

PSYCHIATRIC NEWS

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Last month U.S. Surgeon General Jerome Adams, M.D., M.P.H., issued an advisory calling on more individuals, including family, friends, and those at risk for an opioid overdose, to keep naloxone on hand. He also said, however, that increased naloxone availability must occur along with expanded access to evidence-based treatment for opioid use disorder.

Surgeon General Urges More Americans to Carry Naloxone

The U.S. Surgeon General is urging patients with opioid use disorder and their loved ones to obtain an overdose-reversing medication and keep it close. **BY LINDA M. RICHMOND**

The U.S. Surgeon General issued a public health advisory for the first time in more than a decade in which he urged more Americans to carry a medication that can reverse the effects of opioid overdoses. But the prohibitive cost of the two consumer-friendly forms of the medication may thwart widespread adoption.

Naloxone is already carried by many first responders to administer to individuals who have overdosed on an opioid to temporarily reverse its effects, particularly respiratory suppression. Jerome Adams, M.D., M.P.H., is now recommending that more individuals—including substance use disorder treatment providers, those who are

personally at risk for an opioid overdose, and their loved ones—keep the medication on hand.

“It is time to make sure more people have access to this lifesaving medication, because 77 percent of opioid overdose deaths occur outside of a medical setting and more than half occur at home,” Adams said in a news release. The advisory comes as the number of opioid overdose deaths has doubled in the past five years, reaching more than 42,000 deaths in 2016.

The two FDA-approved naloxone products for community use are an intranasal spray and a formulation delivered via an auto-injector. The advisory encourages clinicians to prescribe or dispense these products to individuals who are at increased risk for opioid overdose as well as to their friends and family. Clinicians are also urged to determine whether the medications are covered by patients’ insurance or are available at low cost or no cost to them and whether a prescription is needed in their state. The advisory noted that there are laws in most states to protect health care professionals dispensing naloxone from criminal or

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Past APA President Marcia Goin, M.D., is remembered.



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Imaging study offers clues about resiliency to depression.

STARRS Findings Shed More Light On Army Suicides

More time in training and more time at home between deployments may help prevent suicide deaths among U.S. Army soldiers. **BY AARON LEVIN**

The latest published findings from the Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS) has found that the odds of a suicide attempt among U.S. Army soldiers were greater for those who deployed within their first year in the service and for those with less than six months between their first and second deployments.

The results may have implications for Army training and length of time between deployments, wrote Robert Ursano, M.D., and colleagues in *JAMA Psychiatry* on April 18. Ursano is a professor of psychiatry and neuroscience and director of the Center for the Study

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A large portion of the \$1.1 billion allocated to the HEAL initiative will help fund research that will look for new pain-related biomarkers and new drug targets for pain medications.

NIH to Put \$1.1 Billion Toward Tackling Opioid Crisis

The Helping to End Addiction Long-term (HEAL) initiative will support research into new avenues to prevent addiction, while also boosting efforts to implement existing addiction therapies in communities. **BY NICK ZAGORSKI**

The National Institutes of Health (NIH) in April announced the launch of the Helping to End Addiction Long-term (HEAL)—an aggressive and ambitious initiative to develop scientific solutions to the country's ongoing opioid crisis.

“Over the last year, NIH has worked with stakeholders and experts across scientific disciplines and sectors to identify areas of opportunity for research to combat the opioid crisis,” said NIH Director Francis Collins, M.D., Ph.D., in a press release. “The focus of these discussions has centered on ways to reduce the over-prescription of opioids, accelerate development of effective non-opioid therapies for pain, and provide more flexible options for treating opioid addiction. NIH is committed to bringing the full power of the biomedical research enterprise to bear on this crisis.”

Backed by a funding boost from the \$1.3 trillion omnibus package passed by Congress in late March, that power will include \$1.1 billion in support for opioid/pain-related research for the coming fiscal year—nearly double the most recent funding levels. The detailed research plan is still being finalized, but NIH aims to use the funding for a range of projects that will involve the expertise of every one of its institutes and centers. Such projects will be centered around two flagship missions: preventing addiction through enhanced pain management and improving treatments for opioid use disorder.

A major focus of the mission to prevent addiction to pain medications

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Coming in the Next Issue!

This issue of *Psychiatric News* went to press just prior to the start of APA's 2018 Annual Meeting in New York. Coverage of the meeting will begin in the June 1 issue.



California Could Be Landmark for PAD In a Diverse Population

As currently practiced, physician-assisted death is highly circumscribed—it is difficult to access, and some patients die of their illness without having used the lethal prescription. This is the second article in a series begun in the May 4 issue. **BY MARK MORAN**

“Ann” was a 66-year-old woman with metastatic breast cancer who had unsuccessfully tried numerous treatments, was given a prognosis of less than six months to live, and entered hospice care. She would become one of the first patients to qualify for physician aid in dying (PAD) under California’s End of Life Option Act, which went into effect in June 2016. The law gave her the option of using a lethal dose of an agent prescribed by a physician to end her life at a time of her own choosing.

“She had spoken with her oncologist and primary care provider, as well as others in her treatment team, and she believed it would give her some peace of mind, knowing she had that option if her suffering became unbearable,” recalls Nathan Fairman, M.D., a psychiatrist, palliative care specialist, and director of the End of Life Option Act Program at the University of California, Davis. “Her husband and two children were involved in those discussions and supportive of her interest. She and her doctors completed the steps required by the law and she was prescribed the drug.”

Ann kept the drug (a lethal dose of secobarbital) in storage and survived for another two months before succumbing to the cancer, never using the prescription.

It’s a not uncommon scenario in jurisdictions that have approved aid-in-dying laws. “Many of the patients who request PAD are adamant that they don’t want to die,” Fairman told *Psychiatric News*. “But they accept that they are dying, and they do not want to suffer. It is not uncommon for patients to initiate this process with the caveat that they are not planning to use the drug. They will say, ‘I want to get my ducks in a row, so if something happens, I can have the option of having a more peaceful exit.’”

PAD is garnering increasing attention and debate. Yet the “facts on the

The phrase Coda da Vita, or “tail of life”, was coined by psychiatrist J. Michael Bostwick, M.D., of the Mayo Clinic. *Psychiatric News* thanks Dr. Bostwick for use of the phrase for this series.

CODA da VITA



Robert Durell

Psychiatrist and palliative care expert Nathan Fairman, M.D., says physician-assisted death in California requires a high degree of assertiveness on the part of patients with a short time to live.

ground” about PAD as described by Fairman and as indicated in data about the laws suggest that the actual practice of PAD has been highly circumscribed:

only a small number of individuals with terminal illness qualify for and take advantage of PAD; many who do qualify die of their terminal illness without having used the lethal prescription; and patients almost uniformly are not looking forward to dying but want to control the timing and manner of a death that is imminent.

see **California** on page 20

Facts About PAD Laws

Some features of physician-aid-in-dying (PAD) laws are consistent across all jurisdictions that have approved the process. These include the following:

- **Requesting PAD:** All jurisdictions require an oral and a written request for the prescription and a subsequent reiteration of the oral request. Written requests must be signed and dated by the patient and witnessed by at least two individuals attesting that to the best of their knowledge, the patient is capable, acting voluntarily, and not under coercive pressure to request the medication.
- **Terminal illness:** All jurisdictions define a “terminal disease” as a medically confirmed disease that is incurable and irreversible and that will, within reasonable medical judgment, produce death within six months. The attending (primary) physician is responsible for making the initial determination that the patient is suffering from a terminal disease, and that determination must be confirmed by a consulting physician who is similarly qualified to make a diagnosis and prognosis of the patient’s disease.
- **Determinations of competency:** All jurisdictions require competency to be affirmed by two clinicians—an attending (primary) physician and a consulting physician. California defines “capacity to make medical decisions” as the patient’s ability—in the opinion of the attending or consulting physician—to not only make and communicate health care decisions, but also to understand the nature, consequences, benefits, risks, and other options.

APA’s Resource Document on Physician Assisted Death, developed by a task force of the Council on Psychiatry and Law, was approved by the Joint Reference Committee in October 2017. It is posted at <https://www.psychiatry.org/psychiatrists/search-directories-databases/library-and-archive/resource-documents>.

Loss of Enjoyment, Autonomy, Dignity: Top Reasons for Seeking PAD

Research on mental illness among patients requesting PAD suggests most are not depressed. However, because the laws may not protect all patients with mental illness, there is a need for systematic evaluation of their mental status. **BY MARK MORAN**

A total of 218 people last year received prescriptions to end their lives at a time of their choosing in 2017, according to the 2017 Data Report on the Oregon Death With Dignity Act (DWDA).

As of January 19, 2018, 143 people had died in 2017 from ingesting the prescribed medications, including 14 who had received the prescriptions in prior years. Of the 143 DWDA deaths during 2017, most patients (80.4 percent) were aged 65 years or older.

Most patients had cancer (76.9 percent), followed by amyotrophic lateral sclerosis (ALS) (7.0 percent) and heart/circulatory disease (6.3 percent). The majority of patients (90.2 percent) died at home, and most (90.9 percent) were

enrolled in hospice care.

As in previous years, the three most frequently reported end-of-life concerns were decreasing ability to participate in activities that made life enjoyable (88.1 percent), loss of autonomy (87.4 percent), and loss of dignity (67.1 percent).

Importantly, few patients have been referred for psychiatric evaluation beyond the two physicians required by state law to affirm a patient’s competency to make a request for PAD. Of the patients who were successful in qualifying in 2017, just five were referred for psychiatric evaluation; in 2016 the total was six. (Data are not gathered about psychiatric referrals for those patients who may not have qualified for a

variety of reasons, including because they were deemed to have mental illness that compromised their decision-making capacity.)

Oregon psychiatrist Linda Ganzini, M.D., was an early pioneer in studying the intersection between mental illness and terminal medical disease and has been prolific in publishing about PAD in Oregon. In a 2008 paper in the *British Medical Journal*, Ganzini and colleagues assessed the prevalence of depression and anxiety in 58 Oregonians, terminally ill with cancer or amyotrophic lateral sclerosis, who had either requested aid in dying from a physician or contacted an aid-in-dying advocacy organization.

Of the 58, 18 received a prescription for a lethal drug under the Death with Dignity Act, and nine died by lethal ingestion. Of the 18, 15 participants who received a prescription for a lethal drug did not meet criteria for depression. However, three patients did meet criteria; those three died by lethal ingestion.

Ganzini and colleagues concluded *continued on facing page*

Restrictive Family Leave Policies Found At Top U.S. Medical Schools

Family leave policies at some top-tier medical schools make it difficult for women faculty members to maintain careers while starting families.

BY REBECCA GREENBERG

Parental leave policies at top medical schools fall short of the recommendations by the American Academy of Pediatrics (AAP) that employees be given 12 weeks of paid family leave, according to a report published in *JAMA* earlier this year. The authors of the report found that salary, leave duration, and who qualified as “primary caregiver” varied widely among the institutions examined. Such policies are increasingly seen as disadvantageous to women.

“Retaining women during child-bearing years is central to gender parity, as even short workforce interruptions can have long-term consequences—and may partially explain the gender wage gap,” wrote Christina Mangurian, M.D., and colleagues. Mangurian is an associate professor of clinical psychiatry at the University of California San Francisco (UCSF) School of Medicine and the UCSF Department of Psychiatry’s vice chair of diversity.

The authors reviewed family leave policies at 12 top-tier medical schools between September 2016 and August



istock/monkeybusinessimages

2017. On average, full salary support was 8.6 weeks, but varied widely among the institutions. Three schools provided more than 8 weeks with full pay and eight schools allowed leave extension (typically for medical reasons).

The mean length of family leave at the 12 institutions was 17.9 weeks. Four schools provided more than 8 weeks of some salary support, with varied salary coverage.

“Most policies had restrictions such

as being at the discretion of the department (three schools) or only available to ‘primary caregivers’ who care for a child more than 50% of the time (five schools),” the authors wrote. “Restricting family leave availability to the primary caregiver prevents partners from taking any leave, potentially contributing to the attrition of women by not facilitating cooperative parenting.”

Mangurian told *Psychiatric News*

that the results were used to successfully advocate for 12 weeks of child-bearing leave at UCSF. (Beginning in July 2019, all faculty will be entitled to 12 weeks of paid childbearing leave.) She said the group then decided to disseminate the findings to help other advocates build the case for expanding leave policies at their home institutions.

“It’s all about leadership,” she said. “I think some schools are more progressive because they have leaders who understand these policies are necessary to retain talent.”

The report comes 25 years after the Family and Medical Leave Act first made qualifying employees eligible for up to 12 weeks of unpaid family and medical leave, Mangurian noted.

“We still have a long way to go,” she said, pointing out that today the United States is the only developed nation without mandated family leave.

