, known to the initiated as Bimshire and to others as Barbados, became a republic. I read about it in English, French, and American newspapers and imagined it had even wider coverage. Friends wrote to congratulate me, claiming it was a notable event. Others described the accompanying celebrations, expected me to be pleased by the news, and asked how things would be different now. Professor Richard Drayton, a historian at King's College London and an expert in the long relationship between Barbados and the United Kingdom, commented on the Caribbean island's journey to becoming a republic (*Stabroek News*, November 29, 2021).

Drayton explained that following Barbados's independence from Britain in 1966, the winds of what he called "the



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

Black Power moment" buffeted the Caribbean islands in the 1970s. The result was that Guyana, Trinidad and Tobago, and Dominica took the status of a republic. For several reasons, Barbados did not follow this trend and remained in the British Commonwealth with Queen Elizabeth as head of state. However, the island's political leaders did make changes after independence that suggested they were keeping an eye on becoming a republic. Professor Drayton buttressed this point with examples: The island's Anglican Church was disestablished and disendowed in 1969, putting that faith group

on its own fiscal bottom and disentangling the connections between church and state. In 1970, the Central Bank of Barbados took over fiscal policy. In 1974, Barbados replaced its reliance on the Judicial Committee of the Privy Council with the new Caribbean Court of Justice as its highest appellate court. Drayton's examples indicated a steady maturing of Barbados's intention of fracturing the ties to the mother country. Nevertheless, some palpable hesitancy remains among some of the island's citizens about this new status that dispenses with the queen as their head of state.

Judging from his other writings, Drayton understood that the 1966 independence was only a first step toward economic, cultural, spiritual, and psychological decolonization. In a certain sense, this new phase of becoming a republic should be viewed as a marker of entrance into what Drayton sees as secondary decolonization. We Barbadians, at home and in the diaspora, must cease being "alienated from ourselves." It should be obvious that build-

ing a post-colonial future that is closely linked to British interests is not true independence. Drayton acknowledged that most Barbadians did support the move to become a republic; however, it was not a position passionately held. He worried that some citizens may not even have understood what was in the decision and what it meant for the lives of those "on the underside of the society, living on biscuits, rice, and a little corned beef." He was not confident that there was broad understanding of "what the Republic is for" or in what ways it is truly ours.

My own observations confirm Drayton's, and I turn to a cynical preoccupation of mine. Some Barbadians, likely among elders, remain enamored of British royalty and hopeful that for the foreseeable future they will be protected by a lingering magical connection to their beloved queen. Jamaican Professor Frederick Hickling tried mightily to help West Indians confront their history of slavery and oppression at the hands of the British. (See, for


*continued on facing page*



with bipolar II data is quite uncertain, he said.

Aiken cautioned that Caplyta—as with other antipsychotics—should be seen as a short-term solution for bipolar disorder. “All the antipsychotics approved over the last decade look great when it comes to managing depressive symptoms over a few weeks,” he told *Psychiatric News*. “As a field, though, we need to focus not just on acute symptoms, but also on treatments that improve long-term functioning in patients.” When considering longer-term outcomes such as relapse rates, mood stabilizers like lithium still have the most robust efficacy data, Aiken noted.

Durgam is hopeful that this recent approval will be just the first in a long series for Caplyta. Intra-Cellular Therapies is currently conducting phase 3 studies testing Caplyta for both major depression and depression with mixed features (in which patients exhibit features of both depression and mania) in adults. The company has also begun preliminary studies evaluating Caplyta for the treatment of schizophrenia and bipolar disorder in youth. **PN**

 The Caplyta label is posted at [https://www.accessdata.fda.gov/drugsatfda\\_docs/label/2021/209500s005s006lbl.pdf](https://www.accessdata.fda.gov/drugsatfda_docs/label/2021/209500s005s006lbl.pdf). The AJP study, “Efficacy and Safety of Lumateperone for Major Depressive Episodes Associated With Bipolar I or Bipolar II Disorder: A Phase 3 Randomized Placebo-Controlled Trial,” is posted at <https://ajp.psychiatryonline.org/doi/full/10.1176/appi.ajp.2021.20091339>.

## Risk of Suicide Varies By Patients' SUD

*Opioid, sedative/hypnotic, and hallucinogen use disorders are associated with greatest risk. BY TERRI D'ARRIGO*

Substance use disorders (SUDs) have long been linked to an increased risk of suicide, but many of the studies suggesting this link have been small. Now researchers in a large population-based study in the *Journal of Psychiatric Research* have determined the risk of suicide associated with specific SUDs.

Quantifying risk for patients with each SUD may help mental health professionals allocate resources, said study researcher Alexis Edwards, Ph.D., an associate professor in the Department of Psychiatry at Virginia Commonwealth University in Richmond.

“There are limited resources for addressing suicide prevention and intervention, so this can help clinicians [identify] who they should be paying the closest attention to,” Edwards told *Psychiatric News*. “This isn’t to say they shouldn’t worry about other patients with risk, but that knowing which substance use disorders have the highest risk can help them target the limited resources they have.”

Edwards and colleagues examined data from more than 6.9 million adults in the Swedish Total Population Register who had lived in Sweden for at least two years as of January 1, 2003. They obtained data from the Swedish Cause of Death Register to determine the prevalence of suicide death in this

population from January 1, 2003, through December 31, 2016. They also obtained data about the prevalence of SUDs involving opioids, sedative/hypnotics, hallucinogens, cannabis, amphetamine, cocaine, alcohol, and multi-substance SUDs from various Swedish health registries.

Overall, 15,616 people in the study, or 0.2% of the total study population, died by suicide. Compared with people who did not have an SUD, those who had any SUD had 3.67 times the risk of suicide death, and those with multisubstance use disorders had 3.87 times the risk. People with opioid use disorder had 6.39 times the risk of death by suicide, followed by those with SUDs involving sedative/hypnotics, hallucinogens, cannabis, amphetamine, cocaine, or alcohol, who had 4.62, 4.11, 3.10, 2.76, 2.73, and 2.55 times the risk, respectively.

In a secondary analysis, the researchers controlled for familial factors, such as shared genes and exposure to parental divorce, low socioeconomic position, or other stressors. Results from these models indicated that risk increased further for people with alco-

hol use disorder compared with those without SUD. Risk remained significantly elevated, although slightly less so, for people with opioid use disorder and sedative/hypnotics use disorders compared with people without SUD.

“Even when controlling for familial factors that might contribute

see **Suicide** on page 32

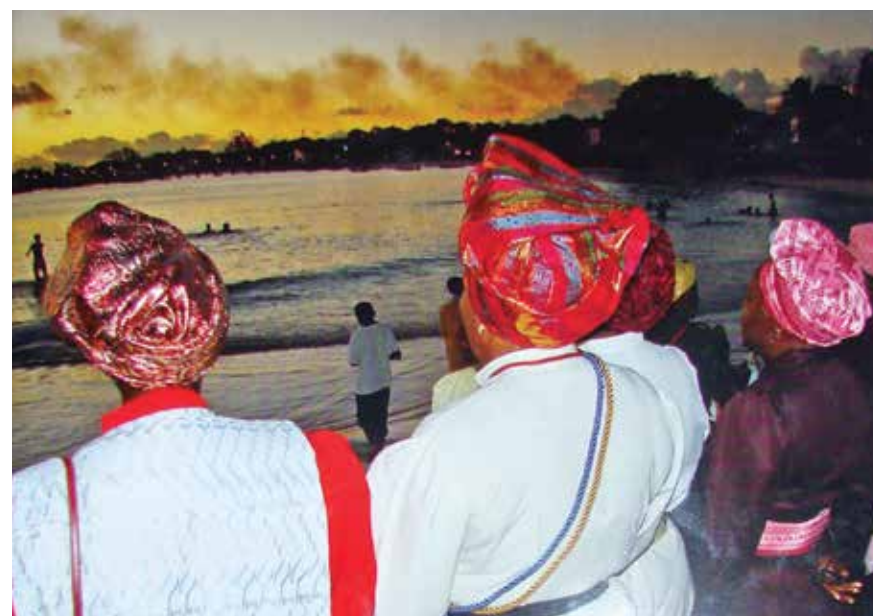


Virginia Commonwealth University/Kevin Morley

Knowing which SUDs have the highest risk can help health professionals target limited resources, says Alexis Edwards, Ph.D.

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example, F. W. Hickling, *Decolonization of Psychiatry in Jamaica*, New York: Springer; 2021.) Hickling thought that the British exploitation of Caribbean Blacks stemmed from a psychological belief that European colonizers were inherently superior to the colonized. Hickling’s work is clearly now an antecedent to the present reflections of American psychoanalysts on the theme of White privilege and superiority. For example, Donald Moss, writing in the April 2021 *Journal of the American Psychoanalytic Association* in the article “On Having Whiteness,” was concerned about how this sense of superiority could become an instrument of power. The more one exercised dominion power, the more one became certain and confident in its implementation. Moss applied his theorizing to understanding better how and why the developed countries of the world treated so shamefully those that were still in the process of developing. Of course, Frantz Fanon had already artic-



Women at a 2008 Baptismal Service of the Barbados Sons of God Spiritual Baptist Church.

ulated similar ideas in writing about France’s colonial involvement in Algeria and other countries. Fanon and Hickling both wanted Caribbean peoples to give up mimicking the White

colonizers and to develop pride and confidence in Caribbean traditions. This is plainly a part of Drayton’s idea of secondary decolonization.

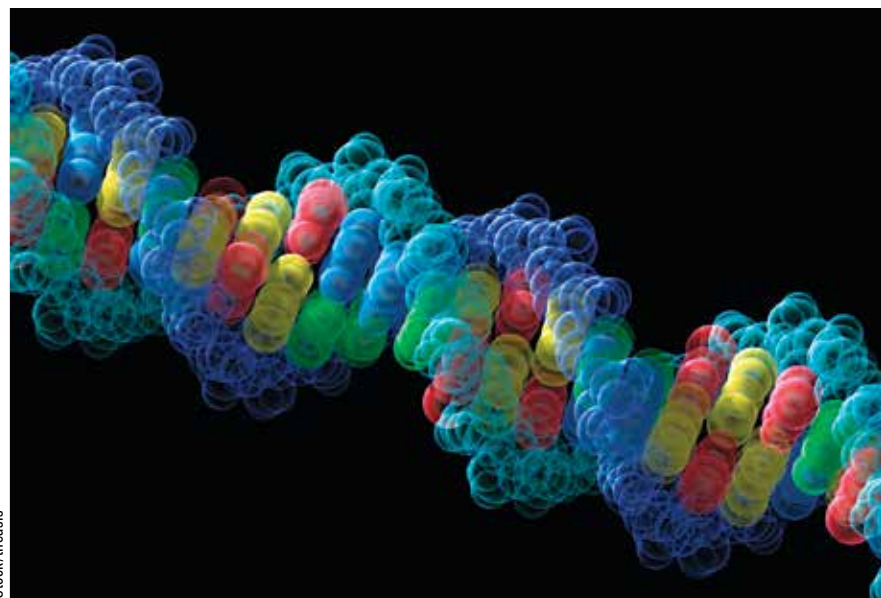
Fanon, Hickling, and Moss all under-

stood the impact of images imposed by enslavers and colonizers on their victims’ psyches. Barbados has made significant strides between 1966 and 2021. Still, its citizens must think carefully about their new political status and their own worth. It is not an easy task, as I am talking about an improvement in personal and group identity. However, the island is well supplied, at home and throughout the diaspora, with insightful individuals who can point the way to a deeper sense of confidence and self-reliance. The photograph at left, which I took in 2008, shows women at a baptismal beach service of the island’s Sons of God Spiritual Baptist Church. They are witnessing the baptism taking place in the living waters of the sea. In their culturally syncretic sacred garments, they evoke a symbolic rebirth and commitment to a new life, relevant to the post-colonial order. “We are people, too.” **PN**

 “On Having Whiteness” is posted at <https://journals.sagepub.com/doi/10.1177/00030651211008507#>.



# Global Initiative Aims to Uncover Genetics of Eating Disorders



Researchers hope to learn more about metabolic and other risk factors that contribute to anorexia, bulimia, and binge eating. **BY NICK ZAGORSKI**

In the past, societal—and even some scientific—perceptions of eating disorders were beset by myths and exaggerations; for instance, it was once a popular belief that if patients were not experiencing severe weight loss, their eating disorder was not serious.

“Fortunately, our collective knowledge about eating disorders has expanded greatly, and facts are replacing fiction,” said Cynthia Bulik, Ph.D., the Distinguished Professor of Psychiatry at the University of North Carolina

(UNC) School of Medicine and the founding director of the UNC Center of Excellence for Eating Disorders. For Bulik, one of the remaining frontiers in the study of eating disorders is how genes influence the risk of developing these disorders.

