APA President Jeffrey Geller, M.D., M.P.H., emphasized the ways telehealth has allowed Americans who might otherwise be cut off from mental health services during the pandemic to receive treatment.

The hearing, titled “High Anxiety and Stress: Legislation to Improve Mental Health During Crisis,” addressed 22 pieces of legislation related to mental health care pending before Congress. Geller expressed APA’s support for legislation that would achieve the following:

- Require the Department of Health and Human Services to collect, analyze, and make publicly available data on race and ethnicity related to COVID-19 testing, hospitalization, and mortality as well as the mental health effects of the pandemic.
- Enforce the parity law, which requires insurers to cover mental health at the same levels as other medical care.
- Continue expanded telehealth rules beyond the COVID-19 emergency.

Numerous psychiatrists have put their lives on the line to care for COVID-19 patients, and some have paid the ultimate price.

A common definition of a hero is a person noted for courageous acts that help others at great personal risk. Since the coronavirus pandemic, many physicians have been called heroes by the media for their work on the front lines. This is particularly true for those working in the emergency rooms or ICU units where COVID-19 patients are being housed and treated. Early on, especially in New York, many were without adequate safety gear, intensifying their personal health risks.
FROM THE PRESIDENT
A Race for a Bigger Brain

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

This is the third in a series of articles on the history of racism in APA and psychiatry.

In the first decade of the 20th century, as reported in the American Journal of Insanity (which became the American Journal of Psychiatry in 1921), the accepted belief by educated white people was that there were almost no Black people in the United States. Rather, there were “colored” people who were the product of generations of the offspring of white men and Black women. The offspring of white women and Black men were thought to be so small in number as to fail to contribute to the size of the overall U.S. population. (Frederick O’Malley, considered an expert in race at the time, said in what was more hubris than science, “No considerable crossing of the negroes with the white females has ever taken place.”)

In 1914 Dr. Mary O’Malley, a psychiatrist at Saint Elizabeths Hospital in Washington, D.C., wrote in the journal that the so-called “mulatto” learned more easily, the facial angle in the mulatto is larger than in the negro; that the cranial capacity has been increased, but that there has been no increase in the vital force; that the race may have gained in an intellectual way but not in a moral. The reason is that while the “mulatto” learned more easily, the Black person worked harder at it and excelled above people of a mixed race. O’Malley also pointed out that the colored race (“colored” is her term) was awash in self-deception so the histories they provided about themselves are contaminated with inaccuracies. They also lacked the ability to use the experiences of their own lives to influence their present behaviors. “They dwell in the present, and neither the past nor the future is taken into account.” This, she indicated, explained why colored people were so superstitious. Moreover, she continued, the ignorance of colored people led them to pay no attention to hygienic practices, to eat and drink to excess, and to engage in promiscuous relations.

As I indicated in my previous column (see https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2020.7b27), in 1910 these behaviors were believed to have been occurring for the last 50 years because “colored” people were no longer under the “rigorous supervision of the master.” With this perspective, O’Malley conducted a study comparing mental illness in white (n=455) and “colored” (n=345) women who had been patients at St. Elizabeth’s Hospital.

O’Malley found that the increase in mental disorders in Black people was “obvious” since they had attained their freedom; the symptoms of psychosis and prevalence of dementia praecox (schizophrenia) were not different from whites’; bipolar disorder was uncommon and hysteria rare in Black people; Black people were immune to the effects of alcohol; and involutional melancholia and depression were rare. That depressive syndromes were rare in Black people was because “these individuals do not react to the graver emotions—grief, remorse, etc.—owing to the fact that they have no strict moral standards and no scrupulosity as to social convention and the absence of self-deprecatory ideas of sin.”

Racist Assumptions Won Out Over Facts

When O’Malley began her study, why did she think she would find a difference in mental illness between continued on facing page

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APA’S COVID-19 RESOURCE CENTER

This regularly updated site brings together a number of resources from APA and other authoritative sources to help members stay informed of changing government regulations and other practice-related news and care for their patients and themselves. It can be accessed at psychiatry.org/coronavirus.
whites and Blacks? The answer does not lie in social determinants of health; racial differences in access to health care; or different diets, educational opportunities, or parenting styles. The answer is embedded in the concept of the “colored” or “negro” brain as it was referred to then. When one did find Black people in hard-life conditions, these were not contributors to mental illness, but the results of a brain exposed to more than it could handle. Dr. Charles Edward Woodruff, in a 71-page article in the journal in 1901, went so far as to say degeneration and disease had progressed so far in Blacks that he thought they were headed to “inevitable extinction.” Long before O’Malley was conducting her research, there had been pushback against the commonly held belief that Black people were inferior because their brains were smaller and structurally different from whites. Friedrich Tiedemann, a German expert in brain anatomy and a “Foreign Fellow” of the Royal Society of London, gave a talk to that group in 1837. He emphatically stated his studies had led him to conclude that the size of brains in white people and in Black people did not differ, that there was no difference in the internal structure of the brain between the two races, and that the Black brain bore no more resemblance to the brain of an orangutan than did a white brain. Tiedemann went on to say that “the apparent inferiority of the Negro is altogether the result of the demoralizing influence of slavery and the long-continued oppression and cruelty which have been exercised towards this unhappy portion of mankind...” History tells us his work neither persuaded the professional community nor the general population.