“Despite the benefits of paid child-bearing leave for parent and infant, no federal law requires U.S. employers to provide paid childbearing leave,” the authors wrote. “Future longitudinal studies are needed to assess policies at other institutions and examine the association between leave policies and retention of women in academic medicine, adjusting for characteristics affecting retention, such as child care availability and costs, household characteristics, job satisfaction, and burnout.” **PN**

➔ “Paid Family Leave Policies at Top U.S. Medical Schools” is posted at <https://jamanetwork.com/journals/jama/fullarticle/2672622>.

continued from facing page

that most patients who request aid in dying do not have a depressive disorder, but that the law “may not adequately protect all mentally ill patients,” and called for increased vigilance and systematic examination for depression using standardized instruments such as the PHQ-9.

In a 2014 editorial in *General Hospital Psychiatry*, she argued against making psychiatric consultation mandatory for PAD patients. Instead, she advocated “careful systematic screening for depression along with longitudinal evaluation by health care system and hospice social workers for psychosocial concerns and referral to psychiatrists or psychologists with

expertise in care of patients at the end of life of those at higher likelihood for depression.”

Ganzini has also studied mental health outcomes of family members of Oregonians who request PAD. A 2009 paper in the *Journal of Pain and Symptom Management* surveyed 95 family members of decedent Oregonians who had explicitly requested aid in dying, including 59 whose loved one received a lethal prescription and 36 whose loved one died by ingestion of the lethal medication. For comparison purposes, family members of Oregonians who died of cancer or amyotrophic lateral sclerosis and had not requested PAD also were surveyed.

Fourteen months after death, 11 percent of family members whose loved one requested aid in dying had a major depressive disorder, 2 percent had prolonged grief, and 38 percent had received mental health care. “Among those whose family member requested aid in dying, whether or not the patient accessed a lethal prescription had no influence on subsequent depression, grief, or mental

health services use,” Ganzini and colleagues reported. “[F]amily members of Oregonians who received a lethal prescription were more likely to believe that their loved one’s choices were honored and less likely to have regrets about how the loved one died.”

Ganzini and colleague concluded, “Pursuit of aid in dying does not have negative effects on surviving family members and may be associated with greater preparation and acceptance of death.” **PN**

➔ “Prevalence of Depression and Anxiety in Patients Requesting Physicians’ Aid in Dying: Cross Sectional Survey” is posted at <https://www.bmj.com/content/337/bmj.a1682>. “Psychiatric Evaluations for Individuals Requesting Assisted Death in Washington and Oregon Should Not Be Mandatory” is posted at <https://www.deathwithdignity.org/wp-content/uploads/2018/03/Psych-Evals-Not-Necessary-Ganzini-2014.pdf>. “Mental Health Outcomes of Family Members of Oregonians Who Request Physician Aid in Dying” is posted at [https://www.jpsmjournal.com/article/S0885-3924\(09\)00707-6/fulltext](https://www.jpsmjournal.com/article/S0885-3924(09)00707-6/fulltext).

Resources on Physician Aid in Dying

In addition to the resources listed at the end of this article, the following are other articles that provide useful information on physician aid in dying:

- “Oregonians’ Reasons for Requesting Physician Aid in Dying” by Linda Ganzini, M.D.: <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/414824>
- “The Challenge of New Legislation on Physician Assisted Death” by Linda Ganzini, M.D.: <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2497783>
- “Differentiating Suicide From Life-Ending Acts and End-of-Life Decisions: A Model Based on Chronic Kidney Disease and Dialysis” by J. Michael Bostwick, M.D., and Lew Cohen, M.D.: [https://www.psychosomaticsjournal.com/article/S0033-3182\(09\)70754-6/fulltext](https://www.psychosomaticsjournal.com/article/S0033-3182(09)70754-6/fulltext)

U Mass Opens Mindfulness Division As Other Institutions Embrace Practice

While practicing mindfulness is not a panacea for stress and burnout, it can help improve physicians' well-being. **BY RICHARD KAREL**

"Mindfulness" is no longer an esoteric concept understood by only a few. Walk into Whole Foods, and there on the magazine rack is a copy of *Mindful* with a cover story titled "Make Peace With Your Anxious Brain." Googling the term results in 86,000,000 results. Mindfulness podcasts and apps are proliferating, and now the University of Massachusetts Medical School has opened a new, stand-alone mindfulness division under the direction of psychiatrist Judson Brewer, M.D., Ph.D.

In addition to his new title, Brewer is director of research at the medical school's Center for Mindfulness, an associate professor of medicine and psychiatry, and a research affiliate in the Department of Brain and Cognitive

Sciences at MIT. He has also developed three apps—"Craving to Quit" for smoking cessation, "Eat Right: Now!" for mindful eating, and most recently, "Unwinding Anxiety."

One of Brewer's many studies, "Finding the Right Match: Mindfulness Training May Potentiate the Therapeutic Effect of Non-Judgment of Inner Experience on Smoking Cessation," was published in *Substance Use and Misuse* in 2014. In September 2017 he published a study on the broad neurophysiological impact of meditation on the brain, "Meditation Is Associated With Increased Brain Network Integration," in *Neuroimage*.

A working definition of mindfulness is "paying attention in a particular way, on purpose, in the present moment, and nonjudgmentally," said Brewer.

Properly employed, it can enhance empathy and emotional resilience.

Empathy—the ability to understand and relate to another's feelings—is clearly a critical skill for physicians. As medical students move into their third

"If we can't empathize with our patients, that relationship is not going to magically form itself."

—Judson Brewer, M.D., Ph.D.



year of school, empathy declines, and by the time physicians start practicing, up to 60 percent report burnout, Brewer observed.

This is even more critical for psychiatrists, he noted. "Our job is to be with and listen to our patients, to develop a compassionate relationship.

If we can't empathize with our patients, that relationship is not going to magically form itself."

As the executive and research director of the Center for Mindfulness and Compassion at the Cambridge Health Alliance (CHA), Zev Schuman-Olivier, M.D., is involved on a daily basis in bringing mindfulness into practice. The CHA is one of four main teaching hospitals for Harvard Medical School's psychiatry program.

Compassion and mindfulness are critically related, said Schuman-Olivier. Mindfulness can be challenging as it brings to light thoughts and emotions previously avoided. "Many of us have not just a judgmental autopilot but also a self-critical autopilot,"

see *Mindfulness* on page 9



WHY I ASPIRED TO BE A PSYCHIATRIST

Personal Experience Led to Unusual Career Path

BY MICHELLE RIBA, M.D., M.S.

While I always knew I wanted to be a physician, it wasn't until a series of events occurred—both unfortunate and fortunate—that helped crystallize my desire to be a psychiatrist.

Beginning with the unfortunate:

My mother had been sick for about six years before she passed away in 1966, about a week after I completed high school. I was 16 and my sister was 13. I actually don't know what she died from, but piecing the story together, I think she had been given bad medical care and probably had cervical cancer that had metastasized. In those days, having the "Big C" was very stigmatizing and frightening (as it is today in many instances). In fact, I think she was told she had arthritis, and when she received radiation, no one directly questioned this. My sister and I never met her doctor.

In my college freshman English class, we were asked to write about a recent memorable event, and I wrote about my mother's passing; how depressed my sister, father, and I were; and how difficult it was to concentrate. The English professor wrote on the paper "Excellent". How could this paper and my feelings be "excellent"? I guess I was hoping that someone would talk to me about how I was feeling, but that didn't happen. I became very



Michelle Riba, M.D., M.S., is program director of the Psychosomatic Medicine Fellowship at the University of Michigan, where she is also director of the Comprehensive

Depression Center and director of the PsychOncology Program at the Comprehensive Cancer Center. She is also a past president of APA.

contemplative about what the possibilities could be for improved care for patients and families related to cancer and thought maybe I would be a hematologist/oncologist.

Now the fortunate:

In medical school at the University of Connecticut (UCONN), a fellow classmate and I were assigned during our eight-week, third-year psychiatry clerkship to an inpatient service at a local community hospital where there was also a robust ambulatory clinic and consultation-liaison service. We were so busy seeing patients, receiving excellent core lectures, and learning so much about being part of an inpatient multidisciplinary team that I found myself seriously considering psychiatry.

Mentors at UCONN—Drs. Allan Tasman, Mahlon Hale, David Goldberg, Roger Meyer, and Javier

Escobar—all helped me think through what I could do in psychiatry. Dr. Hale organized an opportunity for me to be part of the UCONN Hemophilia Treatment Clinic, where psychiatric services were very much needed as the AIDS crisis was developing.

One of my first papers was about AIDS presenting as mania. A senior hematologist, Dr. Fred Rickles, facilitated my participation on the National Hemophilia Foundation (NHF) Psychosocial Committee and then an NHF Women's Committee, because of the impact of Hemophilia/AIDS on women and families. It was a powerful experience and allowed me to see how I might mesh my interest in cancer and blood disorders with psychiatry. It also demonstrated the importance and power of working with patients and families, as well as large medical organizations.

I started reading about the new field of psychoncology, led by Dr. Jimmie C. Holland, and I remember the exact moment when Dr. Tasman informed me that Dr. Holland was a "she"—not a "he"—and that there was a new subspecialty in psychiatry where I could mesh oncology/hematology and psychiatry and perhaps try to make a difference. I should note that at the time there were very few female academic role models in psychiatry, and Dr. Tasman played a pivotal role in arranging for me to serve on the Women's Academic Task Force at the Associ-

ation for Academic Psychiatry (AAP).

When our family moved to Michigan, I was again fortunate to have strong mentors at the University of Michigan—Dr. John Greden, chair of the Department of Psychiatry, and Dr. Max Wicha, director of the Comprehensive Cancer Center, who both helped me build and direct its PsychOncology Program. It was also quite exciting when Dr. Holland turned over the chairmanship of the World Psychiatric Association's Section on PsychOncology to me and my colleague, Dr. Luigi Grassi.

APA and its leaders have also been instrumental in my development. Mentors and long-time friends like Drs. Tasman, John Oldham, Leah Dickstein, Jack McIntyre, and Pedro Ruiz; colleagues who were resident leaders with me such as Doug Ziedonis, Patty Ordorica, and Saul Levin, M.D., M.P.A.; and friends like Drs. Tom Wise, Phil Muskin, Richard Balon, Edmond Pi, and Laura Roberts have made this journey an exceptional one. It has been a privilege to have served as president of the APA, as well as AAP and the American Association of Directors of Psychiatric Residency Training.

Psychiatry has afforded me so many exceptional experiences. For example, I have traveled the world as a member of the Executive Committee of the World Psychiatric Association. It has been a gift to mentor talented fellows in my capacity as the director of the University of Michigan Fellowship Training in Consultation-Liaison

continued on facing page

Marcia Goin, M.D., Former APA President, Dies

This respected educator and researcher dedicated her presidency to implementing forceful advocacy programs and responding to the professional needs of all members regardless of their work setting. **BY MARK MORAN**

Marcia Kraft Goin, M.D., Ph.D., D.Sc., who was the 130th president of APA for the 2003-2004 term, died last month.

Goin had long been involved with APA before being elected to its top leadership position. She had served as vice president (2000-2001), trustee at large (1997-2000), and a member of the APA Committee on the Practice of Psychotherapy and the APA Commission on Public Policy, Litigation, and Advocacy. In addition to her private practice of psychiatry, Goin had been director of psychiatry residency training at the adult psychiatric outpatient department of the Los Angeles County General Hospital/University of Southern California School of Medicine.



Marcia Goin, M.D., delivers her presidential address at the Opening Session of APA's 2004 Annual Meeting in New York.

Goin was a prolific author of papers and book chapters on a wide range of topics—psychotherapy of personality disorders, suicide and no-suicide contracts, medication compliance, body dysmorphic disorder, and psychotherapy in the public sector, among others. She also published a series of seminal papers with her husband, John, a plastic surgeon, and a book on the psychological effects of plastic surgery.

Combining her background in residency training and psychotherapy, Goin became a national leader in research on how to teach psychotherapy to residents, including pioneering the use of videotape to teach psychotherapy techniques and on how to teach supervisors how to supervise.

Goin was elected president-elect of APA in early 2002, when the country was still reeling from the terrorist attacks on September 11, 2001. During her presidential address at APA's Annual Meeting in New York in 2004, Goin recalled the days and weeks immediately following the attacks.

"There were not many wounded, only many dead—but those enduring psychic trauma were countless," Goin said. "Our initial attention was naturally directed to the psychic trauma of those who had lost loved ones, associates, and friends and to those who had witnessed the events and survived the catastrophe. Many people with limited awareness of the emotional effects of trauma began to live with it on a daily basis. They learned that being brave, strong, and determined does not necessarily eliminate psychological vulnerability. Depression, anxiety, and posttraumatic stress syndrome took on a new reality."

Her presidential year coincided with the invasion of Iraq. In the same presidential address in 2004, Goin noted that that summer she had attended a conference in Cairo convened by the Mediterranean division of the World Health Organization and the World

Psychiatric Association to discuss mental health and rehabilitation of the people in Iraq. War was not a new topic for her; she and her husband had been volunteers in Vietnam in 1964, providing humanitarian relief.