“Eating disorders have historically been conceptualized as psychosocial illnesses, influenced by factors like parenting style and unrealistic societal depictions of beauty,” said Bulik, who is also the associate director of the UNC Center for Psychiatric Genomics.

“Social pressures toward thinness surely play a role [in these disorders], but we are starting to appreciate that genetic risk factors strongly contribute to whether these environmental factors precipitate an eating disorder.”

Though researchers have known for some time that there is a hereditary component to eating disorders, the first insight into which genes might be involved did not come until 2017. At that time, a genomic analysis of nearly 3,500 people with anorexia nervosa uncovered the first area on the genome (known as a locus) that was associated with the eating disorder. That locus was known to be associated with diabetes risk, suggesting a possible link between the two disorders. A follow-up study published in 2019—with nearly 17,000 DNA samples from people with anorexia—uncovered eight additional anorexia risk loci, implicating genes associated with body mass index and autoimmune diseases.

“The increasing number of genetic samples now available has ... enabled us to examine the extent to which genes that influence anorexia also influence other traits, which has produced some remarkable associations,” Bulik noted. For example, genes associated with anorexia nervosa have not only been implicated in other psychiatric disorders, particularly obsessive-compulsive disorder, but also with body shape and weight, metabolism, and physical activity.

This suggests that anorexia nervosa may be a “metabo-psychiatric disorder” that requires clinicians to consider both metabolic and psychological risk factors when exploring prevention and treatment measures, Bulik said.

While researchers have begun to chip away at the mysteries surrounding the genetics of anorexia nervosa, they are limited to the few loci that have been identified to date. (For comparison, researchers have identified more than 200 risk loci for schizophrenia, another multi-component disorder that affects not just the brain but also metabolic and cardiac systems.)

Additionally, the field has yet to identify any specific loci linked with other major eating disorders such as bulimia nervosa or binge-eating disorder—the latter of which was not even recognized officially until DSM-5.

“We know these two disorders are also heritable, and they share some symptom profiles; but how genetically similar are they to each other, or to anorexia nervosa?” Bulik asked. Some preliminary analyses published in 2020 suggest that binge-eating disorder and bulimia also have metabo-psychiatric properties; however, people with either of these disorders are more likely to have genetic profiles associated with obesity rather than physical fitness.

Researchers around the world are hoping that the launch of the Eating Disorders Genetics Initiative (EDGI) will lead to new understandings of the role genetics plays in eating disorders. EDGI is a global initiative funded by the National Institute of Mental Health (NIMH) that ultimately aims to collect

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## FIRST PERSON

# Rational Prescribing Is Caring Psychopharmacology

**BY H. PAUL PUTMAN III, M.D.**

It's a treat when one of my favorite authors writes about one of my favorite topics, as with Steven Pinker's *Rationality: What It Is, Why It Seems Scarce, Why It Matters*. Due to the influence of scholarly mentors, I have always found comfort in the pursuit of truth as we can best define it, utilizing rationality and the scientific method. Simply put, it has always seemed rational to be rational.

It made perfect sense to me to title my recent book from APA Publishing *Rational Psychopharmacology: A Book of Clinical Skills*. The publishers had some concerns about the title, fearing it might offend practitioners who felt I was calling other methods of practice *irrational*, and we failed to identify a better one. While the response has been positive from



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*Psychopharmacology: A Book of Clinical Skills* from APA Publishing. Members may purchase the book at a discount at <https://www.appi.org/Products/Psychopharmacology/Rational-Psychopharmacology>.

readers, some potential readers have indicated that by stressing rationality, they feel I might be turning my back on compassionate concern for the individual and a rich therapeutic alliance. Surprised by this reaction, I find myself pondering this false dichotomy: Why is being rational associated by some with being cold, aloof, uncaring, and dog-

matic? Also, why is it offensive to describe some behaviors as irrational when they ignore or denigrate rationality?

In his book, Pinker describes how societies can progressively choose newer, truth-promoting norms that reward accurate beliefs and deemphasize inaccurate ones. This would include support for the rationality of the scientific method, upon which modern medicine must be based. Though we strive to practice only evidence-based medicine, there is often not enough evidence. Educated judgments must be made frequently, and irrational ones deprive our patients of the best care.

To my mind, accepting the responsibility of helping a patient find relief demands that I offer only my very best goodwill and intention. I can proceed only with an intact therapeutic alliance in which the patient and I look at their

problems from the same side of the table, working to benefit only them. As they look to me for information and guidance, I cannot betray their trust by offering any less than my best, including the most science has to offer: A rational approach to assessing the medical literature, patient assessment, treatment selection, and monitoring. As we work together in our alliance, I assist patients in understanding this rational process, which we then use together to address their problems. To offer anything less would be unethical, as well as uncaring. How can I say my patients matter to me when I am less than careful about my assessments and recommendations? When am I not as rational as I can be?

Rationality itself is not cold, uncaring, distanced, or aloof. It is a fully engaged partnership seeking and utilizing the most valid norms of truth finding we can currently access. Seeking rationality *is* caring. **PN**



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DNA samples from over 100,000 people with anorexia, bulimia, or binge-eating disorder, along with DNA from people without these disorders. NIMH-supported researchers in Australia, Denmark, New Zealand, and the United States have joined with researchers and clinicians from other countries to collect these samples, despite the restrictions that the COVID-19 pandemic has placed on clinical research.

That a genetic study of this size could be attempted in people with an eating disorder underscores the recognition of how increasingly common these disorders have become. One recent analysis suggested that the prevalence of any eating disorder more than doubled since 2000, from 3.5% in 2000 to 7.8% in 2018. Though women still make up most cases, new incidences are rising faster in men than women, dispelling another historical myth that eating disorders are limited to teen girls, Bulik said. "Eating disorders do not discriminate and can affect people of any age, ancestry, gender, or socioeconomic status."

Eating disorders, particularly anorexia and bulimia nervosa, also carry high mortality risk due to malnutrition or suicide. The potential for the onset or recurrence of an eating disorder has only increased since the COVID-19 pandemic began. A survey conducted by Bulik and colleagues early in the pandemic found that about 80% of people in the United States with an eating disorder history were concerned that their symptoms might worsen due to complications such as social isolation and reports of COVID-related weight gain. Subsequent studies using hospital admissions data have confirmed this pandemic-fueled rise in disordered eating.

"As we are seeing with other psychiatric illnesses, genetic discoveries will not be a panacea for eating disorders," Bulik cautioned. But researchers hope the identification of additional variants will help to unravel the complexity of these illnesses and offer insight into how genes and environment increase risk. "This ongoing global research offers hope not only for understanding but also for developing new treatments that are based on the underlying biology of the illnesses," she added. **PN**

**More information about the Eating Disorders Genetics Initiative is posted at <https://edgi.org/>. "Significant Locus and Metabolic Genetic Correlations Revealed in Genome-Wide Association Study of Anorexia Nervosa" is posted at <https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.2017.16121402>. "Genome-wide Association Study Identifies Eight Risk Loci and Implicates Metabo-Psychiatric Origins for Anorexia Nervosa" is posted at <https://www.nature.com/articles/s41588-019-0439-2>.**



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## Involving People With Mental Illness In Research Important to Addressing Social Determinants of Health

*People with serious mental illness have shown they can be vital members of a community-based participatory research team.* **BY PATRICK CORRIGAN, PSY.D.**

**P**eople with serious mental illness die 10 to 20 years earlier than people of the same age—largely because of social determinants of health and mental health that undermine health and wellness.

For many people with serious mental illness, common social determinants are poverty, lack of access to quality health and mental health care, stigma surrounding mental illness and its treatment, discrimination, high rates of smoking and alcohol and drug use, and poor diet and exercise patterns. People of color have an especially hard time accessing care—and care that is culturally sensitive.

Interventions are beginning to emerge to overcome these barriers to health. They include medical practices that decrease the side effects of psychiatric treatments, psychoeducation to teach people how to manage health and wellness, instrumental and interpersonal supports that assist people to navigate their community, and shared decision-making that assures individuals have ultimate control over their health and wellness plan.

Research is essential for the development and evaluation of strategies to address social determinants of health and mental health as a public health imperative at all levels of government.



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Community-based participatory research (CBPR) is the first principle: Research meant to test concepts and interventions specific to a community needs to be steeped in that community. This does not mean people are subjects of the research but rather partners in all facets of its conduct. Investigators and members of each community as partners define hypotheses, methods, analyses, and summaries of the research and development effort. CBPR is especially notable "coming into" and "going out of" a targeted research project. "Coming in," members of the community have fundamental insights about what needs to be examined to make sense of their problems and ways to impact them; "going out" is ownership. Researchers on the CBPR team often go on to the next research project when

data are analyzed and reports written up. Community members are likely to make use of the insights to meaningfully impact their neighborhood over time. The final plan is not something developed in the ivory tower by researchers who differ from the community, but by the community itself. This kind of ownership gives credibility.

Who is community? They are people with shared experience relevant to health and wellness. Typically, CBPR focuses on diversity, especially in terms of ethnicity and religious heritage. Public health investigators also may seek to include additional communities of concern including women, LGBTQ individuals, veterans, and rural residents.

People with serious mental illness are a community worthy of CBPR. They have shared experience and similar needs vis-à-vis the health care system. Some might ask whether people with serious mental illness can capably participate in CBPR given their social and cognitive disabilities. The answer is yes, they can be vital members of the CBPR team, especially when team members provide reasonable accommodations.

This is meant to be a clarion call for psychiatrists and health care professionals of all kinds. Psychiatrists need to be mindful of the many ways they can help people with mental health challenges address their physical health needs, both within their own practice and in partnership with other health care professionals. **PN**

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## Collaborative Care Improves Quality of Life In Patients With Heart Failure

*While patients who received blended cardiac and depression care after leaving the hospital for heart failure reported improvements on mental health measures, they did not differ from those who did not receive such care on measures of rehospitalization and death. BY NICK ZAGORSKI*

Results from a large clinical study have provided more evidence that collaborative care—a model which integrates mental health or other specialty care into primary care settings—can improve the mood and quality of life of people with heart failure. Collaborative care did not appear to reduce mortality or hospitalization in these patients more than doctors' usual care, echoing a trend

seen in previous studies of patients with heart problems. The results were published in *JAMA Internal Medicine*.

Heart failure, a progressive disease in which the heart muscles weaken and reduce pumping ability, affects millions of adults in the United States. Studies suggest that as many as 40% of heart failure patients have comorbid depression, which significantly increases their risk of poor health outcomes.

"As a clinical investigator, you would love to see an intervention lead to reductions in mortality or hospital readmission," said lead investigator Bruce Rollman, M.D., M.P.H., a professor of medicine, psychiatry, biomedical informatics, and clinical and translational science at the University of Pittsburgh Medical Center. But Rollman told *Psychiatric News* that the study still offered encouraging results.

"We successfully delivered a collaborative care program focused on two illnesses [depression and heart failure] over the telephone," he said. "Our use of a potent control group also demonstrated that the benefits from collaborative care for depression were due to our treatment and not just increased attention from hospital staff after discharge."

The study, known as the Hopeful Heart Trial, included 629 adults with heart failure recently discharged from a hospital who screened positive for depression (using the nine-item Patient Health Questionnaire). The participants were divided into three treatment groups for the 12-month study:

- **Enhanced usual care:** Patients received periodic phone calls from nurses who reviewed the patient's cardiac history, provided heart failure education, and encouraged adherence to heart medications and maintaining a healthy lifestyle.

- **Blended care:** In addition to discussing heart failure during follow-up calls, the nurses provided psychoeducation, monitored the patients' mood symptoms, and discussed treatment options for depression.

- **Usual care:** Patients received usual care from their physician, which could include medications for both heart failure and depression as well as referrals to specialty cardiac or mental health care.

After 12 months, patients who received blended care reported significantly better mood and mental health-related quality of life compared with the usual care group. Patients who received blended care also reported improved mood compared with patients in the usual care and enhanced usual care groups.

However, patients in all three groups had similar physical functioning, rehospitalization rates, and mortality at the 12-month follow-up.

"The study's modest findings of improved mood are important, but the overall study results are disappointing," noted Christopher M. Callahan, M.D., a research scientist at the Indiana University Center for Aging Research at Regenstrief Institute, in an editorial that accompanied the study. "Given that collaborative care trials for either heart failure or for depression alone demonstrate efficacy, why has the potential synergy in treating both not been realized?"

One potential reason for the lack of impact on hospital readmission and mortality may be due to the barriers that some patients face when trying to access collaborative care services, including transportation to appointments and access to healthy foods, he noted.

"[F]inancial toxicity originating from the best intentions in health care contributes to the roots of medication nonadherence, missed appointments, poor diets, lack of leisure-time physical activity, and poorer mental health-related quality of life," Callahan wrote.