In the November 1894 issue of *Sewanee Review*, America’s oldest continuously published literary quarterly, the author of “The Material Advancement of the Negro” stated with absolute certitude, “The physiologist sees in the negro the lowest physical and mental order of the human being. The structure of the native African is so unanal-ogous to that of the Caucasian, that even so eminent a scientist as Mr. Darwin hesitated to designate him as higher than a sub-species of mankind.” An article in the *American Anthropologist* in 1896 described the Black man as “an example of arrested or retarded development.” The brain of the Black person was described in the same period in the journal *Alienist and Neurologist* as “sluggish and uncultivated brains for vigorous and effective action.” In that decade, it was thought that recent work was confirming that of earlier “cranologists”: They believed that there was a material difference in the shape and dimension of the heads of white people and Black people. (This ignores Tiedmann’s work.) But no one had yet done a systematic study.

**Scientific** Debate Continues

This was to be rectified by Robert Bennett Bean, an anatomist and self-appointed world expert in the comparison between the white and the Black brain. In 1904 he reported to the Association of American Anatomists the results of his analysis of 37 brains from Black people and 17 from white people. Further study brought that number to 103 brains of Black people and 49 of white people. His article in the *American Journal of Anatomy* has more charts, tables, and figures than an entire issue of the *American Journal of Psychiatry* does today. After making his measurements, examining the brain from different angles, looking into sulci, weighing brains, and looking at gender effects, Bean concluded the following:

- **Black brains are smaller than white brains, especially in the frontal lobes.**
- **The less white blood that has mixed in with Black blood, the more accurate one can be in distinguishing between white and Black brains.**
- **The anterior half of the corpus callosum is smaller in Black brains than white brains.**
- **From these structural differences, he deduced the following:**
  - Black people are more objective; white people more subjective.
  - Black people have lower mental facilities well developed (for example, smell, sight, handcraftsmanship, body-sense, and melody).
  - White people have higher mental facilities well developed (for example, self-control, willpower, ethical and aesthetic senses, and reason).

Bean had largely succeeded in his intent to show there were differences between the brains of the two races. He had a problem, however. He did not find a difference in the weight of Blacks’ and whites’ brains. According to Bean’s pre-conceived notions, the brains of Black people should have weighed less. In an ingenious display of pseudoscientific hocus-pocus, Bean said that the reason there was no weight difference was because he was comparing the brains of a disproportionate number of high-class Blacks and low-class whites. He presented five reasons that it turned out this way, each more racist than the next and all focused in one way or another on his belief that Blacks have “less respect for the dead.” One example: “It is generally known that the low-
est class of whites is unclaimed, especially among women, who are apt to be prostitutes, or depraved, or the like, while among Negroes it is known that even the better class neglect their dead unless provision has been made for their care after death.” Bean agreed with a predecessor that the white brain was a “greyhound” while the Black brain was a “bulldog.”

Bean’s mentor, Franklin P. Mall, dis-pleased and distrusting of Bean’s results, conducted his own study in 1909, even using some of the same brains as had Bean. Mall’s results did not support Bean’s measurements. Mall challenged each man of medicine who had posited racial differences between the brains of the two races, dissecting their methods and outcomes with the precision of a pathologist with his dissecting tools. Mall concluded that all earlier work on the brains needed to be dismissed, and new data, scientifically studied, were needed.

Bean was not about to be deprived of his racist views on brain differences. In 1914 he published another article, carrying on as though Mall had never studied anything. He found the temporal lobe was smaller in Blacks’ brains. But of course he did!

Once the white-Black brain differences were “proven,” it became a “fact,” written as if in indecipherable ink. In a 1934 article in *Science* from the Johns Hop-
kins School of Hygiene and Public Health, the authors reminded the reader, “It is an accepted view that the skull capacity and the brain weight of the Negro, whether pure or mixed with white races, tends on the average to be smaller than the same dimensions in whites.” They then wrote, “The amount of precise data upon which this opinion rests is, however, meager.” This is a rac-
ist introduction to the authors’ review and amounted to quack science. As men of science, they could have instead written, “There are meager data in sup-
port of the belief that the Black brain is smaller than the white brain.”

In 1957, when reliable measure-
ments were possible, a comparison of white and Black brains using an electroencephalogram showed no signifi-
cant differences. Nonetheless, the ques-
tion of the white-Black brain compari-
sons didn’t disappear. In 1969 a South African in the Department of Medicine at the University of Cape Town proclaimed that all the so-called evidence that had gone before—about 150 years’ worth—was based on insub-
stantial evidence. In 2010 an article on variability in frontotemporal brain structure began, “The question about potential differences in brain anatomy across populations of differing race and ethnicity remains a controversial issue.” These researchers found that the only difference between white and Black brains was that the left orbito-frontal cortex was larger in Blacks. And in 2020, an unreplicated brain study showed that Black people experience more pain than white people to the same stimuli in a lab. In the 21st century we have fine-
tuned our understanding of brain development. Brain development is sensitive to many factors including socioeconomic factors. If there are reliable and valid differences between white and Black brain structure and size, what we are observing may well be the differential effects of white and Black socioeconomic environments and not a difference due to skin color. We should stop looking at whose brain is bigger and start looking at how we can get everyone’s brain directing us to work together. Maybe then “We shall overcome.”