A special concern of Goin's was the criminalization of people with mental

illness, which became a defining priority during her presidential year. "The Los Angeles County jail is now considered to be the largest psychiatric hospital in the country," Goin said in her 2004 address. "Approximately 2,500 of its inmates are being treated for mental disorders at any one time. Fortunately, in the late 1990s a grand jury investigation resulted in the upgrading of psychiatric care in the county jail, and it is now considered one of the best psychiatric hospitals in the country. Following my visits to the jail, I remain haunted by memories of the mentally ill inmates in the holding area: a young woman screaming at unseen visions, a middle-aged man cringing in terror from paranoid delusions, young and old, male and female visibly suffering in their mental distress. Is jail really our nation's preferred institutional treatment of choice?"

Among the many awards she received were a Certificate of Merit from the American Society of Plastic Surgeons

see **Marcia Goin** on page 18

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Psychiatry, and I thank Dr. Gregory Dalack for his support for so many years. We were just in Ghana to help develop a program to enhance mental health services and improve training in psychiatry for our residents. And I appreciate the leadership training I have received from ELAM (Executive Leadership for Academic Women).

I have also been so fortunate to have a wonderful and loving family—my husband, Arthur; daughters Alissa and Erica; son-in-law Jim; grandchildren Oscar and Jeanie; my sister and her family; devoted parents and grandparents; and friends who have been so nurturing. My colleagues and friends at the University of Michigan have been incredible partners.

With sincere gratitude and appreciation, my patients have been my guideposts, teaching me every day the importance of the incredible work we do in psychiatry. Most of my patients have cancer or a hematological disorder. They tell me that the psychosocial issues—anxiety, depression—are often harder to deal with than the underlying malignancy. I am very proud of the professional work we do and deeply appreciative for the opportunity to be a psychiatrist. **PN**

Psychiatric News invites you to share your story of why you aspired to be a psychiatrist. If you are interested, please send an email to cbrown@psych.org.

Pioneering Child Psychiatrist Who Broke Racial Barriers Dies

After a long and distinguished career that advanced the field of child psychiatry, Beatrice Hamburg, M.D., died April 15 in Washington, D.C. She was 94 years old.

Hamburg was the first African American to attend Vassar College and the first African-American woman to attend Yale Medical School. She held professorships at Stanford, Harvard, Mount Sinai, and—most recently—at Weill Cornell Medical College. She served as executive director of the President's Commission on Mental Health under President Jimmy Carter and later as president of the William T. Grant Foundation, a philanthropic organization dedicated to research on children's issues. She was also a member of the National Academy of Medicine.

Hamburg was known as a trailblazer in child and adolescent psychiatry and advanced the concept of adolescent peer counseling. In an obituary in the *Washington Post*, Virginia Anthony, the former executive director of the American Academy of Child and Adolescent Psychiatry, was quoted as saying, "She taught high school kids to essentially say to their friends, 'I'm worried about you ... I'm concerned. I miss the old you,' and so she implemented that at Stanford, and then it took hold in California and moved across the country and over to Europe. It was a very significant preventative concept."

She is survived by her husband, David Hamburg, M.D., two children, and three grandchildren. Hamburg and her husband, who was president of the Institute of Medicine from 1975 to 1980, studied the biology of stress—physical, mental, and situational—and how people cope. In 2004 they co-wrote a book, *Learning to Live Together: Preventing Hatred and Violence in Child and Adolescent Development*. In 2007 the couple received the 2007 Rhoda and Bernard Sarnat International Award in Mental Health from the Institute of Medicine for their achievements in medicine and public service. In 2015, the couple received the Pardes Humanitarian Prize in Mental Health from the Brain & Behavior Research Foundation.

Their daughter, Margaret Hamburg, M.D., is a physician who also works in public health. She was commissioner of the U.S. Food and Drug Administration under the Obama administration and is now president of the American Association for the Advancement of Science. In an interview published on its website, the daughter described her parents as "unusually big thinkers who were committed to the world of service and using knowledge to improve the condition of others."



AMA Honors Public Servants for Contributions to Mental Health

Each year the AMA recognizes figures in government service who have dedicated themselves to the advancement of public health. **BY REBECCA GREENBERG**

The AMA presented its prestigious Dr. Nathan Davis Award for Outstanding Government Service in February to two individuals for

their strong advocacy and outstanding accomplishments in the area of health and mental health.

They are Nancy Backus, mayor of

Auburn, Wash., and Josh Shapiro, J.D., attorney general of the Commonwealth of Pennsylvania.

Since her election in 2014, Backus has led several programs focused on reducing homelessness and drug addiction in Auburn, convening task forces and serving on related boards to



Nancy Backus

Josh Shapiro, J.D.

address the associated problems.

“A fearless leader who has tackled head-on the challenges that too many elected officials avoid, Mayor Backus has made a name for herself advocating for the underserved and marginalized,” said AMA Board Chair Gerald E. Harmon, M.D., in a press release.

In 2016 Backus formed the Blue Ribbon Committee for Auburn, with the goal of making Auburn the healthiest city in her state by 2020. The committee’s accomplishments included Real Emergency Aid Depends on You (R.E.A.D.Y.), a one-hour course designed to increase awareness about common mental health issues, remove the fear and stigma surrounding mental illness, and teach basic skills that can be used to handle a mental health crisis.

Other areas in which she has been active include women’s rights, the opioid crisis, and improving access to care.

Shapiro has concentrated on the opioid crisis in Montgomery County, Pa. In addition to working with law enforcement agencies, he has taken a public health approach to Pennsylvania’s opioid epidemic. He is collaborating with medical experts to reduce unnecessary prescriptions and is at the forefront of a coalition of 39 attorneys general to urge Congress to pass the Road to Recovery Act, whose goal is to make treatment for substance use more affordable and accessible.

“During the past 20 years of his career in public service, Attorney General Shapiro has developed a strong rapport with physicians in Montgomery County and leveraged those relationships to address one of the largest public health crises of our time,” said Harmon in a press release.

The Dr. Nathan Davis Award, named for the founding father of the AMA, recognizes elected and career officials in federal, state, or municipal service whose outstanding contributions have promoted the art and science of medicine and the betterment of public health. **PN**

Advertisement

Iowa Mental Health Law Fills Residential Treatment Gap

Iowa's new law provides a range of residential and assertive community treatment options for patients with mental illness. **BY LINDA M. RICHMOND**

The Iowa Psychiatric Society, a district branch of APA, played a big role in the passage of a sweeping mental health bill that aims to improve access to treatment, particularly for individuals in crisis, in Iowa.

House File 2456 (HF 2456) provides for six mental health “access centers” offering immediate short-term crisis care, 22 Assertive Community Treatment Teams, and the development of intensive residential service homes, among other provisions. The blueprint for the bill was based on the recommendations made by a stakeholder workgroup, explained Jerome Greenfield, M.D., who served on the workgroup and is outgoing president of APA's Iowa Psychiatric Society. He is also the health services administrator for the Iowa Department of Corrections.

The Iowa Senate had been receiving a lot of feedback from the public about problems accessing mental health care and policies that weren't meeting their needs, said Greenfield. For example, law enforcement officers were frequently called upon to transport individuals in crisis to a facility six or seven hours across the state, because none was available in the community. Patients were hospitalized many hours away from their families and had no follow-up resources upon discharge. Others in need of mental health treatment languished in emergency rooms for days while waiting for a bed to open on a psychiatric ward.

The state has faced a critical shortage of acute psychiatric services since the closure in 2015 of two of its four state mental hospitals when then-Gov. Terry Branstad declared them outdated. Iowa ranks last in the country for state mental hospital beds per capita, with just two beds for every 100,000 Iowa residents, compared with a national average of 12 for every 100,000



Gabriel Butler Klein

Jerome Greenfield, M.D., served on the complex service needs workgroup that helped write the blueprint for Iowa's new mental health law. He believes it will save the state money by preventing inpatient psychiatric hospitalizations and incarceration.

people, according to a 2016 report by the Treatment Advocacy Center. Making matters worse, a string of local hospitals has also trimmed or shuttered their psychiatric units in recent years, citing financial losses.

The workgroup, convened by the Iowa legislature, came together in late 2017 to address the lack of treatment and support options for people with complex mental health and substance use needs. Greenfield was one of two psychiatrists serving on the workgroup, along with other mental health professionals, advocates, law enforcement personnel, and public health officials. The workgroup's recommendations, made in a December report,

were enacted into HF 2456, which was signed by Gov. Kim Reynolds March 29.

“It's very exciting,” Greenfield said. “It's a privilege to serve on a committee like this. When you see something get approved unanimously, 98-0 with bipartisan support, we need more of this.”

As recommended by the workgroup, the law creates six mental health “access centers,” to be located strategically throughout Iowa by the end of 2019. “The idea is, no one should have to be transferred more than two hours away from their home,” he said.

The access centers will accommodate as many as 16 patients each and provide immediate, short-term care, including assessment, treatment, and the arrangement of follow-up care in the community. Instead of beds, there will be reclining chairs. “They will be far more comfortable than an emergency department, but not like a private room,” explained Greenfield. Examples of services include suicide intervention, medication management, and nursing care.

“The idea is, instead of sitting in an emergency department waiting for an open psychiatric bed, patients can start treatment right away,” Greenfield said. “Detox and stabilization can be done in the access center, but if not, staff can work on finding a hospital bed.”

However, prior to treatment at an access center, prospective patients would need to be medically cleared first, Greenfield explained. The centers may also play a role in jail diversion, with law enforcement dropping charges against individuals with mental illness who agree to treatment there.

“Given the tight budget situation we already have, the idea was to create a system not totally reliant on inpatient

psychiatric hospitalization to meet the needs,” explained Emily Piper, a lobbyist for APA's Iowa Psychiatric Society. “It won't work for everyone, but there are certain times a patient doesn't need to be in an inpatient setting. This provides more opportunities for treatment.” The access centers were modeled after similar care options in Texas and Tennessee, she said.

Other provisions in HF 2456 recommended by the workgroup include the development of the following:

- Twenty-two Assertive Community Treatment (ACT) teams to be in operation by the end of 2019 (up from 10 ACT teams), which will provide intensive case management services to people with serious mental illness by visiting them as often as daily in their homes to help them manage their daily living tasks.
- Small intensive residential service homes throughout the state to house a total of 120 people by the end of 2019. These are for individuals who have the most serious and persistent mental illness and need intensive, 24-hour-a-day supported community living.
- Mental health crisis services, including mobile-response crisis services and a 24-hour crisis hotline.

Iowa Democrats have raised questions about whether the Republican-led legislature will provide sufficient funding for implementation of the mental health bill, since the state GOP has proposed a budget cut of more than \$1 billion per year, according to the *Des Moines Register*.

Iowa's 14 existing mental health regions will fund the bill initially with existing cash reserves. Greenfield said he expects the bill to be cost-effective for the state because it will reduce psychiatric hospitalizations and incarceration for people with mental illness. **PN**

Iowa House File 2456 is posted at <https://www.legis.iowa.gov/legislation/Bill-Book?ga=87&ba=hf2456>. The Complex Service Needs Workgroup Report is posted at https://dhs.iowa.gov/sites/default/files/ComplexServiceNeeds_WorkgroupReport.pdf.

Mindfulness

continued from page 6

Schuman-Olivier noted. To progress in the practice of mindfulness, it is necessary to develop compassion—for oneself and for others. Further, he said, there is a need for a “middle path” where mindfulness practice is used with medication.

Many people need medication to function day to day, and for these patients, part of mindfulness is

“accepting that there is a place for medication in your life right now.”

His concern that mindfulness-based practices may be seen as a simple solution to complex problems is shared by Michelle Dossett, M.D., Ph.D., M.P.H., an internist and clinical researcher at the Benson-Henry Institute of Mind-Body Medicine at Massachusetts General Hospital and an assistant professor of medicine at Harvard Medical School.

“Part of the problem we are getting into is that mindfulness is being put

out there as the magic pill that's going to fix everything,” said Dossett. Mindfulness should not be divorced from a more inclusive approach to wellness, she commented. Dossett uses the term “wellness” because she is concerned that meditation or mindfulness

“Finding the Right Match: Mindfulness Training May Potentiate the Therapeutic Effect of Non-Judgment of Inner Experience on Smoking Cessation” is posted at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4096689/>. “Meditation Is Associated With Increased Brain Network Integration” is posted at <https://www.ncbi.nlm.nih.gov/pubmed/28663069>. Resources to help psychiatrists improve their well-being and avoid burnout are posted on APA's website at psychiatry.org/wellness.

practices alone are not enough. “You can meditate all you want, you can practice mindfulness all you want, but if you are stressed out, sleep-deprived, feeding your body junk, and not moving your body, you are not going to be optimally resilient to stress.” **PN**



Smoking Cessation Pharmacotherapies Are Not Hazardous to Heart

Varenicline, bupropion, and the nicotine patch pose no more risks of heart attacks, strokes, or other major cardiovascular complications than placebo, even among smokers with psychiatric illness. **BY NICK ZAGORSKI**

The single biggest step smokers can take to reduce their risks of serious health risks and premature death is to quit. Most guidelines agree that the best approach to quitting is counseling coupled with pharmacotherapy such as varenicline, bupropion, or nicotine replacement. Despite the proven efficacy of smoking cessation medications, however, some clinicians remain hesitant to prescribe them due to concerns over possible side effects of the medications, including cardiovascular safety.