Rollman acknowledged that finances and other barriers may have impacted the effect of blended care and is planning a follow-up trial to address this; his new blended care study will employ social workers who will help heart failure patients referred to cardiac rehabilitation following hospital discharge navigate the health care landscape and address their social needs (for example, affordable medications, transportation, housing, and food).

The Hopeful Heart study was funded by a grant from the National Heart, Lung, and Blood Institute. **PN**

**2** "Efficacy of Blended Collaborative Care for Patients With Heart Failure and Comorbid Depression: A Randomized Clinical Trial" is posted at <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2783455>. The editorial, "Moving Toward Fully Blended Collaborative Care: Integrating Medical and Social Care" is posted at <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2783461>.

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## PSYCHIATRIC NEWS *Special Report*

# Be Prepared to Address Technological Addictions in Psychiatric Practice

*In an ever-expanding high-tech environment, some individuals who are overly preoccupied with technology and online activity may need psychiatric help. BY PETROS LEVOUNIS, M.D., M.A.*

**T**hough online technologies like interconnected computers and electronic messaging can trace their origins to the 1960s, the online world did not take off until the end of the 20th century with the advent of a public World Wide Web and the rise of the cellular phone. Since then, however, we have seen an explosion in online applications that have connected people across the globe in ways never imagined. Billions of text messages are sent across smartphones each day, keeping distant friends and family in touch, while consumers can find almost any product they need without leaving their house.

The benefits offered by online technologies have become more evident since the COVID-19 pandemic began, as offices, schools, and health care centers transitioned to virtual services to continue operating under socially restrictive guidelines. Though

this “new normal” has been imperfect, the ability to work, learn, and socialize remotely has mitigated many of the adverse impacts of this pandemic.

But the seemingly endless bounty offered by online technology is not without risks. Just as happens with substances like alcohol or opioids, some people become so caught up in their virtual world that their real world—jobs, finances, relationships, physical health—begins to suffer. As smartphones and other modern devices become more and more integrated into all facets of life, understanding, identifying, and treating these technological addictions will become a significant aspect of psychiatric care.

### Medical Illness vs. Societal Ill

When conceptualizing technology-related addictions, we limit our scope to the people who exhibit



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discount at <https://www.appi.org/Products/Addiction-Psychiatry/Technological-Addictions>.

a true medical disorder. Most people can use technologies for extended periods without ill effect. Parents, teachers, and doctors may bemoan that today's youth are spending too much time online, but in most cases the children do not develop clinical problems. And although there is a growing consensus that social media is decreasing our civility and increasing tribalization, negative online behaviors are not necessarily indicative of an underlying disorder. The question of how online technologies are

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influencing our wellness, happiness, and creativity is extremely relevant, but let us leave that discussion for another day and invite the sociologists, philosophers, and policymakers to join the conversation.

From a psychiatric perspective, we are primarily concerned with those individuals who continue to be preoccupied with a technology despite experiencing internal preoccupation and external consequences. Just as with substance use disorders, people with a genuine technological addiction can develop tolerance and require greater time or intensity in their behavior to achieve the same effect. People with a technological addiction also think obsessively about their behavior when not online, and they experience withdrawal symptoms if they are shut out from their technology of choice.

Only one technological addiction has been semi-officially recognized by APA as of DSM-5: internet gaming disorder is in Section III of our manual as a condition for further study. However, addiction specialists generally agree on seven major online behaviors of concern: internet gaming, online gambling, online shopping, cybersex, internet surfing, texting/emailing, and social media.

problematic gaming can occur on both high-performance computers and basic smartphones, as game developers have become more adept at keeping players in a psychological “flow state.” A game’s challenge rises concurrently with a player’s skill and experience, such that the player becomes neither bored nor anxious, encouraging (or rather forcing) longer play.

- **Internet gambling disorder:** While gambling disorder is recognized in DSM-5, the internet has broadened the opportunities for problematic gambling immensely. In addition to virtual recreations of casinos and racetracks, online gambling can be found in a range of fantasy sports leagues and brokerage firms that let people engage in wild and speculative trading of stocks and other investments like cryptocurrencies. Some online sites have even prospered by offering casino-like games without any tangible payoff; this has led some experts to reconceptualize addictive gambling not as a rewards-based disorder, but an irresistible attraction to the thrill of risking something of value.
- **Online shopping disorder:** This category includes traditional purchase shopping as well as


Cybersex: An All-Inclusive Term

- Online Pornography
- Online Dating
- Sex Chats
- Sex Webcams
- Teledildonics

instantaneous. As with addictive substances (think tobacco, intravenous heroin, or alprazolam), the quicker the onset of action, the greater the addictiveness of the drug or the behavior.

- **Cybersex:** Though internet pornography springs to mind when thinking about cybersex, this disorder also includes more active and social behaviors like adult webcams, sex chats, and even unhealthy online dating. The current frontier in this field is teledildonics, a form of virtual sex in which webcam viewers can remotely control sexual stimulation devices used by the host. As with shopping or gambling, sex addiction is not new, but online technologies

“From a psychiatric perspective, we are primarily concerned with those individuals who continue to be preoccupied with a technology despite experiencing internal preoccupation and external consequences.”



Technology’s Seven Discontents

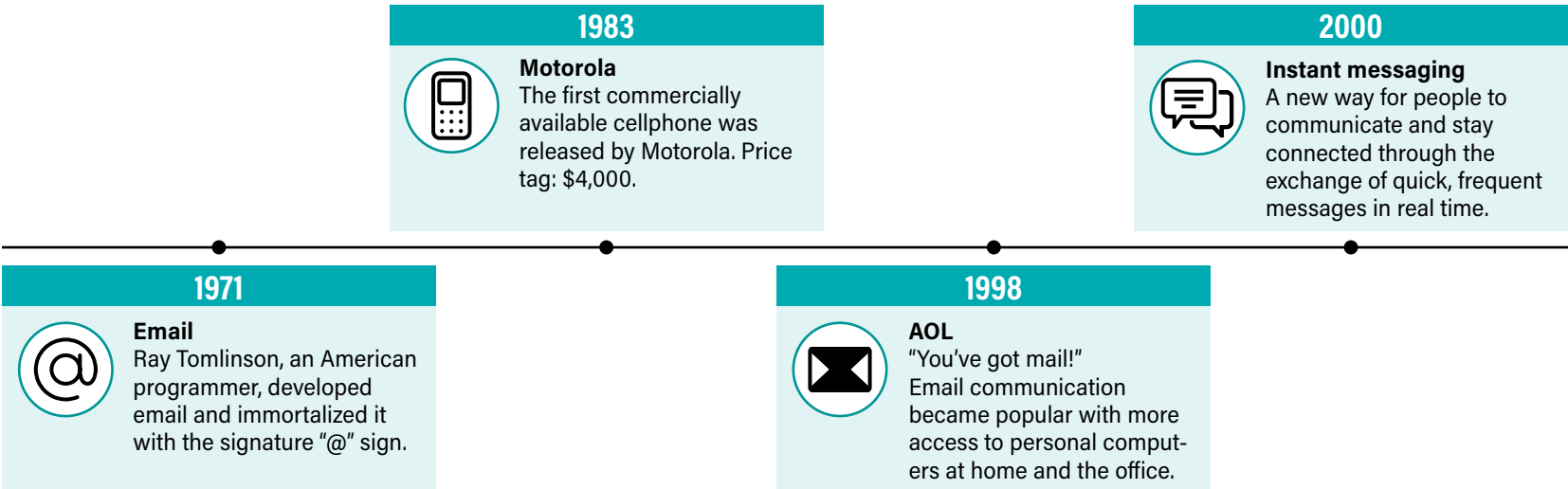
- **Internet gaming disorder:** Given its inclusion in the back pages of DSM-5 as well as in the most recent International Statistical Classification of Diseases (as gaming disorder), problematic gaming can be seen as the prototype disorder that can help professionals develop diagnostic criteria and treatment plans for other technological addictions. This disorder rose to prominence during the heyday of massive multiplayer online games like World of Warcraft, with stories of gamers losing themselves in their online world at the expense of real-world connections. Today,

auction shopping, which adds some of the thrill of gambling. As with gambling, problematic shopping was around in the brick-and-mortar days, but the online experience has exacerbated the risks by shrinking the path to purchase. This four-step model posits that consumers go through a period of awareness (*there’s a new product out*), consideration (*that might be good for me*), conversion (*I’m going to the store this weekend to buy it*), and evaluation (*I like it and will tell my friends*) with each purchase. With endless advertising, boundless product reviews, and time-limited flash sales, the internet has made this cycle near

have let people explore sexuality with far more accessibility, affordability, and anonymity than ever before, which may be of particular concern with younger individuals.

- **Internet surfing and infobesity:** While people have joked that no one has yet found the end of the internet, the vast amount of online information can lead to a pair of related problems. The first is the classic journey of surfing from one webpage to the next via hyperlinks or search engines, as a user’s momentary interests distract from a prespecified task. Soon, people

Timeline of Electronic Communication





find they wasted hours of potential productivity going down online rabbit holes. On the other hand, people who stay focused on a task while online can find themselves experiencing information overload, or “infobesity.” In this proposed disorder, users find so much information on their topic of interest that they don’t know how to sort through it all and proceed, leading to a state of productive paralysis.

- **Texting/email addiction:** Communication is an important component of human behavior, and it’s undeniable that texts and emails have become a preferred tool for keeping in touch with friends, family, and coworkers. In some instances, though, the time devoted to online chatting and the content of communication become unhealthy, with sexting and cyberbullying being two prominent examples.
- **Social media addiction:** It may be appropriate to end the list with social media since this topic may have the fuzziest delineation between healthy and unhealthy use. Many people believe if social media apps like Facebook or Twitter disappeared altogether, the world would be much improved. As previously noted, however, debates

### Diagnostic Dilemmas: All for One or One for All?

In examining the above list, one can see that these (proposed) disorders have not arisen from the depths of the World Wide Web; most of these online behaviors have addictive reflections in the real world. Our professional great grandparents Emil Kraepelin and Eugene Bleuler, for example, described compulsive shopping disorder more than a century ago, while accounts of compulsive gambling or sex addiction are older still. Even some problematic elements of social media use, such as obsessive following of photos and videos from influencers, resemble the problems seen a generation ago among youth who obsessed over fashion magazines. Given these connections, some might wonder whether we need to establish a class of technological addictions; perhaps it is better to incorporate these problems into existing frameworks of behavioral addictions—for instance, making internet gambling disorder a subtype or specifier of gambling disorder.

But while the base behaviors are similar, conducting these behaviors through a digital intermediary can alter many fundamental aspects of the disorder. In gambling disorder, for instance, individuals are diagnosed who meet a minimum set of criteria over the previous 12-month span,

addiction. There is certainly a rationale for this. Consider online gaming: While the ability to maintain gamers in a “flow state” contributes to addictive gaming, developers also increasingly entice gamers with elements derived from gambling (loot boxes that offer prizes of varying rarity) and shopping (releasing a game for free but incorporating microtransactions to unlock bonuses or cosmetic upgrades) arenas. Likewise, many online gambling sites have taken to gamifying their experience (for instance, by enabling players to level up their casino avatar the more they play) or adding sexual elements to separate themselves from physical casinos.

However, individuals have different motivations and gratifications when conducting each of these online activities. While gambling can be seen as a thrill of risking something of value, shopping is done for the thrill of acquiring something of value. In addition, data suggest that certain demographics may be at elevated risk of different addictions. Online gaming addiction occurs more frequently in men, while social media addiction is more likely to afflict women; texting addiction is seen more often in young adults, while shopping addiction is more common in older adults. Understanding these differences will help professionals develop more robust screening tools and treatment strategies.

**“The relevant issue is whether patients are experiencing significant symptoms and consequences due to their social media use.”**



on the repercussions of the social media era are somewhat beyond the scope of everyday clinical psychiatry. The relevant issue is whether patients are experiencing significant symptoms and consequences due to their social media use. As social media is still a rapidly evolving space, identifying addictive use is difficult, but one strong warning sign could be extended passive use of social media, where one is more voyeur than active participant. Another red flag may be related to FOMO, or the “fear of missing out” on the latest news developments or the fabulous lives of others, as a person’s driving factor in social media use.