**Consider Becoming an APA Officer or Trustee**

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

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

APA encourages you to consider a nomination to diversify the elected leadership of APA. APA members believe that the professional issues of most importance to you are ad-dressed. More information about APA’s election and nomination requirements are posted at psychiatry.org/election.
APA Task Force Charged With Examining Structural Racism Throughout Psychiatry

APA President Jeffrey Geller, M.D., M.P.H., and Task Force Chair Cheryl Wills, M.D., answer questions about the task force, including its composition and goals.

APA President Jeffrey Geller, M.D., M.P.H., announced the formation of the Presidential Task Force to Address Structural Racism Throughout Psychiatry during a virtual town hall on June 15. The town hall, titled “Member Town Hall—APA Addresses Structural Racism, Part One,” was held in response to spreading protests against systemic racism and demands from psychiatrists that APA examine structural racism within the Association and the profession (see Psychiatric News, https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2020.7a34).

The charge of the task force is broad—it covers identifying structural racism, educating people about it, and proposing solutions in several areas in which structural racism has resulted in negative outcomes for minorities including within APA and with regard to access to care, treatment, hospital and clinic administration, health insurance, and psychiatric academia.

It is a massive endeavor, and we understand the need to clean our own house first. But as we look inward at APA, we also intend to educate our members about structural racism to begin to change a culture that has had such a serious health impact on Black Americans for 400 years. (In 1619 the first slaves, about 20 of them, arrived in what would become the United States, landing in what would become the state of Virginia.)

The task force held its first meeting on June 27 and conducted its first survey, which addressed the mental health care of Black patients. The results are posted at http://apapsych structural racial survey 1.

The task force is planning a second virtual town hall for August 24 (see box on facing page).

APA CEO and Medical Director Saul Levin, M.D., M.P.A., said that for APA, this is a time for reflection, knowledge, accountability, and action. “I am committed to ensuring that this task force, coupled with important actions by our organization, our leadership, our entire membership, and our administration under my supervision, helps us dismantle systemic racism in our communities.”

Chairing the task force is Cheryl Wills, M.D., APA Area 4 trustee. Other members include Renée Binder, M.D., former APA president; Frank Clark, M.D., an APA delegate to the AMA’s Section Council on Psychiatry; Charles DiKe, M.D., M.P.H., a member of the Ethics Committee; Mary Jo Fitz-Gerald, M.D., M.B.A., speaker-elect of the APA Assembly; Danielle Hairston, M.D., president of the APA Caucus of Black Psychiatrists; Hunter McQuistion, M.D., a community psychiatrist; Michele Reid, M.D., APA trustee-at-large; Steven Starks, M.D., chair-elect of the Assembly Committee of Minority and Underrepresented Groups and the Assembly representative of the Caucus of Black Psychiatrists; Richard Summers, M.D., APA treasurer; and Sanya Virani, M.D., M.P.H., APA’s resident-fellow member trustee.

Below Geller and Wills answer questions they have received about the task force.

Dr. Geller responds:

Q: What is your objective in creating the Task Force to Address Structural Racism Throughout Psychiatry?
A: As I have mentioned in my prior articles, racism is not new to psychiatry. Throughout our history, we have marginalized and discriminated against minority psychiatrists and minority patients. This has significantly impacted Black Americans, who, because of their unwilling arrival in this country and history of maltreatment, discrimination, and segregation (which existed legally in my lifetime) have been marginalized in terms of education, health care, employment, and housing.

One result of this history is a culture in which Black psychiatrists are underrepresented in academia, psychiatry, and leadership positions, and Black patients suffer more from chronic medical illness and untreated mental illness because of lack of access to care. Even those who receive treatment are often misdiagnosed because psychiatrists are not trained to account for Black patients’ trauma or their lived experiences.

Q: Why did you include members of the Board of Trustees?
A: As I mentioned, part of the task force’s charge is to evaluate structural racism within APA. I included Board and Assembly members who are familiar with APA’s organizational and governance structure and can be leaders in making changes to ensure that APA as an organization is inclusive of minority members in its operations and leadership.

Q: What is the charge of the task force?
A: Focusing on organized psychiatry, psychiatrists, psychiatric trainees, psychiatric patients, and others who work to serve psychiatric patients, the task force is initially charged with the following:
1. Providing education and resources on APA’s and psychiatry’s history regarding structural racism.
2. Explaining the current impact of structural racism on the mental health of our patients and colleagues.
3. Developing achievable and actionable recommendations for change to eliminate structural racism in APA and psychiatry.
4. Providing reports with specific recommendations for achievable actions to the APA Board of Trustees at each of its meetings through May 2021.
5. Monitoring the implementation of tasks 1 to 4.

Structural racism has significantly influenced institutional racism and bias in our organizations. We are starting with structural racism as it affects Black individuals, but this is a long-term task. I will seek to continue the task force as a committee or some other component of APA to ensure that the work continues and expands to encompass other minority groups. This cannot be a “one and done” proposition.