A study published April 9 in *JAMA Internal Medicine* concluded that relative to placebo, smoking cessation medications pose no risk of serious cardiovascular events in most smokers, including

those who have a psychiatric disorder.

These findings are the latest to come from the Evaluating Adverse Events in a Global Smoking Cessation Study (EAGLES)—a large clinical trial that enrolled over 8,000 smokers from 140 clinical centers across the world. The trial was initially designed to assess the potential risk of psychiatric side effects in smokers taking varenicline or bupropion (and as reported in 2016, these medications posed no increased neuropsychiatric risks). The study was later extended so the investigators could monitor long-term cardiovascular risks as well.

As lead EAGLES investigator Neal Benowitz, M.D., a professor of medicine at the University of California, San Francisco, explained, the cardiovascular concerns over varenicline and bupropion stem from their mechanisms of action. Varenicline binds to nicotine receptors that stimulate blood flow; bupropion is an amphetamine-like compound that can increase blood pressure and heart rate.

No formal studies had identified any cardiovascular problems with these cessation medications, but the anecdotal evidence was enough that drug regulatory agencies in the United States and Europe requested that the manufacturers of varenicline (Pfizer) and bupropion (GlaxoSmithKline) conduct a large study that hopefully would provide some definitive answers.

The 8,058 EAGLES participants (including 4,116 with a psychiatric disorder) were randomly assigned to receive either varenicline (1 mg twice daily), bupropion (150 mg twice daily), a nicotine patch (an active control group), or placebo pills (passive control) for 12 weeks. The participants were then followed for an additional 40 weeks.

About 4,600 participants remained enrolled in the study at the end of the 52 weeks; of these, 26 participants experienced a major cardiovascular event (defined as a heart-related death, nonfatal heart attack, or nonfatal stroke), and 21 others had some cardiovascular complication such as peripheral

cardiovascular disease or the need for bypass surgery.

There were no differences in the frequency of a cardiovascular event among any of the four treatment groups, nor was there any indication that adverse outcomes were more frequent in participants with a psychiatric disorder.

Benowitz acknowledged that since the total number of cardiovascular events was so small, a very slight cardiovascular risk in one of the treatments might go unnoticed. Even if that were the case, though, that risk would be far outweighed by all the health benefits of smoking cessation, he said.

“We hope that this study will reassure physicians that if a smoker comes into their clinic looking to quit, medication-assisted therapy is still the recommended approach,” he said.

One caveat of the study Benowitz noted is that none of the participants had any unstable cardiovascular or psychiatric problems, such as uncontrolled blood pressure, a recent heart attack, or an active substance use disorder (other than smoking). These populations would require some special considerations. Bupropion, for example, should be avoided in people with a history or risk of seizures, eating disorders, or unstable blood pressure, while varenicline is cleared by the kidneys and should not be used in people with kidney disease.

As noted above, EAGLES was funded by Pfizer and GlaxoSmithKline, at the behest of the Food and Drug Administration and European Medicines Agency. **PN**

“Cardiovascular Safety of Varenicline, Bupropion, and Nicotine Patch in Smokers: A Randomized Clinical Trial” is posted at <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2677060>.

Lamotrigine May Cause Rare Immune System Reaction, FDA Warns

According to the agency, there have been several reports of hemophagocytic lymphohistiocytosis (HLH) in patients taking lamotrigine.

The Food and Drug Administration (FDA) in April issued a safety announcement warning that the anticonvulsant medication lamotrigine (sold under the brand name Lamictal) can cause a rare but serious immune reaction. Lamotrigine is approved for the treatment of patients with epilepsy and maintenance treatment of bipolar I disorder to delay the time to occurrence of mood episodes in adults 18 and older.

According to the agency, there have been several reports of hemophagocytic lymphohistiocytosis (HLH) in

patients taking lamotrigine. HLH, which triggers an uncontrolled immune system response, typically presents as a persistent fever (usually greater than 101°F). HLH can lead to severe problems with blood cells and organs throughout the body such as the liver, kidneys, and lungs.

“Health care professionals should be aware that prompt recognition and early treatment are important for improving HLH outcomes and decreasing mortality,” the FDA notice stated. “Evaluate patients who develop fever or rash promptly, and discontinue lamotrigine if HLH or another serious immune-related adverse reaction is suspected and an alternative etiology for the signs and symptoms cannot be established.”

The FDA noted that since

lamotrigine’s approval in 1994, the agency has identified eight cases worldwide of confirmed or suspected HLH associated with the medicine in children and adults. “This number includes only reports submitted to FDA and found in the medical literature, so there are likely additional cases about which we are unaware,” the notice stated.

In the eight cases examined, symptoms of HLH were reported to have occurred within 8 to 24 days following treatment initiation. “We determined there was reasonable evidence that lamotrigine was the cause of HLH in these eight cases based on the timing of events and the order in which they occurred. The patients in these cases required hospitalization and received drug and other medical treatments,

with one dying.”

The agency is now requiring that the prescribing information in the lamotrigine label contain a warning about the risk of HLH. Other serious adverse reactions already included in the drug label include serious rashes, suicidal thoughts and actions, and aseptic meningitis.

Health care providers are encouraged to report adverse events involving lamotrigine to the FDA MedWatch program. **PN**

“FDA Warns of Serious Immune System Reaction With Seizure and Mental Health Medicine Lamotrigine (Lamictal)” is posted at <https://www.fda.gov/Drugs/DrugSafety/ucm605470.htm>. The FDA’s MedWatch Voluntary Reporting Form is posted at <https://www.accessdata.fda.gov/scripts/medwatch/index.cfm?action=reporting.home>.



Brains of Teen Girls Resilient to Depression Differ From Brains of Others

Understanding how the brains of those who appear resilient to mental illness differ from others may offer a target for therapeutic interventions. **BY NICK ZAGORSKI**

While numerous studies have examined the risk factors that increase one's chance of developing mental illness, fewer have explored the factors

that might have a protective effect.

"It's absolutely important to think about how we can treat depressive symptoms, but we [clinicians] might be missing a therapeutic opportunity by not putting enough focus on working with individuals to operationalize their strengths," said Adina Fischer, M.D., Ph.D., a resident and postdoctoral fellow at Stanford University.

"It might be easier to protect

someone from developing a mental disorder rather than trying to correct abnormalities in brain circuitry once someone has experienced depression," she continued. Such a proactive approach could prove especially useful during adolescence—a period marked by rapid brain development coupled with increasing stress.

Fischer was the lead author of an article that appeared in *JAMA Psychiatry* in March, which offered clues about how the brains of adolescents who appear resilient to depression might differ from adolescents who develop depression.

For the longitudinal study, Fischer and colleagues conducted clinical and behavioral assessments every 18 months on a group of girls from age 9 to 18. Half of the girls had a mother with recurrent major depressive disorder (MDD) episodes during her daughter's lifetime (high risk); the other half had mothers with no history of depression (low risk). Approximately six years after the start of the study, adolescents in the high-risk and low-risk groups received a resting-state



Adina Fischer, M.D., Ph.D., believes studying resilience is important since it might be easier to protect someone from developing depression rather than trying to correct abnormal circuits after depression onset.

functional magnetic resonance imaging (fMRI) scan.

Fischer and colleagues compared
see Resilient on page 19

Advertisement

AJP Board Member Responds to NYT Story On Antidepressant Withdrawal

AJP Editorial Board member Roy Perlis, M.D., M.Sc., says the New York Times article could do "profound" damage to the progress made against stigma of mental illness. BY MARK MORAN

A New York Times article on long-term use of antidepressants "invites readers to make fallacious jumps connecting islands of truth in pursuit of a titillating, and stigma-perpetuating, theory: psychiatric disease and the suffering it brings are a failing of character best addressed through clean living or perhaps cleansed with redemptive suffering."

So wrote Roy Perlis, M.D., M.Sc., a member of the Editorial Board of the *American Journal of Psychiatry* (AJP), in a hotly critical editorial published just 18 days after the *Times* published its article under the headline, "Many People Taking Antidepressants Discover They Cannot Quit."

The AJP editorial faults the *Times* article for at least two large errors: deploying public health data about the growth in antidepressant use in

tandem with anecdotal reports about severe problems with withdrawal from medications (what Perlis calls an "ecological fallacy") and then painting those anecdotes as darkly illustrative of a couple of known realities (those "islands of truth")—namely, that some patients experience withdrawal requiring lengthy tapers and that there is a need for more and better data on the long-term use and safety of antidepressants.

Given that the article was published in a respected news outlet with an international reputation, it could have serious consequences for people with depression, Perlis told *Psychiatric News*.

"A reasonable person struggling with depression who read that article might say, 'I should not get treatment that includes antidepressants,'" he said. "That would be exactly the wrong



Roy Perlis, M.D., M.Sc.

message to take away from that article, but it's easy to see how someone might.

"For all the progress that has been made in conveying to people that depression is an illness that is

diagnosable and for which there is a range of treatments—for all that progress, the amount of damage that an article like this can do is profound. For clinicians and researchers who spend the bulk of their time trying to improve treatment of depression, to see those efforts set back however unintentionally is infuriating and requires a response."

The response was fast—almost lightning fast in the world of peer-reviewed medical journal publishing. "It's a reflection of the urgency that we saw in responding to this," Perlis said.

He said the *Times* article generated enormous "buzz" among psychiatrists, including members of the AJP Editorial Board, and a decision was made to write a response. AJP Editor Robert Freedman, M.D., turned to Perlis, who is director of the Center for Quantitative Health at Massachusetts General Hospital and a professor of psychiatry at Harvard Medical School. (The editorial notes that he has received consulting fees from or served on scientific advisory boards for Genomind, Psy Therapeutics, and RID Ventures, and he holds equity in Psy Therapeutics.)

"I am grateful to Dr. Perlis, an
see *NYT Story* on page 19



FROM THE EXPERTS

Narcissism and Its Discontents

BY GLEN O. GABBARD, M.D., AND HOLLY CRISP, M.D.

The term "narcissism" has seized the popular culture in the last couple of years in a way that few might have imagined 10 years ago. Yet psychiatrists and mental health professionals continue to find the diagnosis of narcissistic personality disorder (NPD) a vexing challenge that produces a good deal of discontent. Does pathological narcissism denote too much self-love? Profound insecurity? Low self-esteem? Too much self-esteem? Selfishness? Aloofness? A conviction that one is smarter, better looking, more fashionable, or better connected than others? Incapable of tuning in to what others are feeling or thinking? Used as an adjective, "narcissistic" may refer to someone who is thoroughly unpleasant and obnoxious, someone who bristles easily and is sensitive to slights, or someone whose success and confidence are envied.

Almost everyone recognizes an attribute such as healthy self-interest as a kind of narcissism that involves self-care and pride in a job well done. Whether a self-serving behavior is pathological or not may depend on other factors, such as the phase of one's life cycle. An adolescent girl who spends hours obsessing about how she wishes to appear in the



Glen O. Gabbard, M.D., is a clinical professor of psychiatry at Baylor College of Medicine and a training and supervising analyst at the Center for Psychoanalytic Studies in Houston. Holly Crisp, M.D., is a clinical associate professor at Baylor and a faculty member at the Center for Psychoanalytic Studies in Houston. They are the authors of *Narcissism and Its*



Discontents: Diagnostic Dilemmas and Treatment Strategies With Narcissistic Patients, which APA members may purchase at a discount at https://www.appi.org/Narcissism_and_Its_Discontents.

photo she is about to place on social media may well be seen as "normal" for her stage in life. However, the same phenomenon in a 48-year-old would raise concern. To complicate matters further, one person labeled "narcissistic" may respond to a slight by having an emotional meltdown, while another with the same label may appear to be impervious to any insult because of his or her apparent self-confidence.

The discontent of clinicians is also linked to the frustration they experience with their attempts to treat narcissistic patients, who may insist on dictating the conditions of treatment, ignore the comments of their psychiatrists, and "correct" their clinicians by indicating to them where they have gone wrong and pointing out what they should say and when they should say it. Moreover, these patients are often frustrating because some disappear from treatment abruptly without explanation. On the other end of the continuum, when these patients stick with treatment, it may be protracted with very little sign of change. Indeed, they may seem impervious to the observations of the clinician who is treating them and yet stay in treatment without making substantial improvements. These treatments may be among the longest and most arduous and may seem interminable.

From the perspective of two psychiatrists who have treated many narcissistic patients over the years, we must conclude that NPD is nothing if not pleomorphic. It is a multi-headed hydra that may present in a variety of ways depending on the idiosyncrasies of the patient and the context in which the patient lives and works. Research suggests that there is a grandiose form of narcissism that fits the criteria of DSM-5, a vulnerable or hypervigilant variant that sees narcissistic injury around

every corner, and a high-functioning type whose narcissism may surface only after a considerable period of knowing the person. However, narcissistic issues may also contribute to comorbidity in patients who present with primary mood disorders, anxiety disorders, and substance use disorders.