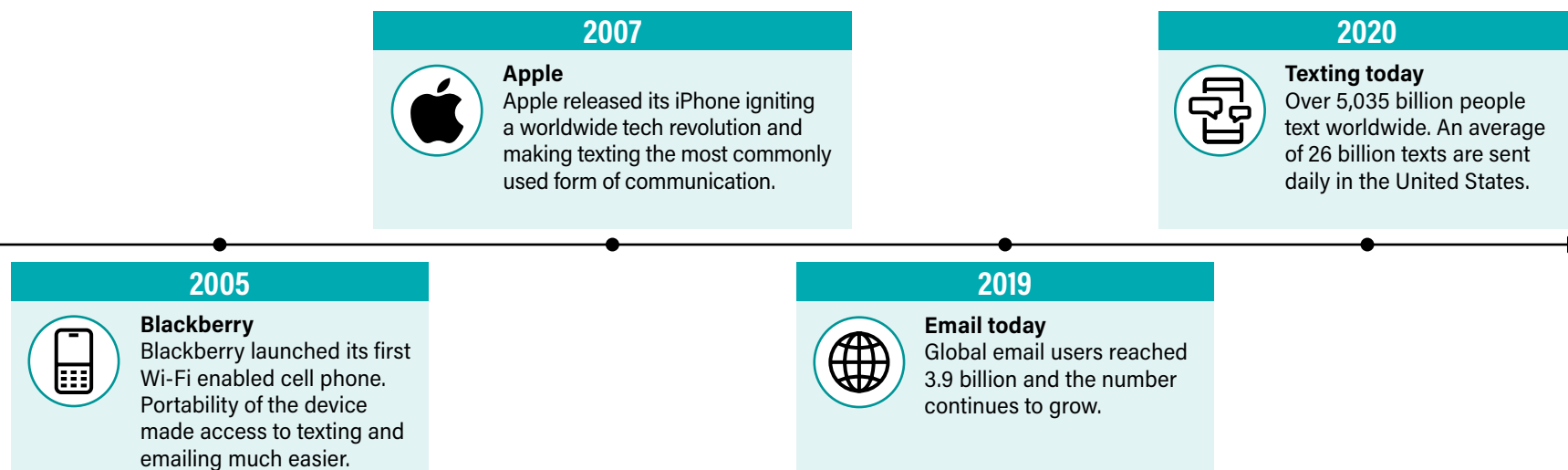
reflecting that gambling episodes are often sporadic and not always financially ruinous. With online gambling, the same at-risk individual now has 24/7 access to casinos, and the symptoms for diagnosis of a disorder might emerge in a couple of months or even weeks. Likewise, many people engage in cybersex specifically to experience “online dissociation,” which makes the psychology of the disorder quite different from that of those who have real-world sexual dysfunction.

Another option floated by some professionals is to develop broad diagnostic criteria based on platforms, such as internet addiction or smartphone

### How Do I know If My Patient Is Addicted to Technology?

For classic substances of misuse, we can reasonably look at well-validated scales, screening instruments, and diagnostic criteria to identify people who might be experiencing an addiction. But when it comes to digital devices, we mostly are at a loss. One factor we can be confident about is that time spent online is not a reliable indicator of a problem. Being routinely engaged with social media is a requirement for many corporate jobs, while competitive gaming and/or online streaming of games

*continued on next page*



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has become a popular pastime and money maker. How can psychiatrists distinguish a healthy, though time-consuming, habit from an unhealthy psychiatric condition?

As noted above, the seven proposed technological addictions are largely unique entities with distinct risk factors and motivations, but at times they share some thematic elements such as thrill seeking, escapism, and financial ramifications. Therefore, the work carried out to define online gaming disorder can provide a framework for diagnosing other technological addictions. Under the current *DSM-5* entry, online gaming disorder is likely present if someone meets five of the following nine symptom criteria over a 12-month period:

- Being preoccupied with video games.
- Experiencing withdrawal symptoms when video games are inaccessible.
- Requiring more and more playing time to gain the same level of satisfaction.

lar disorder, or schizophrenia is the true diagnosis. Having an external culprit like video games or social media is a less stigmatizing—and thus more easily accepted—problem than a psychiatric illness for many.

### Treatment Options and Goals: How to Manage a Modern Necessity

Just as the diagnostic criteria for the seven proposed technological addictions remain a work in progress, the guidance on how to treat patients with such a disorder remains so as well. The best advice currently is to rely on what works well across the broad addiction sphere: providing patients an integrated treatment that incorporates addiction psychotherapy, pharmacological treatment of other psychiatric disorders, and possibly mutual-help (otherwise known as 12-step) facilitation.

The first approach should be professional assessment and counseling, which many general psychiatrists should be prepared to take on themselves. As with substance use disorders and other behavioral addictions, educating and counseling patients about their technological addiction is based on empathy, curiosity, and nonjudgmental support.

### Counseling Guidance

1. Be empathic and curious.
2. State your medical findings.
3. Educate about problematic use and addiction.
4. Advise.
5. Follow up.
6. Refer, if necessary.

Source: National Institute on Alcohol Abuse and Alcoholism, NIAAA.NIH.gov.

ication assistance, there are a few options to consider, but caution is warranted as the evidence is very limited. Patients with internet gambling or internet shopping disorder, who have an impulsivity-driven technological addiction, might respond to naltrexone, which has moderate evidence of efficacy in non-internet gambling disorder. Patients with a compulsive technological addiction like cybersex may benefit from selective serotonin reuptake inhibitors (SSRIs), which are first-line medications for obsessive-compulsive

**“The seven proposed technological addictions are largely unique entities with distinct risk factors and motivations, but at times they share some thematic elements.”**

- Being unable to cut down on game playing despite efforts to do so.
- Giving up other activities to play more frequently.
- Deceiving family members about how much time is spent gaming.
- Using video games to alleviate negative moods.
- Jeopardizing jobs or relationships due to gaming.
- Continuing to play video games despite knowledge of adverse consequences.

When considering whether patients might have a technological addiction, consider whether their online activities may be related to another psychiatric diagnosis. As Robert Glick, M.D., director of the Center for Psychoanalytic Training and Research at Columbia University from 1997 to 2007 taught us, “the chief complaint is often nothing more than a dysfunctional solution to a yet unidentified problem.” The problematic engagement with technology may be a coping mechanism, maladaptive behavior, or a self-medication for an underlying psychiatric condition. Since online gaming disorder became recognized, many families have jumped on it to explain problems in their children, when emergent depression, bipo-

That a proposed disorder is not yet codified in text does not disqualify someone from having a legitimate psychiatric concern.

After initial assessment and counseling, motivational interviewing and cognitive-behavioral therapy that includes mindfulness techniques may be an effective strategy in the management of many technological addictions. Furthermore, peer support groups are now available for all the technological addictions listed.

Some psychiatrists may wonder whether patients with a technological addiction should be discouraged from using technology-based treatment such as internet-based cognitive-behavioral therapy or online 12-step programs, since this may potentially keep their problem front and center. To that, one could argue that our field uses opioids to treat opioid use disorder and nicotine patches for smoking cessation, so we have successfully gone down this road before. The rise of online peer support and recovery groups has been extremely helpful in addiction treatment (even more so during the pandemic), as individuals now can connect with others in a comforting and, if desired, truly anonymous manner.

When it comes to medications, things get tricky, as no medications are approved for any behavioral addiction, technology based or otherwise. The optimal use of medications for most patients is in the management of common psychiatric comorbidities like depression or anxiety, which have been shown to worsen the problematic behavior. If you think a patient might need some med-

spectrum disorders; SSRIs also decrease libido as a side effect, which may be an additional benefit for treating cybersex addiction. Finally, methylphenidate might help manage problematic internet surfing, based on some limited evidence in studies among people with attention-deficit/hyperactivity disorder.

### Conclusion

Though data on the prevalence of technological addictions are sparse, most people use computers, tablets, and smartphones regularly with great benefits and no serious adverse consequences. Research on the phenomenology and nosology of these illnesses will help us further elucidate the distinction between problematic and nonproblematic use of technology, especially in children and young adults. Another area of new research will involve emerging technologies. By the time clinicians get a firmer grasp of today's ailments, the technology of tomorrow—such as virtual reality and smart devices powered by artificial intelligence—will be commonplace enough to bring about a host of new problems. Finally, we will need to be ready to guide our patients, our colleagues, and the general public on how to best handle technology with an eye on maximizing its enormous potential for fulfillment, gratification, and happiness while minimizing its significant risks for dissatisfaction, misery, and despair. **PN**

**Disclosure statement:** The author receives revenue from APA Publishing but has no other financial conflicts to disclose.





# Psychiatrists Have a Role in Managing Pediatric Pain



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*While opioids may be too risky to prescribe to youth experiencing recurrent pain, there are other pharmacological options for helping young patients to find relief. BY NICK ZAGORSKI*

**A**s an attending physician at the Pennsylvania Psychiatric Institute's Child & Adolescent Inpatient Program, Taranjeet Jolly, M.D., has overseen the care of youth with a range of social and emotional issues. During this time, Jolly, who is also an assistant professor of psychiatry at Penn State Health in Hershey, Pa., has also witnessed the psychological and emotional toll that chronic pain can have on children.

While chronic pain is more common among adults, studies estimate that as many as 1 in 3 youth will experience recurring pain symptoms by the end of adolescence. Common symptoms include migraines, abdominal pains, backaches, and limb pain.

"The data also show that pain syndromes are more commonly encountered in clinics in adolescent females than males, but this discrepancy may be because many adolescent boys might not want to report their pain," Jolly said. Such behavior may lead to underestimates of the number of youth experiencing chronic pain, he added.

Chronic pain in children and adolescents can lead to a host of problems for the youth and their families, he continued. "The children typically experience school difficulties from the ongoing pain and resulting poor sleep, while parents are constantly leaving work to help with doctor's visits or taking care of the child." Pain can lead to such problems as depression, anxiety, and loss of self-esteem. These symptoms, along with reductions in physical activity, can lead to obesity, which can further lower children's self-esteem, Jolly added.

The economic impact of pediatric pain on families can also be significant. One analysis suggested that the average

cost of living for a family with a child with chronic pain can be significantly higher than that of families with a child not experiencing these symptoms. This stems from the direct cost of medical care that they seek, as well as parents' economic losses.

Early intervention is critical when treating youth with pain, but few physicians are trained to provide this care, Jolly said. As a result, it may take up to three years for children to see a pediatric pain specialist, and they might see five different physicians before see-

ing analysis involving four psychotropic medications with clinical evidence of reducing symptoms of pediatric chronic pain: the tricyclic antidepressant amitriptyline, the serotonin-norepinephrine reuptake inhibitor duloxetine, the selective serotonin reuptake inhibitor citalopram, and the anti-anxiety drug buspirone.

While there were only five studies included in the analysis, the findings pointed to the effectiveness of amitriptyline, duloxetine, and citalopram in pediatric pain management, with amitriptyline showing the strongest effect.

Jolly cautioned that patients can experience side effects while taking amitriptyline and other tricyclics so it's important to start patients at low



**Children with chronic pain and their families struggle with not only the physical but also the emotional or psychological aspect of the pain.**

**Getting psychological help might be a crucial early intervention. —Taranjeet Jolly, M.D.**

ing a pediatric pain specialist. This might lead to a significant delay in addressing the physical and emotional burden from chronic pain leading to mental health issues such as anxiety or depression.

Given the strong connection between physical and emotional pain, Jolly believes that psychiatrists can play a role in closing this treatment gap by screening youth for chronic pain and helping patients manage this pain and other comorbidities.

There are only a few pharmacological guidelines on treating youth with pain, and available ones have very limited data, Jolly said.

He recently conducted a meta-anal-

ysis involving four psychotropic medications with clinical evidence of reducing symptoms of pediatric chronic pain: the tricyclic antidepressant amitriptyline, the serotonin-norepinephrine reuptake inhibitor duloxetine, the selective serotonin reuptake inhibitor citalopram, and the anti-anxiety drug buspirone.

Regardless of the antidepressant prescribed to youth, the data suggest it can take as long as 12 to 13 weeks to see significant reductions in the intensity of children's pain, Jolly said. This time frame is different from that of adults—some patients report pain improvements as early as one week after treatment.

One theory Jolly offered as to why it can take months before youth experience pain relief from antidepressants is that the improvement in chronic pain

may be secondary to decreased anxiety, improved mood, and functioning, which typically take six to eight weeks of treatment. Studies have shown that children and adolescents—particularly females—exhibit strong correlations between their levels of physical pain and their how they are feeling emotionally.

Studies have shown that chronic stress can rewire the neural connections in the brain's pain centers, he explained. "After a while of dealing with pain, the mood and pain circuits become a two-way channel; if you are having a rough day, your brain [responds] much in the same manner as if you are experiencing physical pain. This can make you sensitive to future pain sensations just as pain makes you more sensitive to the effects of stress."

Understanding whether psychotropics offer primary pain relief in children is important, since it will guide treatment selection, Jolly noted. It can be tempting to pick a medication like amitriptyline for youth with co-occurring depression and pain since it may offer a two-for-one way to manage symptoms. But depending on the history and other clinical features, it might be prudent to find the best option for their depression symptoms first.