Q: Why did you not include members of other minorities on the task force?
A: At this moment in history, in the midst of national protests about unnecessary killings and violence against Black individuals and considering psychiatry’s long history of racism against Black psychiatrists and patients, it is appropriate to begin with the interests of Black people first.

Q: How does the task force intend to address concerns expressed by other underrepresented racial/ethnic groups?
A: While some of the issues cross minority populations, each minority population has unique issues. With respect to the APA structure, I believe that any changes that are made will impact all minority populations, and therefore, the task force is seeking input from APA’s minority and underrepresented caucuses (M/UR) along the way. With respect to M/UR populations’ treatment outside of APA, each group may have different concerns. We are counting on our caucuses and members to bring these concerns to the task force and to work with the task force to identify problems and propose solutions. In addition, I have convened a Board work group to propose a definition of “minority APA member,” a definition that exists now only in the Assembly.
but not in APA as a whole. This action will benefit all minority groups.

Q: Will the scope of the task force’s work extend to addressing racism experienced by patients?

A: There are areas in which APA can help to address racism experienced by patients. For example, APA can be instrumental in educating psychiatrists about how race, trauma, and lived experiences can influence diagnosis and treatment; we can consider racial issues in practice guidelines and in DSM; we can help our members understand how implicit bias may impact their own and others’ treatment of diverse patient populations; and we can ensure that materials produced by APA for the purposes of improving patient care are themselves devoid of all racial insensitivities, bias, and misleading information.

APA also continues to advocate for mental health parity, increased payment for psychiatrists from insurance plans to encourage more members to participate in insurance plans, expanding the Affordable Care Act, and improving access to care.

Q: What work products (“deliverables”) do you expect the task force to develop that will work toward the eradication of racism in psychiatry?

A: I have asked the task force to deliver achievable recommendations to the Board before the next Annual Meeting. The task force has already delivered several work products including the June town hall and has scheduled a second town hall on August 24 to help members learn more about structural and institutional racism and its impact on psychiatrists and patients. The task force has also conducted a mini-survey on how structural racism impacts patients to educate members, whose results are posted at http://apapsy.ch/Structural_Racism_Survey1 and created a website with materials aimed at educating our members and the public about racism; free CME courses for members about how unconscious bias, racism, and microaggressions impact patient care; and definitions of racism, structural racism, institutional racism, equity, and unconscious bias to ensure that we have a common lexicon when discussing the issues. Members should check psychiatry.org/TaskForce for continual updates.

Q: Can members contribute comments that might inform the deliberations of the task force?

A: Absolutely. The task force welcomes comments, ideas, and suggestions. We encourage everyone to participate in the mini-surveys and to send comments to SRTaskForce@psych.org.

Q: How do you plan to study racism at APA and change the current culture?

A: Absolutely. The charge of the task force is huge and will “take a village” to fulfill. Prior to the first meeting of the task force, I had discussions with senior leaders in psychiatry, many of whom are members of M/UR groups, and I have used their valuable feedback to inform how the task force conducts its business. I expect task force work groups to consult with member experts.

I have also met with all of the presidents of the M/UR caucuses to ask that they begin engaging in projects within their caucuses to address issues of institutional racism within APA and within psychiatry that are specific to their minority group and to bring those issues to the task force so we can all work together on resolutions.

Q: Members have already been asked to respond to surveys on structural racism. What are these about, and will there be more?

A: These are brief surveys that enable the task force to get the pulse of the membership on topics and help to frame the issues that are most important to our members and their patients. We received about 450 responses to our first survey but would like to have more member engagement on them. The results of the first survey, which addressed the impact of structural racism on our patients, is posted at http://apapsy.ch/Structural_Racism_Survey1. The second survey asked members about structural racism in APA and closed earlier this month. We expect to have a few more short surveys on other topics as we move along. The information is being used to inform the task force of the most pressing issues for our members and helps us to prioritize our work.

Q: How do you plan to study racism at APA and change the current culture?

A: There are two parts to this answer. The first is the APA governance structure, which I’ve discussed above. Also, we will identify educational resources for APA members and leadership that will enhance our understanding of institutional racism and how bias has or can influence decision-making. We encourage all APA district branches to do the same. Each group in organized psychiatry has a duty to look inward—to identify and accept that there are flaws and to make

Save the Date
Town Hall - APA Addresses Structural Racism, Part Two: The March Continues Monday, August 24, 8 p.m. to 9:30 p.m.

Join APA leadership and an esteemed panel for a virtual town hall to commemorate the 57th anniversary of the March on Washington in August 1963. The March drew attention to the continuing challenges and inequalities faced by Black Americans a century after emancipation. It is also where the Rev. Martin Luther King Jr. gave his now-iconic “I Have a Dream” speech.

The town hall will examine these issues:

- How the Black Lives Matter movement is an outgrowth of the civil rights initiatives reducing the inequalities faced by Black people.
- How racial injustices impact the health and well-being of children and families.
- How far we still must go to address structural racism.

APA Past President Altha Stewart, M.D., and AMA Chief Health Equity Officer and Group Vice President Aletha Maybank, M.D., will join APA President Jeffrey Geller, M.D., M.P.H., to discuss how structural racism plays a role in these inequalities and propose solutions to improve Black Americans’ mental health outcomes.