Hence, treatment must be tailored to the specific narcissistic subtype, the comorbid conditions, and the idiosyncrasies of the person with the disorder. Some narcissistic patients will agree to treatment only if it is on their terms and under their (somewhat omnipotent) control. Still others may quit abruptly when there is a small break in the clinician's empathy or a confrontation that some of the difficulties in the patient's life are his or her own responsibility. Fortunately, there are strategies that one can employ to help the patient out of his problems with self-esteem regulation. Some narcissistic patients can rise to the occasion and make substantial changes. There is an unfortunate stereotype that narcissistic individuals create distress in others but do not themselves feel distressed. This aphorism is misguided in that most narcissists feel desperately disappointed that they do not receive the admiration, acclaim, and love that they long for. Psychiatrists and other mental health professionals can help them come to terms with the associated pain and longing. **PN**



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To What Extent Do Sex Differences Matter When Prescribing?

While most clinicians are used to adjusting medications around pregnancy, it is less common for medication decisions outside the perinatal period to be based on sex alone. **BY MARK MORAN**

Do women and men respond differently to psychoactive medications? Should a patient's sex influence the choice and dose of psychiatric medications?

Some recent animal research suggests that hormonal and other differences between males and females may affect how men and women are differentially impacted by stress, experience psychiatric disorders, and respond to common psychiatric medications.

This research, still in its nascent phase, has yet to be incorporated into human studies of psychiatric medication, let alone into clinical practice where—with a few exceptions—clinicians do not make prescribing decisions based on sex-related differences. This topic was the focus of a recent review article in the *Journal of Psychopharmacology*.

“Recent guidelines have addressed sex differences by considering guidance for the perinatal period but general evidence from translational research that does not refer to pregnancy or breastfeeding has yet to reach the clinician,” wrote Blanca Bolea-Alamanac, M.D., of the Centre for Addiction and Mental Health at the University of Toronto and colleagues. “The development of a branch of psychopharmacology focused on sex differences will help to structure the evidence and increase knowledge translation between preclinical researchers and clinical professionals until these findings are fully integrated

in everyday medical practice.”

In comments to *Psychiatric News*, Bolea-Alamanac noted while most clinicians are used to adjusting medications around pregnancy, it is rare for medication decisions to be based on sex alone.

“Most clinicians make medication and dose choice according to the medication's side-effect profile, and sometimes according to a patient's history or other personal factors such as body weight, but we do not know if this works well for both sexes,” she said.

Preclinical research has in the past tended to use only male animals, a trend that is beginning to change. “We are just starting to understand how hormones and neurosteroids affect the brains of men and women differentially,” she said.

In the review article, Bolea-Alamanac and colleagues summarized animal research showing that different biological mechanisms may underlie sex differences in response to stress. For instance, in female rats, rapid changes in circulating progesterone levels are associated with exaggerated behavioral responses to mild stress and blunted responses to benzodiazepines. Acute treatment with fluoxetine appears to blunt those responses.

“A change in progesterone secretion during the menstrual cycle can clearly have a significant influence on brain function and behavior in females, [and] may also be a factor, together with actions and interactions

with other gonadal hormones, that influences drug effects,” Bolea-Alamanac and colleagues wrote. “For example, anxiolytic effects of a benzodiazepine seen in the early stages of the estrous cycle in female rats were not evoked when the drug was given in the late diestrus phase. These findings highlight the importance of taking into account female hormonal status when working towards developing a sex-specific pharmacology.”

Bolea-Alamanac and colleagues suggested potential lines of future research that may be pursued based on observed differences in humans. For instance, they noted that the neuropeptide oxytocin shows sex-specific effects in a range of social behaviors and may act as a biomarker in posttraumatic stress disorder where sex differences are evident. “Studies in women using hormonal contraception show that some of these oxytocin-mediated effects are likely influenced by sex hormones,” they wrote.

Jennifer Payne, M.D., director of the Women's Mood Disorders Center at Johns Hopkins University School of Medicine, who reviewed the paper for *Psychiatric News*, said the subject of sex differences in psychopharmacology is a ripe one for further research and for consideration by clinicians. “Women

undergo regular hormonal shifts that can profoundly influence mood, metabolism of medications, and influence risk for particular psychiatric illnesses,” she told *Psychiatric News*.

Payne, deputy representative from the Caucus of Women Psychiatrists in the APA Assembly, was instrumental in advocating for the creation of a new Council on Women's Mental Health, which was approved by the Assembly in November 2017.

A 2016 paper in *Dialogues in Clinical Neuroscience* summarized research on sex differences in response to antidepressants and found mixed evidence and uncertain clinical implications.

“Clearer data exist regarding sex differences in antidepressant metabolism, related to absorption, distribution, and elimination,” co-author John J. Sramek, Pharm.D., and colleagues wrote. “A better understanding of the interactions between these many complex systems is probably required to understand sex differences in depression prevalence and treatment response. At the present time, no specific guidelines can be offered, thus the clinician must remain vigilant to the possibility of sex effects either on the levels of exposure achieved with therapeutic dosing

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Advertisement

Researchers Examine Whether Ketamine Can Help Patients With BPD

One of the most clinically challenging conditions, borderline personality disorder (BPD) is marked by a high degree of emotional lability, mood dysregulation, and social dysfunction. **BY MARK MORAN**

Can ketamine—which has demonstrated extraordinary promise in recent years as a fast-acting treatment for major depression and suicidal thinking—also help patients with borderline personality disorder (BPD)?

Sarah Fineberg, M.D., Ph.D., an instructor of psychiatry at Yale University and attending psychiatrist at the Connecticut Mental Health Center, believes the answer to this question may be yes. Fineberg is the principal investigator of an ongoing study, funded by the American Foundation for Suicide Prevention, that will look at the effectiveness of ketamine for reducing suicidality and improving social functioning in patients with BPD.

One of the most clinically challenging conditions, BPD is marked by a high degree of emotional lability, mood dysregulation, and social dysfunction. Evidence from functional magnetic resonance imaging has shown that patients with BPD have hyperactivity in limbic areas of the brain, especially



If ketamine can increase neuroplasticity in patients with BPD, it could open a window of opportunity for the patient to change patterns of behavior that have proven to be socially disruptive, says Sarah Fineberg, M.D., Ph.D.

the amygdala, and hypoactivity in the prefrontal cortex and related areas.

Past APA President John Oldham,

M.D., an expert in BPD, has likened the amygdala of a patient with BPD to the engine of a car “running hot.” Such overactivity may explain why patients with BPD tend to be hypersensitive to stimuli and inclined to overinterpret or misinterpret social cues or facial expressions. The hypoactive prefrontal cortex, which should normally act like the brakes of a car, diminishes the patient’s capacity to reconsider or modulate aggressive impulses. “So with borderline patients, the engine is running hot, and the brakes don’t work,” he said.

In an interview with *Psychiatric News*, Fineberg said her interest in ketamine was piqued by recent studies demonstrating the agent’s possible effectiveness in treating major depression and suicidal thinking, but also by animal research suggesting that ketamine may promote new connections between neurons.

“One of the things we are excited about is data from rodent models

showing that within a day or two after infusion with ketamine, there appears to be an increase in neuroplasticity,” Fineberg said. “This suggests that there is a window in which new neural connections can be made.”

If ketamine, alone or as an adjunct to psychotherapy, could open a window of opportunity for the patient to change patterns of behavior that have proven to be socially disruptive, it could be a game changer, Fineberg said. “If we are able to find some success in that domain, we hope to develop an intervention targeted at social change,” she said.

Fineberg noted that patients with BPD are also 50 times more likely than the general population to attempt or die by suicide. A landmark meta-analysis published in the *American Journal of Psychiatry (AJP)* last year found that a single infusion of ketamine appears to significantly reduce suicidal thoughts in depressed patients in as little as one day, with benefits lasting for up to one week.

While no medications have been formally approved for the treatment of BPD, patients with the disorder are often prescribed pharmacotherapies to help treat affective dysregulation, impulsive-behavioral dyscontrol, and cognitive-perceptual difficulties. (A study published in *AJP* in April found that patients who had BPD who took the mood stabilizer lamotrigine for 12 months reported similar symptoms on the Zanarini Rating Scale for Borderline Personality Disorder as those who took placebo for 12 months.)

Fineberg said available data suggest that more depressed individuals respond to ketamine than to traditional antidepressants. “Since people with BPD have little response to SSRIs, we hope that ketamine will also be more effective in BPD,” she said.

Fineberg’s study of ketamine in BPD will be a randomized, controlled trial with three arms consisting of 15 BPD patients in each arm: a control group receiving midazolam, a preoperative sedative; one active treatment group receiving an ultra-low dose of ketamine (0.25 mg/kg); and one active treatment group receiving the standard dose (0.50 mg/kg) of ketamine.

Patients in each of the study arms will receive one infusion and will be followed for a month. The primary outcome of interest is change in suicidal ideation; secondary outcomes include BPD symptoms, pain, and social functioning.

She said that the research will also seek to quantify social cognition and social functioning in the laboratory, drawing on the work of Reed Montague, Ph.D., and colleagues at Virginia Tech Research Institute. Montague and colleagues have developed computer games that require players to trust and cooperate with each other in order to

continued on facing page

VIEWPOINTS

Improving Physicians’ Well-Being Calls for Systemic Revolution

BY ELLEN B. TABOR, M.D.

Stockholm syndrome is described as behavior that develops in captives in which they begin to gain sympathy for and act like their captors, despite ongoing abuse, and later, after the captives have been freed, they refuse to cooperate with law enforcement to prosecute their captors.

Today’s physicians are the captives. Our captors are regulatory agencies that define the care for which we will be paid, insurance companies that prescribe the care and treatment and outcomes for which we will be paid, patients without whose positive opinion we will not be paid, and the internet whose physician-rating posts influence whether patients will choose to come to us for their care.

Every physician who cares for patients today has the same complaints: too many patients scheduled, not enough time spent with patients, too much time spent documenting care in cumbersome systems and defending



Ellen B. Tabor, M.D., is a medical director at a community hospital in Brooklyn, N.Y.

our decisions to nonclinicians in the insurance industry, too much administrative oversight—the list is long. The reasons we were inspired to become doctors—to care for patients, to use our scientific knowledge, to influence individuals and society to be healthier and to have some autonomy in our professional lives—have been crushed beneath the heels of economic imperatives. We did not set these conditions, but we are captive victims of them.

Is it any wonder we are burned out, exhausted, depressed, and even suicidal? I think not. We are being told that we need to take better care of ourselves, have some “me time,” find someone to talk to, make time for exercise

and massages, and so on. While such advice has its place, it is a reflection of the Stockholm syndrome. The lives physicians find themselves leading are not the ones they expected when they optimistically chose this career and answered to its calling. Instead, what we need to do is speak out that the system is entirely broken. All of us, employers and employees alike, must fight this system and acknowledge its inability to defend us, not from despair per se, but from the cognitive dissonance that this is somehow all right. It is not. We must advocate for our freedom, say what is right, and renew our vows to our patients. What will make us happy and ensure our well-being is being able to satisfy our ego-ideal: to provide good care, based on our knowledge and experience, with our patients’ well-being first and foremost in mind.

Only a revolution in the health care system will achieve this, and this is what all physicians must seek: not accommodation, but revolution. **PN**

▶ To help APA members advocate for systemic reform and bring about positive change at the institutions with which they are involved, APA has created the Toolkit for Well-Being Ambassadors at psychiatry.org/burnout.

Treatments Involving Heat Show Promise For Alleviating Depression

Researchers are thinking outside the box in their search for nonpharmacologic alternatives for the treatment of depression.

BY RICHARD KAREL

Clinically induced hyperthermia is gaining interest as a new approach to treating clinical depression, with evidence from different studies starting to converge with promising results.

Among those evaluating hyperthermia for depression are Charles Raison, M.D., a psychiatrist at the University of Wisconsin at Madison; Maren Nyer, Ph.D., a psychologist in the Department of Psychiatry at Massachusetts General Hospital; and Johannes Naumann, M.D., an internist at the University of Freiburg in Germany.

Raison employed an infrared whole-body heat unit in his study, Naumann used whole-body immersion in a very hot bath, and Nyer studied people taking Bikram (“hot”) yoga. All three found statistically significant reductions in depression following these hyperthermic treatments.

In Raison’s initial research, 16 subjects received whole-body infrared heat



and 14 received sham heat. The active group was exposed to infrared heat until the core body temperature reached 101.3 degrees Fahrenheit. The study, “Whole-Body Hyperthermia for the Treatment of Major Depressive Disorder,” was published in the August 2016 *JAMA Psychiatry*. The authors noted, however, that since the study lacked a placebo control, it is possible that the observed antidepressant effects may have resulted from nonspecific aspects of the intervention.