Other options for pain relief that are commonly used in children are NSAIDs (non-steroidal anti-inflammatory drugs) and the anticonvulsants pregabalin and gabapentin; Jolly said the latter two agents should be dosed with extreme caution as children metabolize these drugs differently from adults. He does not recommend using opioids or cannabis, as he does not believe that the benefits of these drugs outweigh the potential risks of their use.

"And don't forget that optimal pain care requires behavioral and physical interventions in addition to pharmacological care," he said. Several studies have demonstrated that cognitive-behavioral therapy, pain education, and mindfulness-based techniques are effective in children experiencing pain. Psychiatrists should also be aware of how physical therapy, yoga, and acupuncture might help young patients experiencing pain.

"I strongly believe psychiatrists, along with other primary care physicians such as pediatricians, should become more active in pediatric pain management," said Jolly. **PN**

**2** "Are Psychotropic Medications Effective in Chronic Pain Management in Children and Adolescents? A Meta-Analysis of Randomized Control Trials" is posted at <https://www.dovepress.com/are-psychotropic-medications-effective-in-chronic-pain-management-in-c-peer-reviewed-fulltext-article-JPR>.





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## Geographic Region May Play Role In Late-Life Depression Severity

*Patients in the Northeast and non-Hispanic White patients are more likely to receive depression care.* **BY TERRI D'ARRIGO**

**T**he severity of late-life depression varies by geographic region, a study in the *American Journal of Geriatric Psychiatry* has found. The results also suggest that geographic region may play a role in racial and ethnic disparities and outcomes in late-life depression.

Olivia I. Okereke, M.D., M.S., an associate professor of psychiatry at Harvard Medical School and director of geriatric psychiatry at Massachusetts General Hospital, and colleagues analyzed data from 25,502 adults who participated in the VITamin D and Omega-3 Trial (VITAL) Depression Endpoint Prevention study. Men in the study were at least 50 years old and women in the study were at least 55 years old. Participants identified as Asian, Black, Hispanic, non-Hispanic White, and Other race/ethnicity (such as Native American, Alaska Native, more than one race,

and others), and they lived in four geographic regions, the Northeast, Midwest, Southeast, and West.

"Geographic region itself is an understudied depression risk factor,"

measured by frequency, such as whether they had symptoms "more than half the days" or "nearly every day." Participants were also asked whether they had been diagnosed with depression, took antidepressants, or received counseling for their depression.

Overall, participants in the Midwest,



**Nationwide, systemwide efforts may not be enough to address racial/ethnic disparities in late-life depression.**

**—Chirag Vyas, M.B.B.S., M.P.H.**

lead author Chirag Vyas, M.B.B.S., M.P.H., a postdoctoral fellow in the Department of Psychiatry at Massachusetts General Hospital in Boston, told *Psychiatric News*.

All participants were given the Patient Health Questionnaire-8, and the intensity of their symptoms was

but not other regions, had less severe depression compared with participants in the Northeast. Yet within the Midwest, Black and Hispanic participants had symptom levels that were 23% and 99% higher, respectively, compared with non-Hispanic Whites. In the Northeast, Black participants and those who iden-

tified as Other race/ethnicity had up to 30% higher depression severity compared with non-Hispanic Whites. There were no racial/ethnic differences in depression severity among people living in the Southeast or West.

Compared with participants who had been diagnosed with depression and lived in the Northeast, those with diagnosed depression in all other regions were less likely to receive depression care, although the disparity was only statistically significant in the Midwest. Vyas noted that psychiatrist shortages may explain why participants outside of the Northeast with depression were less likely to receive care.

Across all regions, Black participants had a 50% or higher likelihood of not receiving any depression care compared with non-Hispanic Whites, even when accounting for similar depressive symptom severity.

"Although we adjusted for several known social and health determinants in our statistical models, it is possible that the unmeasured confounders such as neighborhood factors, patient-physician factors, or access to care might have influenced these findings," Vyas explained. For example, health professionals may be less sensitive to depressive symptoms among Black patients compared with non-Hispanic White patients, leading to undertreatment, he said.

"This study not only addressed regional differences in late-life depression but also highlighted the potential role of geographic region of racial/ethnic disparities in depression," Vyas added. "Overall, nationwide, system-wide efforts may not be adequate to mitigate racial/ethnic disparities in late-life depression, and region-specific, targeted, and tailored strategies may prove beneficial."

This study was supported by the National Institute of Mental Health. **PN**

**➤ "Geographic Region, Racial/Ethnic Disparities, and Late-Life Depression: Results From a Large US Cohort of Older Adults" is posted at <https://www.sciencedirect.com/science/article/pii/S1064748121005492>.**

## Best App

*continued from page 8*

states have adopted statutes specifically authorizing PADs in the past decade.

"We recommend them for people who have had psychotic episodes or periods of incoherence from which they've recovered. That can be someone with schizophrenia, bipolar disorder, or some other crisis during which they cannot make treatment decisions," Swartz said. Many clinicians have the misperception that patients with schizophrenia and other psychotic disorders lack sufficient insight about their disorder to complete

a plan, he added. Landmark research reported in 2006 by Jeffrey W. Swanson, Ph.D., Swartz, and colleagues in the *American Journal of Psychiatry* refuted this: While only 3% of participants with severe mental illness given information about PADs completed one, among those given assistance, 61% of participants did so, he said.

Some states require extra steps for PADs to become legally binding, such as having it witnessed or notarized. My Mental Health Crisis Plan informs users of the specific steps needed in their state. Even for patients who don't wish to take those final extra steps, just

developing a crisis plan is very powerful, Cohen said. "It is good for the therapeutic alliance. You and your clinician are sitting down and talking about potential warning signs that things are not going well, as well as the key things that help you recover."

Cohen added, "We envision these being set up when individuals are being discharged from the hospital or for [Assertive Community Treatment] teams to use with their patients." Psychiatrists are in a unique position to advise their patients with a history of these types of crises about the important role of PADs in their treatment plan.

"It would have a big impact if psychiatrists introduced the idea of a psychiatric advance directive with their patients," she said. "They're often the most powerful voices in the care of these individuals and could really move the needle on getting more of these set up." **PN**

**➤ The app can be downloaded at the SMI Adviser's website at [smiadviser.org](http://smiadviser.org). "Facilitated Psychiatric Advance Directives: A Randomized Trial of an Intervention to Foster Advance Treatment Planning Among Persons With Severe Mental Illness" is posted at <https://ajp.psychiatryonline.org/doi/full/10.1176/ajp.2006.163.11.1943>.**





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## Research on Youth MH Disparities Needs New Approach, Experts Agree

*During a two-day NIMH conference, researchers reflected on new and ongoing areas of research on youth mental health disparities and shared ways to ensure research is inclusive and equitable.* **BY KATIE O'CONNOR**

**M**ore research is necessary to understand the extent and nuances of youth mental health disparities, but not necessarily more of the same research, concluded experts at the 2021 Youth Mental Health Disparities Conference.

The conference was organized by the National Institute of Mental Health (NIMH), the Eunice Kennedy Shriver National Institute of Child Health and Human Development, and the National Institute on Minority Health and Health Disparities. It was held in response to the Congressional House Committee on Appropriations, which called for “a conference of leading extramural experts on health disparities ... to discuss research opportunities and gaps, as well as evidence-based solutions and therapeutic interventions,” according to NIMH’s website.

The two-day conference emphasized several key points, including that research should more often involve community members, particularly children, adolescents, and their families. Further, research needs to investigate and address root causes of mental health disparities, including structural racism, and not focus exclusively on individuals.

Presenters shared some of the research they are conducting around risk, identification, interventions, and follow-up care. Andrea Spencer, M.D., discussed the work that she and her colleagues have done related to attention-deficit/hyperactivity disorder



Though ADHD is one of the most common pediatric behavioral health conditions, many families still struggle to access care for their children, particularly minority families, explains Andrea Spencer, M.D.

(ADHD) and treatment disparities. Spencer is a child and adolescent psychiatrist at Boston Medical Center, as well as director of Pediatric Integrated Behavioral Health and an assistant professor of psychiatry at the Boston University School of Medicine. She is also the director of the Revolutionizing Equal Access to Care and Health for ADHD (REACH) program, which investigates barriers and stigmas that minority families face when seeking care for their children with ADHD. Through their work, Spencer and her

colleagues have found that the discrimination parents often face delays their children’s ADHD treatment.

Spencer pointed out that Black children aged 5 to 11 years old are twice as likely as their White peers to die from suicide, and ADHD is the most common psychiatric disorder associated with these suicides. “We hypothesize, based on our qualitative data, that the combination of ADHD stigma and racism experienced by Black families is actually leading to treatment delays and increasing distress for these families, and therefore increasing the risk of suicidality and suicide attempts,” she said.

She and her colleagues are conducting a case control study to determine the relationship between discrimina-



Jasmine Jackson

Poverty and homelessness, which unevenly impact minority communities, are both causes and consequences of youth mental health disparities, says Matthew Morton, Ph.D.

tion and suicidality among Black school-age children with ADHD and to identify the contribution of a missed ADHD diagnosis.

During the conference, the conversation also veered into contextual factors and other drivers of health outcomes for youth, such as poverty and food and housing insecurity, which may fall outside the traditional scope of mental health research. Matthew Morton, Ph.D., a research fellow at Chapin Hall at the University of Chicago, shared his research on homelessness among youth during the pandemic. He and his colleagues have found that symptoms of anxiety and depression are significantly associated with young people’s experiences of housing insecurity.

“Longitudinal research makes a compelling case that housing and food insecurity contributes to later mental health problems,” Morton said.

Bonnie Nagel, Ph.D., emphasized the importance of inclusive, equitable, and unbiased research. She is a professor of psychiatry and behavioral neuroscience at Oregon Health & Science University, as well as a principal investigator on the federally funded Adolescent Brain Cognitive Development Study (ABCD). Over the past year, she has chaired the ABCD study’s Justice, Equity, Diversity, and Inclusion Task Force, which has a stated mission of effecting change that promotes equity and diversity within all levels of the study and in the ways the study’s data are used.

Nagel explained that researchers should carefully consider whether it is appropriate to control for race or ethnicity in their studies or to report findings in association with those variables. Given that race is a social construct, there are often more proximal variables, such as the discrimination or socioeconomic disadvantages that participants experience, that better explain race-based findings. Researchers should also avoid including race in their studies’ demographic tables unless there is something specific and important about disparities they are trying to say, she said.

While summarizing the key takeaways of the conference, Lauren Hill, Ph.D., acting director of the NIMH Office for Disparities Research and Workforce Diversity, emphasized that while a great deal of important work around youth mental health disparities is ongoing, there is more work to be done. “It is clear that we have a lot more to learn,” Hill said. **PN**

**2** More information on NIMH’s approach to conducting mental health disparities research is posted at <https://www.nimh.nih.gov/about/organization/od/odwd/nimhs-approach-to-mental-health-disparities-research#addressing-mental-health-disparities-through-research>. More information on REACH is posted at <https://www.bumc.bu.edu/reach4adhd/>.

# Despite Addition to *DSM*, Few Treatments Emerge for Hoarding Disorder

Although patients rarely come forward for help, hoarding is a debilitating yet relatively common disorder that worsens with age. Researchers are working to unlock better treatments.

BY LINDA M. RICHMOND

**H**oarding disorder, defined as a persistent difficulty and distress over discarding personal possessions, typically results in an avalanche of papers, clothing, plastic containers, or even trash, overwhelming individuals' living spaces so they can no longer be used as intended.

A meta-analysis by Adam Postlethwaite and colleagues in June 2018 suggests that hoarding disorder occurs in about 2.5% of the worldwide population in developed countries, making it more prevalent than obsessive-compulsive disorder. Although it was approved as a distinct diagnosis in *DSM-5* in 2013, new treatments have not been forthcoming. Few studies have since investigated evidence-based treatments—either drug or behavioral therapy—for people with hoarding disorder, particularly in the geriatric population, Catherine R. Ayers, Ph.D., sec-



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tion chief of the Outpatient Mental Health Clinics at the La Jolla VA San Diego and a professor of psychiatry at the University of California, San Diego, told *Psychiatric News*.

## Complex Disorder Difficult to Treat

Ayers said the reason for the lack of treatment options is that hoarding is a complex, difficult-to-treat disorder that

is associated with severe impairment, and patients are slow to show improvement. Ayers first realized the prevalence of hoarding disorder while conducting home visits with elderly patients during her training and has devoted her career to better understanding and treating patients with the disorder.