A registration link is posted at psychiatry.org/taskforce.
APA Board Approves New Codes for Suicidal Behavior and Nonsuicidal Self-Injury, Discusses Major New Initiatives

APA Trustees engaged in lively discussion on a broad range of issues at last month’s virtual meeting and approved more than 20 new or revised position statements.

APA’s Board of Trustees approved the addition of definitions and descriptive texts and associated International Classification of Diseases 10th Edition-Clinical Modification (ICD-10-CM) codes for suicidal behavior and nonsuicidal self-injury. The changes will be made to the chapter “Other Conditions That May Be a Focus of Clinical Attention” in Section II of DSM-5-TR.

The Board’s virtual meeting in July encompassed a wide range of issues including early reports from the APA Task Force on Structural Racism Throughout Psychiatry and the Work Group on the Assessment of Psychiatric Bed Needs—both high priorities of APA President Jeffrey Geller, M.D., M.P.H.

The approval of the addition of the associated ICD-10-CM codes and descriptive texts on suicidal behavior and nonsuicidal self-injury came at the request of APA’s DSM Steering Committee. Committee Chair Paul Appelbaum, M.D., told Psychiatric News after the Assembly approved the codes in May that Assembly and Board approvals are usually reserved only for changes to mental disorders listed in their respective chapters in Section II. However, explicit approval was sought in the case of the ICD-10-CM codes and descriptive text on suicidal behavior and nonsuicidal self-injury “because of the clinical and public health significance of these categories.”

The committee’s report to the Assembly stated: “Even when clinicians are primed to identify and record a history of suicidal behavior or ideation, its documentation is unreliable. The risk of not recording suicidal behavior would be reduced if it were a codable entity in DSM-5-TR, as such conditions are typically conserved during hand-offs and in discharge summaries.”

The committee’s report also stressed that “having a freestanding ICD-10-CM code for suicidal behavior helps to recognize that suicidal behavior occurs across conditions from schizophrenia to autism, not only as a depressive symptom.”

DSM-5-TR is scheduled for release next spring, in conjunction with APA’s 2021 Annual Meeting in Los Angeles.

At last month’s meeting, Trustees also discussed structural racism within APA and the profession of psychiatry and the formation of the Task Force on Structural Racism Throughout Psychiatry (see page 4). Task Force Chair Cheryl Wills, M.D., said the composition of the task force—including subject matter experts and current and past Board members—was designed to help produce “actionable items” the Board could approve that would address structural racism.

Danielle Hairston, M.D., president of the APA Caucus of Black Psychiatrists, called structural racism “a system of policies and practices that perpetuate racial inequality” and drew attention to a powerful article by Resident-Fellow Member Trustee Michael Mensah, M.D., M.P.H., in the New England Journal of Medicine titled “Majority Taxes—Toward Anti-racist Allyship in Medicine.”

Mensah is a PGY-4 chief resident at the Semel Institute for Neuroscience and Human Behavior at the University of California, Los Angeles.

The Board meeting was also the occasion for the formal introduction of the APA President’s Ad Hoc Work Group on the Assessment of Psychiatric Bed Needs. Past APA President Anita Everett, M.D., chair of the work group, told Trustees, “The holy grail of system design is understanding how many psychiatric beds in a given community would be necessary to serve the needs of that community.”

(For further coverage of the work group, see the August 21 issue of Psychiatric News.)

Everett said the work group is charged with researching, assessing, and developing recommendations regarding the current capacity of inpatient psychiatric care in the United States. It will accomplish this through a series of subgroups that are charged to work on the following:

• Review the historical and current context of access to psychiatric care.
• Assess the current funding model and identify financial barriers.
• Identify community resources that might mitigate the need for inpatient care for the treatment of mental illness.
• Review disparities and equity in accessing treatment.
• Address the critical shortage of inpatient treatment and services for children.

Geller noted that the lack of availability of inpatient beds drives problems throughout the mental health system. In his address at APA’s Spring Highlights Meeting (a virtual two-day meeting that was planned after APA was unable to hold its 2020 Annual Meeting), Geller said, “Fundamental to extricating ourselves from the current quagmire of services for persons with mental illness is getting to the right number of psychiatric beds.”

Trustees also approved more than 20 new or revised position statements. Among them are the following:

• Issues pertaining to capital sentencing and the death penalty. There should be a moratorium on capital punishment in the United States until jurisdictions seeking to reform the death penalty implement policies and procedures to assure that capital punishment, if used at all, is administered fairly and impartially in accord with the basic requirements of due process.

• Leadership of academic departments of psychiatry. APA strongly believes that training programs in Departments of Psychiatry must be chaired by a psychiatrist. No other mental health professionals have similar training or the same priorities as psychiatrists, and psychiatry residents need strong physician role models in leadership positions. The Accreditation Council on Graduate Medical Education should ensure that psychiatry accreditation standards reflect this position.