How hyperthermia may alleviate depression is not well understood, and Raison, in collaboration with Nyer, is planning a larger trial to try to identify the mechanisms involved.

Both Raison’s and Naumann’s research suggest that the greater the depression, the more pronounced the response. This is consistent with response to other treatments, including medication. While mild depression often responds to placebo, more severe illness does not. In part this may be a function of what is called “regression to the mean”—the more something deviates from average, the more likely over time that it will tend back—regress—toward the mean. But even taking regression into account, the results are encouraging, he said.

The degree of response in Raison’s study was significantly greater than in Naumann’s—about twice as much. It also involved much greater heat for a significantly longer time. While Naumann’s subjects were immersed in a hot bath for about 20 minutes twice weekly for four weeks, Raison’s subjects lay in an infrared unit for 100 minutes once.

In her open-label, eight-week study, Nyer evaluated 29 people who met criteria for major depression. Among those who attended Bikram at least twice weekly, there was a statistically significant improvement in depression as measured by the Hamilton Rating Scale for Depression (HAM-D) and Beck Depression Inventory. Nyer has received a five-year grant of approximately \$740,000 from the National Institutes of Health’s National Center on Complementary and Integrative

Health to conduct a larger, randomized evaluation of Bikram for depression. A description of Nyer’s original pilot from 2013 is available on the Massachusetts General Hospital website, and a summary of her ongoing research can be found under “Mechanisms of Hyperthermic Yoga for the Treatment of Depression” at the National Institutes of Health’s grantome.com website.

Two psychiatrists at Massachusetts General Hospital, Maurizio Fava, M.D., and David Mischoulon, M.D., Ph.D., have been her mentors. In an interview, Mischoulon pointed to Nyer’s work as a response to the need for alternatives to drug therapy.

“Antidepressants have limitations,” he



Charles Raison, M.D., has found that exposure to whole-body infrared heat can alleviate symptoms of depression.

commented. Not all patients respond to them or can tolerate the side effects. Alternatives, such as Bikram yoga, “may be more feasible and more acceptable for a lot of patients,” he concluded.

In Germany, where Naumann works, there have long been anecdotal reports that bathing in hot springs elevates mood. When he began the trial of 36 subjects, his team was skeptical that immersion in a very hot bath for short periods twice weekly could significantly

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win. These games offer researchers the opportunity to examine factors that promote or discourage cooperative, or “pro-social”, behavior.

At the APA Annual Meeting in New York this month, Fineberg presented preliminary data from the study and the clinical and basic research supporting use of ketamine in BPD during a symposium titled “Novel Approaches and New Directions in the Treatment of Borderline Personality Disorder.”

Fineberg said the “buzz” surrounding ketamine has been extraordinary, but what is needed are solid data. Ketamine infusion centers are proliferating—few of which, if any, screen patients for personality disorders, she said. “This is a very hopeful area, but we need to proceed cautiously,” she said. **PN**

“The Effect of a Single Dose of Intravenous Ketamine on Suicidal Ideation: A Systematic Review and Individual Participant Data Meta-Analysis” is posted at <https://ajp.psychiatryonline.org/doi/abs/10.1176/appi.ajp.2017.17040472>. “The Clinical Effectiveness and Cost-Effectiveness of Lamotrigine in Borderline Personality Disorder: A Randomized Placebo-Controlled Trial” is posted at <https://ajp.psychiatryonline.org/doi/full/10.1176/appi.ajp.2018.17091006>.

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BY NICK ZAGORSKI

Cannabinoid Derivative Improves Tourette Symptoms in Phase 2 Study

Therapix Biosciences in April reported positive data from a phase 2 study assessing its cannabinoid-based drug **THX-110** as a treatment for Tourette syndrome. THX-110 is a combination of the FDA-approved synthetic cannabinoid **dronabinol** and the fatty acid palmitoylethanolamide.

In the open-label trial, 16 patients received a daily oral dose of THX-110 for up to 12 weeks. Most of the patients had severe, refractory Tourette syndrome and had failed to respond to such treatments as antipsychotics, behavioral therapy, and deep brain stimulation.

The patients showed an average tic reduction of 21 percent (measured by the Yale Global Tic Severity Scale Total Tic Score). Six patients experienced tic reductions of greater than 25 percent.

Twelve of the 16 patients are continuing in a 24-week extension study.

FDA Rescinds Refusal To Review Alkermes' Depression Drug

The Food and Drug Administration (FDA) in April accepted Alkermes' New Drug Application (NDA) for **ALKS 5461**, a novel, once-daily medication for the adjunctive treatment of major depressive disorder (MDD) in patients with an inadequate response to standard antidepressants. ALKS 5461 is a fixed-dose combination of two opioid compounds, **buprenorphine** and **samidorphan**.

On March 30, the FDA sent a Refusal to File letter to Alkermes stating that the NDA contained insufficient evidence of overall effectiveness for the proposed indication of MDD, and that additional, well-controlled clinical trials were needed prior to the resubmission of the NDA. The FDA also requested that Alkermes conduct a bioavailability study to generate additional data that can compare ALKS 5461 and the reference listed drug, buprenorphine.

In a statement released by Alkermes, the company noted it had productive interactions with the FDA to clarify certain aspects of their NDA submission, which contained data from more than 30 clinical trials involving more than 1,500 patients with MDD. The FDA has now rescinded the refusal letter without requiring additional trials.

Indivior Gets Rights To Library of Orexin Receptor Drugs

Indivior in late March announced that it has entered into a licensing agreement with the biotech C4X Discovery. The company has obtained exclusive rights to develop and commercialize C4X's library of orexin-1 (OX1) receptor antagonist drugs. Pre-clinical studies have suggested that blocking the orexin pathway can decrease drug-seeking behavior and reduce the risk of relapse for a wide range of substances, including stimulants, opiates, and alcohol.

Under the terms of the agreement, Indivior will pay \$10 million up front to C4X, with subsequent milestone payments potentially reaching \$284 million if all development, regulatory, and commercial goals are achieved.

"We believe C4X's OX1 program is one of the most promising early stage programs to potentially treat addiction and look forward to rapidly advancing lead compound C4X3256 into the clinic," said Indivior Chief Scientific Officer Christian Heidebreder, Ph.D., in the company's press release. "Further, we believe there is great potential for additional compounds to be discovered and developed with respect to this important mechanism that will contribute to the continued elucidation of the neurobiological underpinnings of withdrawal symptoms, drug intake, craving, relapse, and comorbid psychiatric associations."

Chantix Fails to Increase Abstinence In Teen Smokers

Pfizer reported in late March that a large, phase 4 study evaluating the effectiveness of **Chantix (varenicline)** for smoking cessation in adolescents failed to meet its primary endpoint.

The phase 4 study enrolled 312 nicotine-dependent adolescents aged 12 to 19. The adolescents were randomly assigned to receive either varenicline or placebo for 12 weeks. Patients in the varenicline group were further divided and assigned to take either 1 mg of varenicline twice daily (high-dose group) or 0.5 mg varenicline twice daily (low-dose group). At the study's end, continuous four-week abstinence rates were no different between the varenicline groups and the placebo group.

The adverse event profile was similar to what has been observed in adults taking varenicline; the most common side effects were nausea, headache, vomiting, agitation, and abnormal dreams. **PN**

NIH

continued from page 3

will be to better understand why some people transition from acute pain to chronic pain. To explore this issue, NIH is launching a new clinical trial that will follow patients with muscle-skeletal pain before and after their surgery to identify biomarkers that might predict who is more likely to develop chronic pain. If researchers can determine ways to keep people from transitioning to chronic pain, they could reduce the need for long-term pain management.

NIH also plans to use technology developed through the BRAIN Initiative to uncover new biomarkers that may predict which individuals will respond to treatments to prevent unnecessary prescriptions.

Rebecca Baker, Ph.D., a special assistant to the NIH Director, told *Psychiatric News* that in addition to long-term goals of identifying new targets for the treatment of pain and biomarkers to determine who will best respond to treatment, the HEAL initiative will also explore more immediate solutions. "We recognize the extent of the public health crisis today and want to put all hands on deck," she said.

One such program will look at expanding nonpharmacological pain management in clinical settings. This work will build on an existing partnership between the NIH and departments of Defense and Veterans Affairs that is testing the feasibility, acceptability, and effectiveness of treating pain in veterans with approaches such as mindfulness, tai chi/yoga, chiropractic care, and behavioral therapy.

Efforts to improve the treatment of opioid use disorder—the second mission of the HEAL initiative—will start by making existing treatments for opioid use disorder more widely available. "Over 2.5 million Americans currently have a severe opioid use disorder, and more than half do not get appropriate care despite a range of approved options," Baker said. "This second mission will focus on implementing medication-assisted therapy in more health care, criminal justice, and community settings."

While many leaders at NIH have previously touched on the importance of public-private partnerships to help quell the opioid epidemic, this new initiative will be funded solely with government money. This development comes following an NIH working group recommendation that limiting industry support to federal projects would minimize any perceptions of industry bias. **PN**

More information on the HEAL initiative is posted at <https://www.nih.gov/research-training/medical-research-initiatives/heal-initiative>.

Heat

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improve severe depression. Subjects remained in the 104-degree Fahrenheit bath as long as they could tolerate—an average of 22 minutes each, Naumann explained. Measures of body temperature with an ear thermometer found an average increase from 98.4 to 102.4 degrees Fahrenheit.

"We thought in the beginning that severely depressed people might not react as strongly as they did, but they really improved a lot in a short time," he said. After only two weeks (four hot baths) of the four-week trial, there was a statistically significant improvement as measured by the HAM-D. The study, "Effects of Hyperthermic Baths on

Depression, Sleep, and Heart Rate Variability in Patients With Depressive Disorder," was published online in March 2017 in *BMC Complementary and Alternative Medicine*.

As with others who are researching hyperthermia and other nonpharmacologic approaches to depression treatment, Naumann believes that the identification and development of a wider range of treatment options that may better meet patients' preferences and encourage treatment compliance is well worth the effort. **PN**

"Whole-Body Hyperthermia for the Treatment of Major Depressive Disorder" is posted at <https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2521478>. "Mechanisms of Hyperthermic Yoga for the Treatment of Depression"

is posted at <http://grantome.com/grant/NIH/K23-AT008043-03>. "Effects of Hyperthermic Baths on Depression, Sleep, and Heart Rate Variability in Patients With Depressive Disorder: a Randomized Clinical Pilot Trial" is posted at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5371197>.



IN MEMORIAM

The names of APA members whose deaths were reported from October 1, 2017, to March 31, 2018, can be accessed at <https://psychnews.psychiatryonline.org/doi/full/10.1176/appi.pn.2018.4b50>. APA honors deceased members each year at the Annual Meeting.



BY NICK ZAGORSKI



Screening for Allele Could Cut Incidence of Carbamazepine Skin Rashes

Patients with the rare allele HLA-B*15:02 are known to be at a greater risk of carbamazepine-induced Stevens-Johnson syndrome (SJS), a severe skin rash. Because of this risk, the Food and Drug Administration (FDA) recommends that patients with ancestry from areas where HLA-B*15:02 is prevalent should undergo genetic screening before starting treatment with carbamazepine.

A study published in *JAMA Neurology* now shows that screening for the related HLA-A*31:01 allele, which is more common than HLA-B*15:02, may also be clinically useful. Investigators in Japan screened 1,130 patients who were prescribed carbamazepine for epilepsy, schizophrenia, bipolar disorder, or other conditions for HLA-A*31:01. The 198 patients who tested positive for HLA-A*31:01 were prescribed alternative medications.

Goin

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(1985), a Distinguished Service Award from the Southern California Psychiatric Society (1991), an Exemplary Psychiatrist Award from the National Alliance for the Mentally Ill (2005), and an Exceptional Mentoring Award from the University of Southern California (2005).

Marcia Goin is survived by her daughters Jessica and Suzanne.

APA leaders expressed condolences to Goin's family and said her contributions to APA were profound and enduring. "Marcia's leadership is a model not only for me personally but for all us," said APA President Anita Everett, M.D. "Her focus on the criminalization of people with mental illness put a spotlight on an issue that continues to be an APA priority."

APA CEO and Medical Director Saul Levin, M.D., M.P.A., added, "We will miss Marcia dearly, for she was thoughtful, calming, and a gracious leader who achieved her initiatives when she was APA President and contributed so much in the psychiatric field." **PN**

The investigators identified 23 cases of adverse skin reactions in this population, resulting in a 2 percent incidence rate. Historical medical data reported a 3.4 percent rate in people taking carbamazepine or related drugs, meaning the screening reduced the number of adverse reactions by about 40 percent.

"Although cost-effectiveness analyses are required, the use of HLA-A*31:01 screening to reduce the rate of carbamazepine-induced cADRs [cutaneous adverse drug reactions] in routine clinical practice appears to be warranted," they wrote.