Randy O. Frost, Ph.D., an expert on hoarding disorder, professor emeritus

of psychology at Smith College, and co-author of soon-to-be published *Hoarding Disorder: A Comprehensive Clinical Guide*, said many patients are reluctant to come forward. Frost told *Psychiatric News* that he urges clinicians to use simple screening tools such as the Hoarding Rating Scale, particularly for patients with anxiety, depression, or attention-deficit disorder or those who present with hygiene problems. One of Frost's research studies examined hoarding in patients entering treatment at a center for anxiety disorders. "Many of them never mentioned hoarding as problem, yet they had significant problems with it. This is something that carries with it stigma and a lack of understanding that this is a mental health disorder."

Frost said hoarding comes down to three problems: excessive levels of acquisition; intense attachments to objects and a desire to save things, despite rarely using them; and a neurocognitive deficit in the ability to organize or categorize objects. One patient's home he visited had clothes and other objects stacked in separate piles up to the ceiling, but her dresser

see **Hoarding** on page 36



## CLIMATE CHANGE & MENTAL HEALTH

# Caucus and New Committee Work Together on Climate Change

BY FERDINAND OSUAGWU, M.D.

**T**he APA Caucus on Climate Change and Mental Health works synergistically with the new APA Committee on Climate Change and Mental Health. I am chair of the caucus, and Jamie Lee Sorenson, M.D., is vice chair. The caucus has identified the following five areas in which to promote awareness of and effective responses to the climate crisis:

- **Increase membership:** The caucus has been reaching out to APA members, communicating our values and the benefits of expanding the influence of the caucus. The membership has grown rapidly, but we still want to increase our numbers. We have an active listserv and expanded our social media presence to make the caucus more visible and diverse, including the creation of the "Climate Concerned Psychiatrists" Facebook page. You can join at <https://www.facebook.com/groups/4300729973322631>.



Ferdinand Osuagwu, M.D., works with MidMichigan Health and is an assistant clinical professor of psychiatry at Central Michigan University. He is the chair of the APA

Caucus on Climate Change and Mental Health. He was an APA Diversity Leadership Fellow in 2016 and served as a member of the APA Council on Children, Adolescents, and Their Families from 2016 to 2018.

- **Build alliances with other APA caucuses:** We have engaged in collaborative efforts in areas of overlapping interest between our caucus and other APA caucuses. Because of the intersectionality of issues associated with climate and mental health, especially social and structural determinants of health, our goals are facilitated by partnering with caucuses whose goals and agendas address inequities, environmental hazards, targeted research, policy development, and public advocacy. We are constantly reaching out to educate and enlist the support

of our colleagues from other caucuses to reduce carbon emissions across the health sector, identify harms our patients are experiencing, educate the public, and shape relevant APA policies and initiatives. This concerted effort is helping to influence the broader health sector and to address its disproportionate overall carbon footprint and contribution to the climate health crisis for our patients and communities.

- **Cultivate new leadership within APA:** We are recruiting early career psychiatrists and fellows in the Minority Fellowship Program (MFP) to develop and advance knowledge of mental health impacts and responses to the climate crisis through training and mentorship. We anticipate a joint meeting of the caucus and members of the MFP in April.

- **Develop global strategic networks:** We are aligning with other global organizations with similar interests. The Caucus on Global Mental Health is one of the largest

APA caucuses with more than 800 members, including many members from outside the United States. We are partnering with the Global Mental Health Caucus Senior Advisory Board to create social media posts on climate change based on the report of the United Nations Intergovernmental Panel on Climate Change. The Global Mental Health Caucus has established connections with the World Psychiatric Association, allowing us to develop effective global networks within it.

- **Advocate and engage policymakers:** We work to influence policies within APA through action papers, and we support APA in its efforts to impact federal policies. Ultimately there must be coordinated and collaborative initiatives to reduce carbon emissions and actualize relevant health and mental health policies.

The APA Committee on Climate Change and Mental Health is chaired

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# App for People With SMI Shows Promise in Remote Trial

*While many clinical studies have been conducted virtually, the study of a mobile app that teaches patients how to regulate dysfunctional thoughts took remote one step further by limiting staff involvement with the study participants to tech support only. BY NICK ZAGORSKI*

A team led by researchers at the University of Washington has completed a fully remote clinical trial involving people with serious mental illness (SMI)—a population that can be hard to recruit and retain in clinical trials. The trial of CORE, a mobile app that teaches patients how to regulate dysfunctional thoughts, demonstrated how SMI patients can benefit from the use of digital health. The results were published in the *Journal of Medical Internet Research (JMIR)*.

While many clinical studies have

been conducted virtually—a trend that some say is likely to outlast the COVID-19 pandemic—the study of CORE took remote one step further by limiting staff involvement with the study participants to tech support only, explained Dror Ben-Zeev, Ph.D., the director of the mHealth for Mental Health Program at the University of Washington School of Medicine. “Everything was driven by the participants,” he said.

To recruit study participants, the researchers used online ads. Adults with self-reported major depression,

bipolar disorder, or schizophrenia who responded to the ads were directed to a study website, where they completed an online consent form and baseline mental health assessment. Any adult who owned a smartphone, was available for 60 days, and could complete the consent form was eligible to participate and was randomized to receive 30 days of access to the CORE mobile app or be placed on a 30-day waitlist. After 30 days, the waitlist group received the app while the other group lost access to the app. Automated text messages reminded the participants to log in at the 30-day and 60-day mark to complete more mental health assessments as well as questionnaires on the usability of the app.

The CORE app offers a range of

game-like exercises to help individuals with SMI manage maladaptive thoughts about themselves or others. The app is designed to build confidence, improve self-care, and reduce self-stigma. Ben-Zeev noted that CORE is a transdiagnostic tool that can help people with a variety of conditions.

“People with depression and bipolar disorder may also hear voices,” Ben-Zeev explained. “Similarly, people with schizophrenia may also experience depression and other mood disturbances. It’s important to develop clinical interventions that are not siloed [to treat] just one category of disorders.”

Overall, 1,123 people signed up for the study, of whom 315 were eligible and randomized. The participants hailed from 45 different states and included many who were unemployed and/or homeless. “With a standard clinical trial, you are primarily recruiting people who are already engaged with the health care system—the patients who can see the ‘volunteers needed’ ads posted at clinics,” Ben-Zeev said. “With the online recruitment we achieved a much greater reach, and at a fraction of the cost.”

After 30 days, the adults who used CORE reported significantly greater improvements in their depression, anxiety, self-esteem, and perceived disability than the adults in the waitlist group. During the next 30 days, the waitlist group experienced similar levels of improvement in these categories, such that both groups had similar assessment scores after 60 days. Most of the participants reported satisfaction with the app and its ease of use.

“We are not advocating for a shift toward fully automated approaches as the preferred model [for clinical trials],” Ben-Zeev and colleagues wrote in *JMIR*. “However, what this study did demonstrate is that when technology is designed with the characteristics of the intended users in mind (i.e., in terms of functionality, accessibility, navigability, and content), deployment of specialty digital mental health tools that do not involve humans in the loop of care can also produce significant clinical benefits.”

The authors reported no funding for this study. **PN**

## Pharma, Telehealth Companies Team Up for Virtual Trial of Depression Drug

To date, most virtual clinical trials in psychiatry have focused on interventions that can be easily conducted online, such as behavioral therapy, or via mental health apps. Last December, Alto Neuroscience announced it is partnering with online mental health provider Cerebral to conduct a virtual open-label trial of its experimental depression drug. The goal is to enroll 200 existing Cerebral users who report treatment-resistant depression to take eight weeks of ALTO-300.

The participants will be shipped the medication and participate in all clinical assessments from the comfort of their home via telehealth; the participants will also be provided mobile EEG devices to measure brain activity and other wearables to monitor sleep and physical activity. Alto will conduct a more traditional open-label trial of ALTO-300 with in-person visits at the same time to see how the results and engagement of participants compare.

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by Elizabeth Haase, M.D. In addition to me, members include Kenneth Thompson, M.D., Jacob Lee, M.D., Joshua Wortzel, M.D., Tony Ng, M.D., Saundra Maass-Robinson, M.D., and James Fleming, M.D. The committee is charged with advancing mental health and climate change initiatives for APA. Its agenda includes the following:

- **Curriculum development:** Medical students, residents, psychiatrists, health and mental health professionals, and the general public need to be educated about the mental health impacts of global warming and the essential roles for psychiatrists and organizational psychiatry in changing behavior and responding to patient and community needs. Working in alliance with the Climate Psychiatry Alliance, the Committee on Climate Mental Health of the Group for the Advancement of Psychiatry, and Medical Societies Consortium on Climate and Health, the committee is developing core curriculum recommendations and materials.

- **APA’s carbon reduction goals:**

The committee helped write and support a successful action paper to the reduce carbon footprint of APA meetings and is preparing further recommendations to help APA meet these targets. These include modification of APA conference processes to retain distance participation, advocacy for virtual residency applicant interviews, and broad sustainability practices to help clinical health systems meet meaningful carbon reduction goals.

- **Innovative clinical resources for communities:**

The committee is developing toolkits and recommendations for mental health professionals that empower them to build resilience and social cohesion in their communities. These include change processes for community transitions that will be required and toolkits on heat and other climate risks. The toolkits consist of simplified documents that provide step-by-step guidance on how to create initiatives to help communities adapt to climate change. In addition, the committee supports APA’s efforts

to promote diversity, environmental justice, structural and social equity, and reparative protection for the communities that are most vulnerable to the acute and longer-term changes of climate instability.

- **Raising climate mental health awareness at all levels:**

The committee is working to strengthen existing links between relevant APA components to enhance the messaging regarding climate change and mental health. The committee is advocating for the creation of APA climate mental health fellowship opportunities for residents and early career psychiatrists to promote leadership in this area. The committee also liaises with the APA communications department to respond to media requests to ensure that mental health is adequately addressed in the work of national leaders and policymakers on climate change and give APA a foremost voice in climate health initiatives.

Stay tuned as these two component groups expand their work. Please join our efforts. Our patients and communities need our help. **PN**

**2** “A Smartphone Intervention for People With Serious Mental Illness: Fully Remote Randomized Controlled Trial of CORE” is posted at <https://www.jmir.org/2021/11/e29201/>. A press release announcing the partnership between Alto Neuroscience and Cerebral is posted at <https://www.altoneuroscience.com/press-releases/cerebral-and-alto-neuroscience-enter-into-strategic-collaboration-to-launch-first-ever-decentralized-study-in-precision-psychiatry>.



BY NICK ZAGORSKI



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## Severe Pediatric Illness Affects Mental Health Of Entire Family

Parents and siblings of children with life-threatening illnesses have higher rates of health care encounters, diagnoses, and prescriptions than family members of children without a health condition, a study in *JAMA Network Open* has found.

"The findings of this cohort study, limited to families of children with 1 of 4 [life-threatening conditions], are consistent with increasing evidence that family members of children with [life-threatening conditions] may have increased health care use and poorer mental and physical health," the authors from the Children's Hospital of Philadelphia and colleagues wrote.

The researchers analyzed data from Cigna insurance claims between July 2015 and December 2017 to classify families with children having one of four life-threatening conditions: extremely premature birth ( $\leq 30$  weeks), congenital heart disease, pediatric cancer, or severe neurologic impairment. The final sample included 6,909 children with one of these serious conditions and their families, who were matched with a control group of 18,619 children with no life-threatening conditions and their families.

Compared with families who did not have a child with a serious illness, the parents and siblings of children with these serious illnesses were 55% to 70% more likely to have a health care encounter (hospitalizations, emergency department visits, and urgent

care visits) and receive a diagnosis of mental health and/or physical problem and medication. The increased health care use was greatest for families of children with cancer or neurologic problems. For example, mothers of children with cancer or a neurologic impairment were 91% and 85% more likely, respectively, to receive a mental health diagnosis than control parents.

"Compared with case newborn infants in the cardiac and prematurity cohorts, most of whose conditions likely substantially improved after several months, ... children in the neurologic and oncologic cohorts were most likely previously healthy and more likely to experience long-duration illnesses with sustained prognostic uncertainty," the authors wrote. This extended period of uncertainty likely creates additional financial and emotional hardships, which contribute to poorer health in families, they added.

**Feudtner C, Nye RT, Boyden JY, et al. Association Between Children With Life-Threatening Conditions and Their Parents' and Siblings' Mental and Physical Health. *JAMA Netw Open*. 2021; 4(12): e2137250. <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2787264>**



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## Childhood Stroke Linked to Long-Term Cognitive Deficits

Having a stroke early in life can impact cognitive abilities years later, according to a study published in *Neurology*. In particular, youth who had a stroke between the ages of 1 month and 6 years scored lower on cognitive tests compared with youth who had a stroke in their first month of life

and those who had a stroke between the ages of 6 and 16 years.

Researchers at University Hospital in Bern, Switzerland, enrolled 52 youth (average age 15) who experienced a stroke at least two years prior and 49 youth with no stroke history (average age 14) for a series of cognitive assessments; these included tests of intelligence, executive function, processing speed, memory, and visual-motor skills. None of the participants had active epilepsy, learning difficulties, or behavioral problems that would affect the cognitive tests.