• Consent to mental health treatment by guardians, health care agents, or other legally designated surrogate decision-makers for adults with mental illness. When a person has been reliably determined to lack decisional capacity according to applicable law, guardians, health care agents, or other surrogate decision-makers should be legally empowered to make any mental health treatment decisions, including for psychiatric hospitalization, medication, and electroconvulsive therapy to which the person would otherwise be entitled to make for him- or herself. In the case of a health care proxy, if the person has specifically limited the authority of the agent regarding any treatment decisions, those limitations must be respected.

Psychiatrists Continue to Advocate During Pandemic

Alan Levy, M.D., and Nita Bhatt, M.D., M.P.H., expressed support for telehealth and mental health parity during a virtual congressional town hall. They also share their experience as advocates and urge other members to get involved—especially at this crucial time. **BY KATIE O’CONNOR**

Despite the continuing COVID-19 pandemic and associated physical distancing orders, psychiatrists are still finding ways to engage with lawmakers and advocate on professional issues and for their patients.

Last month, two Ohio psychiatrists participated in a virtual town hall with Rep. Troy Balderson (R-Ohio) along with physicians from other specialties to share what legislation and regulatory policies are needed in response to the COVID-19 pandemic.

Nita Bhatt, M.D., M.P.H., and Alan Levy, M.D., both members of APA’s Congressional Advocacy Network, emphasized to Balderson the need to extend relaxed telehealth regulations beyond the pandemic and to enforce mental health parity laws. Bhatt is an assistant professor of psychiatry at Wright State University, and Levy is a past president of the Ohio Psychiatric Physicians Association (OPPA) and chair of OPPA’s Telepsychiatry Committee.

“This was a unique opportunity because it was the first town hall of its type,” Bhatt said. “It allowed me to advocate with physicians from across the nation practicing in a diverse range of specialties including orthopedic surgery and emergency medicine.”

During the virtual town hall, Bhatt and Levy expressed support for the Mental Health Parity Compliance Act (HR 3165), sponsored by Reps. Katie Porter (D-Calif.), Gus Bilirakis (R-Fla.), and Donald Norcross (D-N.J.). The legislation would ensure health plans are transparent and accountable in covering treatment for mental and substance use disorders equal to that for other medical conditions.

Balderson has already indicated his support of telehealth, Levy said. “We were really preaching to the choir.” Levy added, however, that it’s still invaluable for psychiatrists to express their views even to legislators who appear to agree with them.

“It’s one thing to try and secure a legislator’s vote, but it’s another to have that legislator share the passion that we have for the bills because then they see Advocacy on page 23

Physicians across specialties expressed support for telemedicine during the town hall, says Nita Bhatt, M.D., M.P.H. “Even dermatologists were advocating for telemedicine,” she says.
Pandemic Hits Health Care, Psychiatrists With Financial Losses

The COVID-19 pandemic is impacting health care systems across the country as well as physicians in private practice. BY KATIE O’CONNOR

Nicole Christian-Brathwaite, M.D., counts herself lucky. As the COVID-19 pandemic has ravaged the finances of the health care system across the country, the Massachusetts health plan that covers most of the patients in her private practice agreed to cover telepsychiatry at the same rate as in-person care, so her core salary remains intact. But many of her patients have lost their jobs, which means they have also lost their insurance, so she instituted a sliding-scale model. Some pay $50 a session, while others have not been able to pay anything. “Obviously, there’s some financial strain on my part,” said Christian-Brathwaite, a child/adolescent and adult psychiatrist. “But people have lost so much that the last thing they need to lose is their psychiatrist.”

Almost every sector of the U.S. health care system has experienced financial loss due to the COVID-19 pandemic, and psychiatrists have not been immune. In many settings in which psychiatrists work—including general and psychiatric hospitals, private practice, university medical centers, and others—they are at risk of incurring a substantial financial loss, explained Robert Trestman, M.D., Ph.D., the chair of APA’s Council of APA members from New Hampshire, Connecticut, Maine, Vermont, New York, New Jersey, Delaware, Maryland, Washington, and the District of Columbia.

In a survey of 217 APA members from May 30 to June 10, 73% of respondents reported that they had experienced a financial loss due to COVID-19, and nearly 60% lost between 1% and 30% of their income. Of those respondents who receive an annual salary, 3% reported that they had been furloughed.

In June the American Hospital Association estimated that U.S. hospitals and health systems could lose at least $323.1 billion in revenue in 2020. “And while potentially catastrophic, these projected losses still may underrepresent the full financial losses hospitals will face in 2020,” a news release stated, adding that the analysis does not account for increasing case rates of COVID-19 in some parts of the country or with potential surges in cases later this year.

Psychiatrists who are employed through health systems have likely experienced salary cutbacks, Trestman said. Many have received at least a 5% to 10% salary reduction and some even more.

Additionally, private practices are also likely to take a financial hit during the pandemic, Trestman said. “Most small practices were not designed to have to go through a major change like moving directly from in-person appointments to telepsychiatry,” he explained. Psychiatrists in private practice had to come up with new billing strategies and develop the infrastructure to connect with their patients virtually. Many also had the extra work of pestering health plans to receive proper reimbursement.

Dan Bristow, M.D., is the immediate past president of the Oregon Psychiatric Physicians Association (OPPA). He has been working exclusively in telepsychiatry for the past several years, so the COVID-19 pandemic didn’t change much about his practice. But robustly as they did for in-person care.