Mushiroda T, Takahashi Y, Onuma T, et al. Association of HLA-A*31:01 Screening With the Incidence of Carbamazepine-Induced Cutaneous Adverse Reactions in a Japanese Population. *JAMA Neurol.* April 2, 2018. [Epub ahead of print] <https://jamanetwork.com/journals/jamaneurology/fullarticle/2676800>



Liver Cancer Linked To Alcohol Found to Be More Lethal

Patients with alcohol-related liver cancer often do not live as long as patients with liver cancer that is not associated with alcohol consumption, according to a study in *Cancer*. The finding highlights the importance of regular liver screenings in patients with alcohol use disorder.

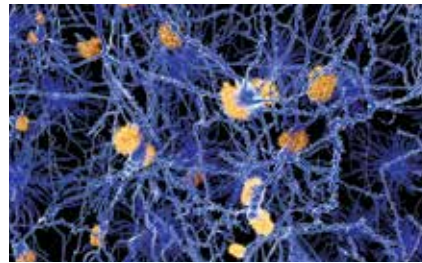
Investigators from Henri Mondor Hospital in Créteil, France, and colleagues tracked the health outcomes of 894 patients with newly diagnosed liver cancer for five years; 65 percent of the participants had a history of chronic alcohol misuse.

At the end of five years, the researchers found that the average survival time was 9.7 months in patients with non-alcohol-related cancer and 5.7 months in patients with alcohol-related cancer. Among the patients with an alcohol history, those who were abstinent from drinking at the time of enrollment had slightly better survival rates (5.8 months versus 5.0 months for non-abstinent patients).

When the patients were matched based on the stage of liver cancer at the time of diagnosis, the survival rates were similar between the two groups. The findings suggest that the

reduced overall survival in patients with alcohol-related liver cancer may be due to these patients having worse liver function and cancer that was more spread out and diffuse at the time of diagnosis.

Costentin C, Mourad A, Lahmek P, et al. Hepatocellular Carcinoma is Diagnosed at a Later Stage in Alcoholic Patients: Results of a Prospective, Nationwide Study. *Cancer.* March 28, 2018. [Epub ahead of print] <https://onlinelibrary.wiley.com/doi/abs/10.1002/cncr.31215>



Alzheimer's Protein Implicated in HIV-Associated Neurocognitive Problems

BACE1, a protein involved in Alzheimer's disease, may be a promising target for treating cognitive problems related to the human immunodeficiency virus (HIV), suggests a study published in the *Journal of Neuroscience*.

Although patients with HIV-associated neurocognitive disorders (HAND) and Alzheimer's have many symptoms in common, it is unclear if these diseases share any similar biological mechanisms. The brains of patients with HAND do not exhibit the amyloid plaques that are found in the brains of patients with Alzheimer's, but there is some evidence that HAND is associated with alterations in how amyloid fragments are processed.

Researchers at the University of Pennsylvania and colleagues analyzed BACE1 and amyloid oligomers in post-mortem brain tissue of patients who were HIV-positive. They found elevated levels of BACE1 and amyloid oligomers in this tissue, but as expected, no evidence of amyloid plaques. When they treated neurons growing in a lab dish with material from HIV-infected white blood cells, the researchers discovered that the neurons started producing more BACE1, eventually reaching toxic levels.

This BACE1 production was dependent on signaling from NMDA receptors, which suggests that inhibiting NMDA and glutamate signals may be a therapeutic option to treat HAND.

Stern A, Ghura S, Gannon P, et al. BACE1 Mediates HIV-associated and Excitotoxic Neuronal Damage Through an APP-dependent Mecha-

nism. *J Neuroscience.* April 9, 2018. [Epub ahead of print] <http://www.jneurosci.org/content/early/2018/04/09/JNEUROSCI.1280-17.2018>



Metformin Found to Block Symptoms of Acute Nicotine Withdrawal

An animal study appearing in *Proceedings of the National Academy of Sciences* suggests that the type 2 diabetes drug metformin can block the symptoms of nicotine withdrawal. If similar effects of the medication are found in smokers, the medication could offer a potential new therapeutic option for smoking cessation, as current medications focus more on preventing nicotine cravings.

For the study, researchers at the Johns Hopkins University School of Medicine and colleagues targeted an enzyme known as AMP-activated protein kinase (AMPK). They found the AMPK pathway is activated in mammals following chronic nicotine use but becomes repressed during nicotine withdrawal. The researchers hypothesized that this shift might contribute to withdrawal symptoms such as anxiety and irritability.

They next tested whether providing metformin—which stimulates AMPK production—prior to nicotine withdrawal might keep the AMPK pathway active once smoking stopped. The researchers found that mice given one week of pre-withdrawal metformin injections still had detectable levels of active, phosphorylated AMPK 24 hours after nicotine withdrawal, whereas mice treated with saline did not. The mice who received metformin also showed almost no anxiety-like behaviors in a pair of behavioral tests 24 hours after nicotine withdrawal.

The researchers noted that these results were achieved using metformin concentrations (250 mg/kg) that did not impact the body weight, food consumption, or glucose levels of the mice under both fed and fasted conditions. **PN**

Brynilsen J, Lee B, Perron I, et al. Activation of AMPK by Metformin Improves Withdrawal Signs Precipitated by Nicotine Withdrawal. *Proc Natl Acad Sci USA.* April 2, 2018. [Epub ahead of print] <http://www.pnas.org/content/early/2018/03/30/1707047115.long>

NYT Story

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associate editor of the *Journal*, for his immediate response to a call for a commentary addressing the *New York Times* article on antidepressant use,” Freedman told *Psychiatric News*. “Discounting the effectiveness of antidepressants is a disservice to patients who can benefit from their appropriate use. We have expedited the publication of his commentary to provide families, patients, and clinicians with a more balanced view of the issue.”

Freedman said *AJP* has commissioned articles that propose longer-term efficacy and safety studies and that provide clinicians with current information on indications and safety for withdrawal after longer term use.

In his editorial, Perlis offered clarity regarding those “islands of truth” the *Times* tried to connect.

First, the matter of withdrawal. “Factually, as the article acknowledges, withdrawal syndromes have been

recognized from the beginning of the modern psychopharmacologic era,” he wrote.

“For this reason, slow, systematic tapers—when necessary, incorporating longer half-life antidepressants—represent a standard of care. And many clinicians will recognize in their practice some of the phenomena noted in the article, such as patients requiring very long tapers of medications. Clinicians will also recognize that in some cases, such symptoms actually represent recurrence of depressive, anxious, and somatic symptoms—the indication for treatment in the first place. That patients are able to *sustain* long-term treatment is testament to half a century of work on tolerability.”

In an interview with *Psychiatric News*, Perlis noted as well that the *Times* had written about patients who had experienced extreme difficulty withdrawing from antidepressants—something he said existing data suggest is extremely rare.

Then there is the matter of the

relative paucity of long-term data. “The article is also undeniably correct that we know far too little about long-term consequences of antidepressants—and nearly every medication in common use in medicine,” Perlis wrote. “That antidepressants are singled out may reflect a unique degree of discomfort with medications that affect the brain, but the big picture reminds us that all medications have off-target or longer-term impact that cannot be captured in the regulatory approval process.”

Perlis also pointed out that the *Times* article appeared just one week after a meta-analysis in *Lancet* based on data on more than 100,000 individuals demonstrated (not for the first time) that antidepressants are generally similar to one another in efficacy and are consistently superior to placebo. “Yet media accounts still routinely treat antidepressant efficacy as an open question and toxicity as a near certainty,” he wrote.

Finally, he said, the editorial is a call to action. “I don’t want people to come away with the idea that our work

is done,” he said. “We do need more long-term data. Let’s use this as an opportunity to learn more about long-term safety and about discontinuation and problems that may be associated with it.”

So what’s the message clinicians should give to patients who may have read the *Times* article?

“The message should be one of reassurance—that we do know a lot about long-term safety though we need to know more,” he said. “We have hundreds of millions of years of patient data, and we know these medications are safe. Does that mean there can’t be rare serious outcomes? No, but that is no different from any other drug on the market.” **PN**

➤ “Anxiety About Antidepressants” is posted at <https://ajp.psychiatryonline.org/doi/full/10.1176/appi.ajp.2018.18040399>. “Many People Taking Antidepressants Discover They Cannot Quit” is posted at <https://www.nytimes.com/2018/04/07/health/antidepressants-withdrawal-prozac-cymbalta.html>.

Prescribing

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or on the clinical efficacy when treating depressed patients.”

Bolea-Alamanc and colleagues argued for better representation of women in clinical trials and reporting of effects by sex in published studies of medication trials. In 2010, the Institute of Medicine released a report brief titled “Women’s Health Research: Progress, Pitfalls and Promise,” which found that while the number of women participating in clinical trials had increased over the previous two decades, they were still

underrepresented. Even when women are included in these trials the results are often not analyzed separately by sex, the report found.

In December 2017, the National Institutes of Health (NIH) amended its inclusion policy to enhance the public reporting of sex/gender and race/ethnicity inclusion data. “With backing from the 21st Century Cures Act, this amendment specifically requires reporting the results of ‘valid analyses’ on sex/gender and race/ethnicity to ClinicalTrials.gov after completing an applicable NIH-defined phase 3 clinical trial,” a representative of the NIH Office of Extramural

Research told *Psychiatric News* by email. “NIH expects this policy to increase the transparency and availability of data about how treatments work among different sex/gender and race/ethnicity groups.”

The NIH Office of Research on Women’s Health was established in September 1990 to strengthen and enhance research related to diseases, disorders, and conditions that affect women; ensure that women are appropriately represented in biomedical and biobehavioral research studies supported by the NIH; and develop opportunities and support for recruitment, retention, reentry, and

advancement of women in biomedical careers.

“As more studies are published, it is likely that gender would be a factor to consider in prescribing, and this may change how we practice in the next decade,” Bolea-Alamanc told *Psychiatric News*. **PN**

➤ The review article “Female Psychopharmacology Matters! Towards a Sex-Specific Psychopharmacology” is posted at <http://journals.sagepub.com/doi/full/10.1177/0269881117747578>. “Sex Differences in the Psychopharmacological Treatment of Depression” is posted at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5286730/>.

Resilient

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data from the fMRI scans of 20 adolescents in the high-risk group who did not develop MDD (resilient) with 20 in the high-risk group who developed MDD (converted) and 25 adolescents in the low-risk group who did not develop depression (control).

Adolescent girls who appeared resilient to depression had greater neural connectivity between the amygdala and prefrontal cortex compared with similarly-aged, at-risk adolescent girls who developed depression and those in the control group. The amygdala and prefrontal cortex are known to play a key role in processing and regulating emotions. Adolescent girls in the resilient group also had more connections in brain regions involved in the executive control network, which regulates behaviors such as cognitive reappraisal and impulse control, than did

adolescents who developed depression or those in the control group.

The authors noted that the three groups of teens reported a similar number of positive and negative life events (such as receiving special recognition at school, moving to a new home, and divorce of parents), so it is unlikely such events contributed to differences in conversion to depression.

Fischer acknowledged that there is only so much that can be inferred from brain scans taken at one point in time, but she told *Psychiatric News* that the patterns of increased connectivity point to resilient teens having more top-down control of their emotions.

“It is not just an issue of what adverse experiences one has,” Fischer explained, “but how such events are interpreted that makes the difference.” The resilient teens may view negative events in a more positive light, she continued, which in turn may strengthen the neural connec-

tions between key brain regions.

It’s still a speculative thought, but Fischer believes once these networks involved in resilience are better mapped out, it might be possible to strengthen them in young people at risk of depression through targeted psychotherapy.

Sophia Frangou, M.D., Ph.D., a professor of psychiatry at the Icahn School of Medicine at Mount Sinai, told *Psychiatric News* that it might be a bit premature to think about therapeutic strategies centered on building resilience. “Is there an avenue for intervention? Absolutely,” she said. “But so far, we only have identified changes at a broad level, and we need to get down to the more fine-grained mechanics.”

As an example, Frangou wondered if the underlying basis for mental resilience is not that some people can respond positively to adverse events and create stronger connections, but that others may lack the neural plasticity to do so.

Although the study by Fischer and colleagues included only 65 adolescents, Frangou said the findings build on and validate some existing knowledge, including work her group has done exploring resilience to bipolar disorder. For one, there seems to be a pattern emerging that resilience is associated with hyperconnectivity; people who are resilient to depression and bipolar disorder generally have more connections to and from the emotional centers of the brain. There is also some overlap in brain regions involved in resilience to depression or bipolar disorder, notably the prefrontal cortex.

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

➤ “Neural Markers of Resilience in Adolescent Females at Familial Risk for Major Depressive Disorder” is posted at <https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2675295>.

Suicide

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of Traumatic Stress at the Uniformed Services University of the Health Sciences (USUHS) in Bethesda, Md.

Army STARRS researchers collected data on 1.6 million active-duty soldiers from 2004 to 2009 in a project designed to investigate risk factors and protective factors for suicide, suicidal behavior, and other mental or behavioral health issues.

“There were nearly 10,000 suicide attempts overall during that time,” said Ursano in an interview. “Suicide attempts are indicators of individuals in need of care. For the Army, they also carry a cost in how they affect units.”