Average test scores for both groups of children were in the normative range for their ages, but those with a stroke history had slightly lower scores in all cognitive domains tested than controls. Among the stroke patients, those who had an early childhood stroke (between 29 days and 6 years) had lower average cognitive scores than those with a late-childhood stroke (6 to 16 years) or a neonatal stroke (before 28 days). The most significant deficits observed for early childhood stroke patients were for working memory, cognitive flexibility, processing speed, and verbal learning.

"Our results suggest that age at stroke is an important factor for post-stroke recovery and modulates long-term cognitive outcome even when controlling for lesion size and lesion location," the researchers wrote.

**Abgottspon S, Thaqi Q, Steiner L, et al. Impact of Age at Pediatric Stroke on Long-term Cognitive Outcome. *Neurology*. December 16, 2021. Online ahead of print. <https://n.neurology.org/content/early/2021/12/16/WNL.0000000000013207>**



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## Carbamazepine Use Linked With Lower Vitamin D

Use of the anticonvulsant/mood stabilizer carbamazepine may lead to lower vitamin D levels in the blood, according to a meta-analysis in *Epilepsy Research*.

The researchers from Temple University and Thomas Jefferson University compiled data from 12 studies that measured vitamin D levels in people taking carbamazepine monotherapy (all included studies involved epilepsy patients); the final sample included 331 people on carbamazepine and 328 controls, both children and adults.

Overall, average vitamin D levels in carbamazepine-treated patients was 21.8 ng/mL compared with 28.0 ng/mL in the controls. The differences in vitamin D were not influenced by age, sex, or geographic region (a proxy for sunlight exposure), the authors wrote. In addition, vitamin D differences were not significantly different when controls were healthy individuals or epilepsy patients taking lamotrigine (also used as a mood stabilizer). "This suggests that the lower [vitamin D] levels in carbamazepine-treated patients is not only due to their disease, although future studies should address this further," the researchers wrote.

They concluded, "[V]itamin D supplementation should be strongly considered for patients prescribed carbamazepine."

**LoPinto-Khoury C, Brennan L, Mintzer S. Impact of Carbamazepine on Vitamin D Levels: A Meta-Analysis. *Epilepsy Res*. 2021; 178: 106829. <https://www.sciencedirect.com/science/article/pii/S0920121121002849>**



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## Women With Borderline Personality, Depression May Respond to rTMS

Repetitive transcranial magnetic stimulation (rTMS) may be effective at reducing depressive symptoms in people with borderline personality disorder (BPD), suggests a small clinical study in the *Journal of Affective Disorders*.

Investigators at the University of Toronto and colleagues enrolled 20 women with comorbid major depressive disorder and BPD for a crossover trial. Over the first three weeks of the study, half the participants received 30 sessions of rTMS therapy (twice daily sessions five days each week) while the other half received a sham stimulation. After a one-week break, the active and sham treatment groups were switched. Each participant's depressive symptoms were measured with the 17-item Hamilton Rating Scale for Depression (HAM-D) at baseline; at the end of each week during the trial; and at follow-up appointments one, four, and 12 weeks posttreatment.

During the first part of the study, the women who received active rTMS

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## Suicide

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[directly] to suicidal behavior, we still see these residual associations between SUD and suicidal behavior," Edwards said.

In another secondary analysis, the researchers looked at deaths of undetermined intent and found that 44.3% of deaths in people with SUD had undetermined intent compared with 17.6% of deaths among people without SUDs.

"This is not surprising because

deaths of undetermined intent tend to be overrepresented among people with SUD. It can be difficult to tell if a suicide was intentional [in this population]," Edwards said.

This study was supported by the National Institute on Alcohol Abuse and Alcoholism, the Swedish Research Council, and Region Skåne. **PN**

**"Comparative Risk of Suicide by Specific Substance Use Disorders: A National Cohort Study" is posted at <https://www.sciencedirect.com/science/article/pii/S0022395621006166>.**





BY TERRI D'ARRIGO

## StrandDx-ASD Receives Breakthrough Designation

The U.S. Food and Drug Administration granted Breakthrough Device designation to Linus Biotechnology Inc.'s **StrandDx-ASD** autism spectrum disorder (ASD) diagnostic aid, the company announced last December. The goal of the FDA Breakthrough Device Program is to provide patients and health care providers with timely access to medical devices by speeding up their development, assessment, and review.

StrandDx-ASD uses a single strand of hair to detect molecular biomarkers associated with ASD. According to the

Breakthrough Device designation label, the test is intended to assess the likelihood of ASD in children from birth to 18 months old and aid in the diagnosis of ASD in patients aged 18 months to 21 years.

## Esmethadone May Be Useful for Depression As Adjunctive Treatment

A study in the *American Journal of Psychiatry* suggests that **REL-1017 (esmethadone)** may be useful as an adjunctive treatment for patients with major depressive disorder (MDD), Relmada Therapeutics announced last December. REL-1017 is a novel N-methyl-D-aspartate (NMDA) receptor.

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experienced a significant drop in their HAM-D scores after three weeks (from an average of 23.1 to 11.0), while scores among those who received the sham TMS dropped from 23.0 to 17.4. During the second part of the study, HAM-D scores among the women who were new to active rTMS dropped from 17.4 to 11.0 after three weeks, while scores in the women who were new to sham TMS remained relatively stable. At the end of the study, nine of the 16 women who completed both trial phases achieved a treatment response (50% or greater reduction in HAM-D scores), and this response was maintained over the follow-up period.

Feffer K, Lee HH, Wu W, et al. Dorsomedial Prefrontal rTMS for Depression in Borderline Personality Disorder: A Pilot Randomized Crossover Trial. *J Affect Disord.* December 20, 2021. Online ahead of print. <https://www.sciencedirect.com/science/article/abs/pii/S0165032721013586>



## Cognitive Issues From Diazepam Use May Be Reversible

There is some evidence suggesting that long-term use of benzodiazepines may cause irreversible cognitive damage that can increase the risk of dementia in older adults. An animal study published in *Translational*

*Psychiatry* now suggests that cognitive problems associated with benzodiazepines may resolve when not taking the medication.

Investigators at the University of Lille in France administered regular food pellets or pellets supplemented with either 15 mg/kg or 30 mg/kg diazepam to groups of male mice (aged 6 months and 12 months) daily for 16 weeks followed by a one-week wash-out period when all mice received regular food. The researchers conducted two rounds of behavioral assessments during the study: once after eight weeks and again following the wash-out period.

After eight weeks, mice in both diazepam groups (15 mg/kg and 30 mg/kg) showed deficits in working memory compared with mice in the regular food group, though only the 15 mg/kg group reached a statistical significance; the effects of diazepam were similar in the 6- and 12-month-old mice.

At the 17-week assessments, the researchers found no differences in working memory among any of the three groups of mice. The animals also performed similarly on spatial and visual memory tasks.

The researchers acknowledged that the exclusion of female mice from the study is a significant limitation, but that the results "provided evidence that diazepam alone was not able to durably impair memory skills and that both dose- and age-related factors did not influence the long-term cognitive outcomes." **PN**

Carton L, Niot C, Kyheng M, et al. Lack of Direct Involvement of a Diazepam Long-Term Treatment in the Occurrence of Irreversible Cognitive Impairment: A Pre-Clinical Approach. *J. Transl Psychiatry.* 2021; 11(1): 612. <https://www.nature.com/articles/s41398-021-01718-8>

In a phase 2 trial, 62 patients with MDD were randomized to REL-1017 (25 mg or 50 mg) or placebo daily for seven days. The primary endpoint was an improvement in the Montgomery-Åsberg Depression Scale (MADRS) score at day 7.

MADRS scores improved on day 4 in patients who took either dose of REL-1017, compared with those who took placebo. The improvement continued through day 14, seven days after the patients stopped taking the medication. From baseline to day 7, MADRS scores decreased a mean of 16.8 points in patients who took 25 mg and 16.6 points in those who took 50 mg compared with 8.8 points in those who took placebo. There were no serious adverse events while the patients took the drug, and there were no symptoms of withdrawal after patients discontinued the drug.

"REL-1017 (Esmethadone) as Adjunctive Treatment in Patients With Major Depressive Disorder: A Phase 2a Double-Blind Randomized Trial" is posted at <https://ajp.psychiatryonline.org/doi/full/10.1176/appi.ajp.2021.21020197>.

## Ansofaxine Shows Promise For Treating Depression

A phase 2 trial of **LY03005 (ansofaxine hydrochloride extended release tablets)** suggests that the medication may help lower symptoms of depression in patients with major depressive disorder (MDD), Luye Pharma Group announced last December.

In the trial, 260 patients with MDD were randomly assigned to receive the treatment with LY03005 at doses of 40 mg, 80 mg, 120 mg, or 160 mg or placebo for six weeks. The primary endpoint was a change in score from baseline on the 17-item Hamilton Depression Rating Scale (HAM-D17). All three doses improved symptoms compared with placebo.

At the end of six weeks, scores dropped at least 50% from baseline in 68% of patients who took 80 mg and 71% of patients who took 160 mg. All three doses of LY03005 were associated with improved symptoms of anxiety as shown by reductions in several measures, including the total HAM-A score, the HAM-A Somatic Anxiety Factor score, and the HAM-D17 Anxiety/Somatization Factor score, the HAM-A Psychic Anxiety Factor score, and the HAM-D17 Cognitive Dysfunction Factor score.

In particular, no significant adverse events were found related to sexual function or weight change, and patients did not experience a significant increase in sleepiness.

## Ketamine May Be Effective For Treatment-Resistant Depression

Last December, Douglas Pharmaceuticals Ltd. announced that patients with treatment-resistant depression who took **R-107 (ketamine)** experienced rapid relief of their depression in a phase 2 trial.

In the trial, 231 patients with treatment-resistant depression received 120 mg of R-107 daily for five days. During that time, 73% of patients experienced rapid remission of their depression symptoms as demonstrated by a change of at least 12 points on their MADRS scores, and mean MADRS scores fell from 31 to 13.

Patients who had an improvement in their mood were then randomized to receive 30 mg, 60 mg, 120 mg, or 180 mg of R-107 or placebo twice a week for 84 days. Patients who took the 180 mg dose had a mean reduction of 6.1 points in their MADRS score at the end of the study compared with the placebo group—a difference that was statistically significant. Those who took 30 mg, 60 mg, or 120 mg of R-107 had mean MADRS score reductions of 1.9, 0.7, and 4.5 points, respectively, compared with placebo; these results were not considered statistically significant.

## Pramipexole-Rasagiline Combo Improves Parkinson's Symptoms

Patients with Parkinson's disease may experience greater symptom improvements when taking **P2B001** (a combination of extended release [ER] **pramipexole** 0.6 mg and **rasagiline** 0.75 mg) than when taking pramipexole or rasagiline alone, according to data released last December by Pharma Two B.

In the phase 3 trial, 544 patients with early Parkinson's disease were randomized to P2B001 once daily, pramipexole ER capsule 0.6 mg once daily, rasagiline ER capsule 0.75 mg once daily, or a titrated dose of pramipexole ER capsule ranging from 1.5 mg to 4.5 mg once daily for 12 weeks.

The total Unified Parkinson Disease Rating Scale (UPDRS) score decreased 2.66 more for patients who took P2B001 than those who took pramipexole 0.6 mg. Scores decreased 3.30 points more for people who took P2B001 than those who took rasagiline 0.75 mg. Patients who took P2B001 experienced less sleepiness compared with those who took a titrated dose of extended release pramipexole.

see **Med Check** on page 35

# Psychotherapy

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“By contrast, White patients, self-pay patients, those with personality disorders, and those who received care in office settings had some of the strongest correlations with receiving psychotherapy.”

APA Area 4 Trustee Eric Plakun, M.D., a founding member of the APA Caucus on Psychotherapy, said the disparity revealed in the study points to a wider public health crisis driven by an insurance industry that disincentivizes treatment aimed at recovery by the most highly trained practitioners and instead has been focused on mere crisis stabilization. He noted that this includes psychotherapy in general and its provision by psychiatrists.

“This is another example of something quite shameful—the best treatment goes to people with the most money and the most privilege.”

He is medical director and CEO of the Austen Riggs Center.