Oregon enforces telemedicine parity, Bristow said, so in some cases it has simply been a matter of reminding psychiatrists that if they are paneled with an insurance plan that pays for in-person services, that plan is obligated to pay the same for telepsychiatry.

“In states without parity, psychiatrists would probably be significantly impacted financially,” he said. “For people in an independent practice, this is a tremendous burden in a time when everybody is already personally burdened with COVID-19. You have to wear two or three different hats just to keep your practice going.”

Concerns About the Future

Before the pandemic, psychiatric and mental health care in general were already seriously underfunded, Trestman pointed out. Now, experts worry about what the financial climate will mean for mental health care in the future.

“One of the ways society’s stigma of mental illness was reflected in the underfunding of psychiatry, such that it’s unusual in any general hospital for the psychiatry department to break even,” Trestman said. Psychiatry, he said, is structurally not designed for sustainability and must instead be cross-funded by other disciplines.

“For-profit health care systems have even less of a need to focus on psychiatry, and at times like these, they’re very likely to disinvest to reduce their costs,” Trestman said. “Virtually every health care system in the nation has lost an enormous amount of money over the last three months. The money that would have been used to cross-subsidize psychiatry from the generally profitable areas, such as elective surgery, is gone.”

But the current situation also creates an opportunity, Trestman said, to renegotiate appropriate compensation for psychiatry so that it is feasible for health care systems to continue to invest.

He pointed out that these financial issues are occurring while there is a growing need for mental health care.

ON MENTAL HEALTH, PEOPLE, AND PLACES

Black Identity Politics and Psychiatry

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

The sequestration caused by the present pandemic has produced for me at least one beneficial outcome: The time to reread and ponder articles published some time ago. I returned recently to a piece by Harvard Professor Orlando Patterson titled “Being and Blackness” and published in The New York Times Book Review (January 8, 2006). In it, Patterson comments on two books. However, my interest here centers only on Tommie Shelby’s We Who Are Dark: The Philosophical Foundations of Black Solidarity (Harvard University Press, 2007).

Patterson makes clear from the start that Shelby dismisses “the notion of an inherent or essential black identity, the idea that one shares some deep-seated common bond or kinship with all black people by virtue of being black.”

Shelby disposes, too, of the idea that “being black means one is, or ought to be, culturally black.” In contrast, Patterson states that Shelby promotes a form of pragmatic nationalism that advocates Black solidarity, despite the racial composition of the political organization in which Blacks and whites may be operating. Patterson claims that Shelby’s Black solidarity is characterized by “special concern, loyalty, and trust” that is distinct from notions of a color-blind liberal reform effort. This Black solidarity is related to Blacks’ history of slavery and race-based discrimination.

I had to be attentive in reading this analysis, as Patterson notes that Black solidarity in this form may not be the solution in every context. For example, Blacks must understand that the socioeconomic challenge they will confront in the United States may not always be linked to their blackness. Still, Shelby seems to grant that Blacks legitimately have “shared political interests” related to their “racial subordination and their collective resolve to triumph over it.”

I confess there is a certain laziness in making excursions into philosophical territory through the eyes of another scholar. However, in this case I felt the trip worthwhile, as it provided a different view of the current context surrounding the struggle over Blacks’ rights and privileges in modern America. Tommie Shelby’s work also clarified for me the new eruptions of Black-white discord within APA. Yes, Black members of APA palpably upset about their perceived treatment within the...
Drug Overdoses Surge Due to Pandemic, Early Reports Show

Though it will take months to finalize the data, preliminary reports show that drug overdoses have increased since the pandemic began. **BY KATIE O’CONNOR**

Since the beginning of the COVID-19 pandemic, substance use disorder (SUD) experts have warned that individuals with SUDs are likely to struggle even more as they face isolation and disruptions in access to care. Though it can take months to finalize data on fatal and nonfatal drug overdoses, preliminary reports are proving those experts right.

The Washington Post reported last month that state and local offices across the country are reporting spikes in drug overdoses. A May report by the Overdose Detection Mapping Application Program (ODMAP), a federal overdose tracking initiative, focused on six unnamed states with reliable overdose data. In two of those states, ODMAP found that there was a statistically significant rise in overdoses since the pandemic began. From January to April nationally, there was a 16.6% increase in suspected overdoses compared with the same period last year. “A comparison of raw numbers yields an increase of 11.39% for fatal overdoses and an increase of 18.64% for nonfatal overdoses during that same time period,” the report stated.

According to Politico, James Carroll, director of National Drug Control Policy in the Executive Office of the President, said that experts expect the death count to continue to rise, especially as not all states have reported their data yet. “These trends are very concerning, but they’re also not surprising,” said Elie Aoun, M.D., a general addictions and forensic psychiatrist at Columbia University and a member of APA’s Council on Addiction Psychiatry. “I’ve seen relapses in my practice, and many people I’ve spoken to have seen similar issues.”

Feelings of isolation and depression can push people in recovery to use drugs again, he explained. “Someone with an addiction is going to say, ‘The way I’m feeling now, during the pandemic, in terms of social isolation and lack of support feels exactly how I felt when I used drugs,’” he said.