Ursano and co-author Murray Stein, M.D., M.P.H., a professor of psychiatry and family medicine and public health at the University of California, were co-principal investigators on Army STARRS. The project not only gathered new data as the United States was fighting two wars; it also pulled together material previously recorded but not held in one place.

“At first, Army STARRS told us much of what we already knew, but now we are able to quantify that information,” commented retired Army psychiatrist Elspeth Cameron Ritchie, M.D., M.P.H., a professor of psychiatry at USUHS and a clinical professor at Georgetown University and George Washington University, in an interview. Ritchie was not involved with the current study. “The important thing about this study is that it not only gathered data but also made some practical suggestions about what may be done to reduce the risk of suicide attempts.”

For the current study, the researchers collected administrative data records on a sample of 593 soldiers who had served between 2004 and 2009, had completed exactly two deployments, and had documented suicide attempts during or after their second deployment. They were matched with a control sample amounting to 19,023 person-months. Most of the soldiers were male (86.5 percent), currently married (67.1 percent), and had joined the Army before age 21 (64.8 percent).

No effects were found relating to military occupational specialty, sex, deployment status, duration of first deployment, or previous mental health diagnosis, said the authors. The risks of combat experience itself or of high-risk military specialties, like combat medics, could not be determined in this study. Time-related variables were adjusted for sociodemographic and service-related factors.

Soldiers who had served 12 months or less before their first deployment had greater odds of a suicide attempt (odds ratio, 1.7) during or after their second deployment. That risk might be reduced if soldiers “had more time to train and acclimate to the military before their initial deployment,” suggested the researchers.

A second variable was “dwell time,” the period between deployments when soldiers recover from their experiences in the war zone and train for future duty. After adjustment, a dwell time of six months or less also was associated with increased risk of a suicide attempt (odds ratio, 1.8). Prior research has found that dwell times for troops of 30 to 36 months are associated with reduced rates of acute stress, anxiety, and depression compared with troops

opposition to PAD tends to revolve not around the laws and the practice of assisted dying as it currently exists, but on how the laws and the practice may evolve in time to be less restrictive. “When the psychiatric field focuses on those difficult and controversial scenarios, we are in danger of missing the thing that is in front of us—how we can help alleviate psychological distress in dying people,” Fairman said.

Entering Uncharted Territory

Oregon was the first state to adopt PAD, with passage of the Death With Dignity Act in 1997. It stood alone until 2009, when a similar law was approved in Washington by public referendum. This was followed in the same year in Montana, where PAD became legal by a court ruling, then later in Colorado, Vermont, the District of Columbia, California, and Hawaii (the law in Hawaii goes into effect in 2019).

As the first state to approve PAD,

Soldiers' Ability to Handle Stress, Adapt to Change May Help Predict Suicide Risk

Another study used Army STARRS data to learn more about conditions leading up to suicide. In a poster at the annual Amygdala Conference in April at the Uniformed Services University for the Health Sciences, psychologist Catherine Dempsey, Ph.D., M.P.H., and colleagues interviewed either the next of kin or first-line supervisors about the prior history of 168 soldiers who died by suicide. They compared that information with 389 control subjects, matched for childhood, adult, and combat experiences.

The researchers looked at reports of recent stressful events, the severity of stress, and how well soldiers managed their own stress to see whether an association existed with greater risk of suicide.

“We did ask questions about combat experiences, [but] we are still in the process of analyzing those data,” said Dempsey in an interview. Dempsey is a contractor with the Henry M. Jackson Foundation for the Advancement of Military Medicine in support of the Center for the Study of Traumatic Stress.

“[Both] next of kin and supervisors similarly reported soldiers who died by suicide were more likely to have experienced recent stressful events when compared with controls,” they concluded. Such events included being left by a spouse or partner in the prior month, ongoing arguments or break-up with family members or a close friend, and a perceived failure or humiliation.

Both sets of informants also noted recent severe stresses in the decedent's career or job, social life, or relationship with family or being in legal difficulty. They also said that the soldiers did a poor job managing stress or adapting to changing situations and in recovering from setbacks.


“Results suggest that the ability to handle stress and adapt to changing situations may be a useful predictor of suicide,” wrote the researchers. “This information may inform prevention efforts.”

who had not been deployed.

Dwell time is not as simple to control as it may seem, said Ritchie. “Military leaders appreciate the need for a longer time between deployments, but if you have a war to fight, you have to balance your options.”

The study indicates that suicide attempts might be reduced by 14.2 percent if the initial training period is greater than 12 months and by 4.0 percent if the dwell time is at least six months, said the authors.

“We were surprised by the clarity of the findings and the strength of the association of risk with early deployment,” added Ursano. “The lack of findings related to length of deployment highlight the dynamic nature of deployment and the many ‘moving parts’ that must be considered.” **PN**

 “Associations of Time-Related Deployment Variables With Risk of Suicide Attempt Among Soldiers” is posted at <https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2678213>.

California

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“In our experience, institutionally [at UC Davis], we are learning that the law is written in such a way that a very small percentage of patients will have success qualifying,” Fairman told *Psychiatric News*. “This is not an easy or quick process for a patient to get through. It requires a high level of assertiveness from patients, health literacy, and time. Depending on the case, there may be as many as four encounters with providers or a pharmacist. In many instances, it just isn't possible for patients who are very near the end of their life.”

Fairman said that the attention focused on PAD threatens to eclipse “the need for high-quality end-of-life care for *all* dying patients, not just those interested and able to access the option of PAD.”

Moreover, the most vociferous

Oregon has the largest database of information about people who have sought PAD (see story on page 4). Because other states modeled their laws after Oregon's, their experience is likely to differ mainly with respect to demographics and implementation.

Several observers who spoke with *Psychiatric News* said that California—by virtue of its size and demographic and socioeconomic diversity—will be a landmark for how PAD is applied in a diverse population. The most recent report from California about PAD includes only data from the first six months of the law's application in 2016.

Fairman said it has been a learning process. As a psychiatrist with expertise in palliative care, he served as an advisor to state senators as the End of Life Option Act was being developed and participated in legislative hearings to provide feedback to legislators about implementation.

The law in California is explicit that

participation in PAD by individual physicians and institutions is entirely optional. “At UC Davis we had a series of conversations with stakeholders throughout the system and decided to participate,” Fairman said.

The institution developed its own policy around PAD, including some elements beyond what is included in the state law—especially the designation of a “patient navigator,” a licensed clinical social worker who provides a psychosocial assessment, helps to identify unmet patient support needs, facilitates enrollment in hospice care, and coordinates communication among providers.

Fairman said the institution has also developed CME training and other educational resources to help physicians learn about the law and—most importantly—learn the set of communication skills necessary to talk to patients about end-of-life care and the possibility of PAD.

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Naloxone

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civil liability, as well as Good Samaritan laws to protect those who administer it in an emergency.

Distributing naloxone in conjunction with training on how to recognize and handle overdoses boosts survival rates, Adams noted in a *JAMA* editorial published April 5. “An important caveat to these findings, however, is that programs and policies aimed at increasing naloxone availability must be coupled with expanded treatment for opioid use disorder to achieve a sustained reduction of overdose deaths,” he added.

“In theory, the advisory is great,” said Andrew J. Saxon, M.D., chair of APA’s Council on Addiction Psychiatry and a professor at the University of Washington School of Medicine. “Naloxone has great potential to reverse opioid overdoses in the field and probably has low risk of serious side effects.”

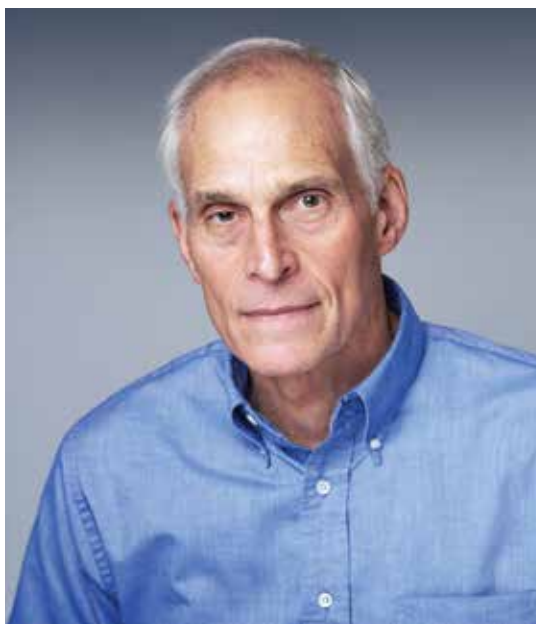
“But it can take people very quickly from nearly dead to having very abrupt, severe withdrawal symptoms,” Saxon said. The accompanying discomfort can trigger people to use more opioids to reduce withdrawal symptoms. Other practical issues may make successful widespread distribution a challenge, he added. One major concern is how to provide the necessary training so that lay people can identify someone who may have overdosed, learn how to prevent aspiration, and understand the need to summon emergency help immediately after administering naloxone. Naloxone has a shelf life of 18 to 24 months. Expired naloxone should be replaced.

Naloxone is available without a prescription in 46 states, but how a

widespread distribution will be paid for is unclear. As demand has increased in recent years for the naloxone products for community use, pharmaceutical companies have responded with massive price hikes. Narcan intranasal spray was recently retailing at a Washington, D.C., CVS Pharmacy for \$135, more than double its average price of a few years ago. And an Evzio auto-injector cost \$4,500 at that same store, more than 6.5 times its \$690 average price tag in 2014. The price hikes prompted a Congressional investigation in 2015 and at least one state, Massachusetts, to win a \$325,000 settlement from drug-maker Amphastar Pharmaceuticals Inc.

“When you think of it in terms of saving a life, the cost is trivial, but there has to be a mechanism to pay for it,” Saxon said.

Saxon is concerned that focus on naloxone will pull attention—and limited public resources—away from the urgent need to provide treatment to the more than 2 million individuals with opioid use disorder (OUD). “I think a more potentially effective intervention would be to ensure that people with the disorder are actually getting the FDA-approved medications—methadone, buprenorphine, or naltrexone—that have been shown to treat the underlying disorder and thereby prevent overdoses,” Saxon said. “Most people with this disorder are not getting the medication.”



Andrew J. Saxon, M.D., says community naloxone distribution is great in theory but in practice poses issues around cost and training requirements and may distract the public from the need for treatment.

according to the Kaiser Family Foundation, a movement by a number of states to add work requirements and other administrative hurdles to their plans jeopardizes access to OUD treatment for these individuals.

APA applauded the Surgeon General for encouraging wider distribution of naloxone. “Opioid use disorder is a significant public health emergency affecting millions of Americans, as well as their friends and families,” said APA CEO and Medical Director Saul Levin, M.D., M.P.A.

“The APA has worked with our psychiatrist members and with other medical organizations to ensure access to treatment for those affected by opioid use disorder, including the use of appropriate medications like naloxone,” Levin said. “We hope that by working together with health providers, communities, and legislators, we can turn the tide on the opioid epidemic.” **PN**

Saxon said lawmakers seeking to curb the opioid epidemic should address coverage gaps in safety net programs like Medicaid and Medicare. He noted that Medicare does not cover methadone treatment. While 4 in 10 people with OUD receive their health coverage under state Medicaid plans,

▶ The *JAMA* editorial, “Increasing Naloxone Awareness and Use: The Role of Health Care Practitioners,” is posted at <https://jamanetwork.com/journals/jama/fullarticle/2678206>. Levin’s statement is posted at <https://www.psychiatry.org/newsroom/news-releases/apa-supports-surgeon-general-recommendation-to-widen-availability-of-naloxone>.

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As an example, when “Ann” received the prescription she never took, she encountered something unanticipated. “To her surprise, having the drug at home brought a new kind of distress around knowing she could bring her suffering to an end but wanting to make sure she didn’t make the mistake of cutting it short when she might have some meaningful life left.”

Fairman added, “This is uncharted territory.”

At last year’s Annual Meeting in San Diego, Rebecca Brendel, M.D., J.D., a consultant to APA’s Ethics Committee, said the experience to date with PAD laws and the evolution of research around determinations of competence in patients with various forms of terminal illness suggest a clinical reality more complex than traditional medical/psychiatric ethics has accounted for: not all desires to die are

necessarily “suicides” as traditionally defined, but—at the same time—some desires to die may be the transient wish born of a dire situation. “We have to become more sophisticated in our thinking about different phenomenologies of patients who wish to die and how we as psychiatrists engage with them,” she said.

Fairman agreed. “We need to be careful in this space, where patients face decisions that will influence the timing of death. One way to think about this is that we ought to aim for a ‘space between two mistakes’—the mistake of saying ‘yes’ too quickly and thereby shortening meaningful life, and the mistake of saying ‘no’ too quickly and prolonging meaningless suffering.” **PN**

▶ The 2016 Data Report on the California End of Life Option Act is posted at <https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/CDPH%20End%20of%20Life%20Option%20Act%20Report.pdf>.

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