He added, “The reason psychiatrists [providing psychotherapy] often operate outside of insurance is because the insurance-based reimbursement system underpays psychiatrists compared with other physicians providing comparable services and generally limits treatment to crisis stabilization,” Plakun said in an interview. “I did not need four years of residency to learn how to do crisis stabilization. That is a much narrower goal than recovery. Helping patients achieve recovery is what I learned, and it’s why I also pursued psychoanalytic training. I wanted to help people lead self-directed lives

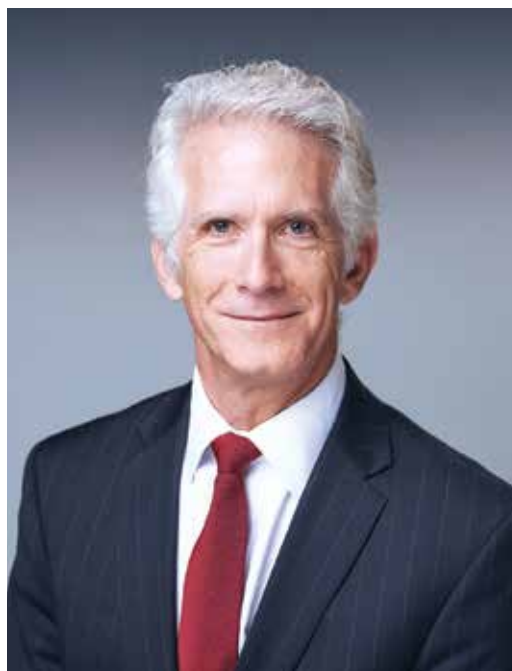
by coming to grips with their strengths and limitations, not just suppressing a symptom or handling a crisis.

“The message in this study isn’t just about psychiatrists and psychotherapy—this is about a mental health crisis in America.”

Robert Trestman, M.D., chair of the APA Council on Healthcare Systems and Financing, said the study results challenge psychiatry to confront questions about its identity. “Olfson’s work is extremely important to help us think about a key issue,” he said. “What does it mean to be a psychiatrist in the 21st century? What distinguishes us from social workers, psychologists, nurse practitioners?” (See box.)

Olfson and Daniel Tadmon, M.Phil., a Ph.D. student in the Department of Sociology at Columbia University, analyzed 21 years of data collected by the U.S. National Ambulatory Medical Care Survey (NAMCS) between January 1996 and December 2016. Each year, the Centers for Disease Control and Prevention’s National Center for Health Statistics fields a nationally representative sample of outpatient visits to physician practices that are not hospital based and not federally funded. Only visits in which patients saw a psychiatrist were included.

The main outcome variable was whether psychotherapy was provided. NAMCS defines psychotherapy as “all



“If we are going to see the patients who need us the most, we need to become leaders of teams of people who can deliver comprehensive, coordinated care,” says Robert Trestman, M.D., chair of the APA Council on Healthcare Systems and Financing.

treatments involving the intentional use of verbal techniques to explore or alter the patient’s emotional life in order to effect symptom reduction or behavior change.” This definition was refined to apply only to visits longer than 30 minutes.

The overall sampled number of psychiatrist visits was 29,673, representing about 26 million national visits yearly. Rates of psychotherapy were analyzed across 12 diagnostic categories. Olfson and Tadmon also looked at psychotherapy by patient sociodemographic characteristics including age, gender, race/ethnicity, source of payment, office setting in which visits occurred, and geographic location.

They found that between 1996 and 2016, the weighted percentage of visits involving psychotherapy declined significantly from 44.4% in 1996-1997 to 21.6% in 2015-2016.

Across the study years, the percentage of psychiatrists providing no psychotherapy in any visit significantly increased. Between 1996 and 2002, 133 of 491 (27%) sampled psychiatrists provided no psychotherapy; between 2003 and 2009, 189 of 547 (35%) provided no psychotherapy; and between 2010 and 2016, 355 of 673 (53%) provided no psychotherapy.

Other findings include the following:

- Visits by patients who were under age 25, visits by patients who identified as Black or Hispanic, and visits in which any class of psychotropic medication was prescribed were less likely to involve psychotherapy.
- Compared with private insurance, Medicare and Medicaid visits were less likely to involve psychotherapy.

Self-pay visits were more likely to involve psychotherapy.

- Visits to psychiatrists in group practices and HMOs or other settings involved psychotherapy less frequently compared with those in solo practices.

- While psychiatric comorbidity was not associated with psychotherapy provision, a diagnosis of dysthymic disorder, obsessive-compulsive disorder, other anxiety disorders, or personality disorders involved psychotherapy more often than other diagnoses, and a diagnosis of major depressive disorder, bipolar disorder, panic disorder, or schizophrenia involved psychotherapy less often.

Olfson told *Psychiatric News* that the study did not look at the length of time in practice as a correlate of psychotherapy. “However, it would be my guess that older psychiatrists trained in an era when psychotherapy was more central to psychiatric practice are more extensively engaged in providing psychotherapy than are their younger and more recently trained colleagues,” he said. “One of my concerns is that some younger psychiatrists may not receive adequate training in evidence-based psychotherapy, and their practice may be structured in such a way that they have few opportunities to develop and refine these skills.”

He said this shift in clinical activities risks narrowing the scope of practice of psychiatry to symptom management and not devoting sufficient clinical attention to problems patients face in their personal relations, families, and work roles. “As part of a broader drive toward specialization in medical practice, there are real risks that mental health care for many patients has become fragmented between providers, and that truly integrated care may be becoming a luxury affordable only to those with the means to pay out of pocket,” Olfson said.

Plakun was an expert witness in the landmark *Wit v. UBH* case. In November 2020, Judge Joseph Spero of the United States District Court for the Northern District of California ruled that the nation’s largest managed behavioral health organization had improperly denied thousands of claims for treatment of mental and substance use disorders. UBH was ordered to use medical necessity criteria and assessment tools developed by nonprofit mental and substance use disorder specialty organizations when making coverage-related determinations. The ruling highlighted eight elements of effective treatment aimed at recovery (*Psychi-*

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## ‘The Challenge We Face Is One of Identity’: Addressing Disparity

A report in the *American Journal of Psychiatry* on trends in psychotherapy by psychiatrists quantifies the diminishing number of psychiatrists who provide psychotherapy. It also documents a growing disparity between the privileged who receive the highest quality care—including psychotherapy and psychopharmacology—and the many who do not.

What is to be done?

Robert Trestman, M.D., chair of APA’s Council on Healthcare Services and Financing, begins with an unavoidable fact: “There are too few psychiatrists to meet the need for psychiatric care in our country,” he said.

But Trestman said there is a way forward in the movement toward integrated, collaborative care. And he said that psychiatrists need to claim leadership in delivering team-based care that is aimed at patients’ recovery rather than merely treating their symptoms.

“We are being pressured to see more people, and there really is a need to do so,” he told *Psychiatric News*. “When you are pushed to see more patients, it is certainly easier and faster to assess, diagnose, and treat them with medication. While this may improve their functional capability, it doesn’t help them find meaning or establish hope in their lives.

“Many of us got into this field because we wanted to get to know our patients and help them improve their lives,” he continued. “The challenge we are facing is one of identity. If we are going to see the patients who need us the most, we need to become leaders of teams of people who can deliver comprehensive, coordinated care to meet complex medical and psychiatric needs. We need to own responsibility for caring for those with the most severe mental illness. We are the only ones trained to care for the whole person.”



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*atric News*, <https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2020.12a17>.)

UBH has appealed the ruling, and APA filed an amicus brief supporting the injunction by Spero.

“Our work now is to extend the elements of effective treatment beyond UBH to all ERISA plans, to commercial insurance, Affordable Care Act plans, Medicare, and Medicaid,” Plakun told *Psychiatric News*. “When one standard governs medical necessity determinations for access to care, those on Medicare and Medicaid will get treatment comparable to those with better insurance or operating out of insurance plans. This

is one way forward toward reducing health disparities.”

Plakun urged APA members to join the APA Caucus on Psychotherapy, which now has 1,200 members. “I know that I am operating at the top of my license when I offer both medication and psychotherapy,” he said. “No other discipline has the training and expertise to provide this kind of integrated treatment as competently as we can.” **PN**

**■** “Trends in Outpatient Psychotherapy Provision by Psychiatrists: 1996-2016” is posted at <https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.2021.21040338>. APA members who wish to join the Caucus on Psychotherapy may do so at <https://www.psychiatry.org/psychiatrists/awards-leadership-opportunities/leadership-opportunities/join-a-caucus>.

## Med Check

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### Intranasal Zavegepant Offers Migraine Relief In Phase 3 Trial

**P**atients who took *intranasal zavegepant* in a phase 3 trial experienced greater relief of migraine pain compared with those who took placebo, Biohaven Pharmaceuticals announced last December.

In the trial, 1,269 patients who had at least a one-year history of migraine with or without aura were randomized to take a single 10 mg dose of zavegepant or placebo when they experienced a migraine attack. Twenty-four percent of patients who took zavegepant reported being free of pain two hours after taking their dose compared with 15% of patients who took placebo. In addition, 40% of patients who took zavegepant reported freedom from their most bothersome symptom at two hours compared with 31% of those who took placebo. **PN**

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# Hoarding

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drawers were empty. She told him that if she put the clothes in the drawers, she feared she would forget about them. Frost said one theory—but unproven—is that individuals with the disorder may have a higher level of intelligence, which results in a richness of association with objects that can be overwhelming to patients and is not present in individuals without the disorder.

The greatest risk factor for hoarding disorder is genetic, and most people with the disorder have a first-degree relative who also has the disorder. At least two-thirds of cases develop before age 20, and with each decade of life, hoarding symptom severity increases, Ayers added.

Having a psychiatric comorbidity amplifies the condition, with major depression seen in 33% to 50% of people with hoarding disorder and obsessive-compulsive disorders seen in 15% of patients, she said at a recent conference held by the Psychiatry Education Network. Ayers advises clinicians to treat patients for the disorder that's most prominent and severe, which is often the hoarding disorder. "Often-times when we successfully treat hoarding, the depression goes away, so the depression is secondary."

## Novel Treatments

What is the best way to manage these patients? The solution that many family members attempt—simply cleaning out the patient's home either partially or completely—can damage relationships with trusted providers and family members and may increase hoarding symptoms, Ayers said.

Frost explained that understanding the root of patients' intense attachment to objects may be one key to helping them. The hoarded objects may be seen as providing an opportunity to experience something or become someone new; for example, one patient said her massive cookbook and recipe collection might allow her to be a good hostess to potential guests. However, the patient's home was too cluttered to allow her to invite guests or cook anything. Objects saved may harken memories of events past in a more visceral way. For others, saving objects may fulfill an exaggerated sense of responsibility to avoid waste: One patient flattened and saved a lifetime of cereal boxes because they could potentially be used as stationery.


Cognitive-behavioral therapy (CBT), typically delivered in the patients' home, has been shown to be the most effective treatment. Yet studies by Ayers have found that most patients didn't make remarkable gains, even after 26 sessions of in-home treatment. "The

neurocognitive deficits typical of patients with hoarding disorder make CBT not a good fit for this group. The cognitive restructuring strategies in CBT are largely dependent on intact executive functioning abilities, and these individuals tend to have deficits in these areas."

Ayers has developed a novel manualized treatment protocol for hoarding disorder called Cognitive Rehabilitation and Exposure/Sorting Therapy (CREST). Each module aims to improve a different facet of patients' executive functioning, particularly planning, preparation, problem solving, and ability to think flexibly, or change plans when something isn't working. Appointments occur in patients' homes or virtually so therapists can encourage patients to repeatedly select and discard their belongings and learn that this gets easier over time. For her next research project, Ayers plans to study how much the cognitive rehabilitation helps and whether the desensitization alone is sufficient.

Frost has also found that systematic exposure exercises help patients become comfortable with resisting their intense urge to acquire. First patients drive by a compelling shop without stopping in; next they walk by the shop without entering; next patients enter the shop and leave without purchasing anything; and finally, they enter the store, pick up a desired item, and put it back without buying it. Patients also write out and carry a card with questions to ask themselves before acquiring items: Do I really need it? Do I have a place for it? Can I afford it? and Do I already have one similar?

Frost said another novel treatment that shows promise for the treatment of hoarding disorder is compassion-focused therapy. "It's important to keep in mind that patients with this disorder have typically come through decades worth of criticism about their behavior, and their behavior has been portrayed to them as a moral fault. For many of these patients, their families have abandoned them." Compassion-focused therapy aims to help individuals cultivate self-compassion, which can help regulate mood and lead to feelings of safety, self-acceptance, and comfort, which in turn can lead to reduced hoarding. **PN**

 **"Prevalence of Hoarding Disorder: A Systematic Review and Meta-Analysis" is posted at <https://www.sciencedirect.com/science/article/pii/S0165032719301521>. "Cognitive Rehabilitation and Exposure/Sorting Therapy (CREST) for Hoarding Disorder in Older Adults: A Randomized Clinical Trial" is posted at <https://www.psychiatrist.com/jcp/mental/crest-for-hoarding-disorder-in-older-adults/>. Hoarding disorder rating scales are posted at <https://hoarding.iocdf.org/professionals/clinical-assessment>.**

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