Yet their access to SUD treatment may also be complicated by the pandemic and the associated inadequate public health response.

Between April 27 and May 8, the Addiction Policy Forum conducted an anonymous survey of its nationwide network of patients with SUDs, those in recovery, and family members of people with SUDs. Of the 1,079 respondents, 34% reported changes or disruptions in accessing treatment or recovery support services.

Kaiser Health News reported that some drug rehabilitation centers around the country have experienced COVID-19–related difficulties, such as outbreaks of the virus or associated financial difficulties that have forced them to close or halt admissions.

The people who may be hurt most by the pandemic are those who are still using drugs or seeking treatment, Aoun explained. “It takes a lot of effort to take that first step and say, ‘Drugs are not working for me anymore, and I need to do something about it,’” he said. The pandemic makes that first step even harder.

Simultaneously, there have been some disruptions in the drug supply. Dealers who may have been considered reliable in the past may be unavailable, causing people to turn to new and unfamiliar dealers and substances, Aoun explained, which may increase the risk of overdose.

When the pandemic first began, some people began to stockpile drugs out of fear that there would be supply chain disruptions, Aoun said. “We know people with addictions are not known for appreciating future rewards,” he said. “They focus on the immediate rewards, and if these drugs are available, they’re going to use them, and this definitely promotes overdoses.”

He added that, despite the challenges that people with SUDs are experiencing, he has seen communities come together in unprecedented ways. “Because of the pandemic, people struggled with finding purpose in their life, and a lot of them ended up serving others,” he said. “They found purpose in creating support systems for the elderly and people with addictions, reaching out to them. These small gestures of hope have brought us together.”

“Cries for Help: Drug Overdoses Are Soaring During the Coronavirus Pandemic” is posted at https://www.washingtonpost.com/health/2020/07/01/coronavirus-drug-overdose/


—continued from facing page—

Association, and the present national climate reinforces their irritation.

There is little point in fanning the flames of discord here in a brief commentary. Still, I have talked with APA members on different sides of the debate and have reached the conclusion that the organization’s leadership has more work to do in structuring the discourse. Some of this further effort will require clearer avoidance of rigid boundaries and arguments that emphasize power and legalistic positions. I acknowledge the important step taken by our president, Dr. Jeffrey Geller, in establishing the Task Force to Address Structural Racism Throughout Psychiatry. I have hopes for its advancement of conversations among our diverse constituencies and emphasis on mutual and attentive listening.

This is 2020, not 1969. Blacks want seats at the influential tables of APA, and whites must understand that Blacks are tired of repeated begging. Such behavior is below the new standard of dignity for minority group members. Blacks must in turn appreciate that they


PROFESSIONAL
NIMH Releases 2020 Strategic Plan for Research

The latest document guiding NIMH’s research priorities will maintain the same core principles it has had for the past five years, but will now live as an online document that will be regularly updated as discoveries are made and new opportunities arise. BY NICK ZAGORSKI

The National Institute of Mental Health (NIMH) has released an updated Strategic Plan for Research. The 2020 plan builds on successes of previous NIMH strategic plans, remaining focused on the following four core goals:

• Define the brain mechanisms underlying complex behaviors.
• Examine mental illness trajectories across the lifespan.
• Strive for prevention and cures.
• Strengthen the public health impact of NIMH-supported research.

Together, these goals provide a framework to direct institute resources to research that spans the mental health continuum over the next five years—from the fundamental neuroscience underlying human behavior to new treatments for mental illness that can benefit patients today.

There have been significant advances in neuroscience and mental health care since the NIMH released its 2015 strategic research plan, NIMH Director Joshua Gordon, M.D., Ph.D., wrote in the introduction to the plan. “In translational sciences, we celebrated the U.S. Food and Drug Administration (FDA) approval of two of the first truly novel antidepressants in decades—esketamine for treatment-resistant depression and brexanolone for postpartum depression,” he wrote. “And in intervention research, NIMH-sponsored studies proving the utility of coordinated specialty care for first-episode psychosis resulted in the nationwide implementation of this evidence-based care model through state-supported mental health clinics.”

Despite these advances, many challenges—including the continual rise in suicide rates across people of all age groups, genders, races, and ethnicities; inequitable access to mental health care; and stigma—remain, Gordon wrote. “These challenges must be met by harnessing promising opportunities. The NIMH Strategic Plan for Research maps out our path,” he continued. “From basic research aimed at understanding how the brain produces behavior, to translational efforts to uncover novel treatment targets, to clinical studies testing novel approaches, we’ve charted numerous routes linking these challenges and opportunities. Each has the potential to deliver significant advances in mental health care.”

In a column published in JAMA Psychiatry, Gordon and NIMH colleagues Shelli Avenevoli, Ph.D., and Jane Pearson, Ph.D., expanded on the institute’s vision for suicide prevention. Noting that recent studies have demonstrated the feasibility of suicide screening and interventions in high-risk settings such as emergency departments, Gordon and colleagues hope to bring more suicide prevention into routine care over the next five years. Some research goals include bundling suicide prevention into a collaborative care model, refining algorithms that scan electronic health records to predict people at high suicide risk, and identifying more rapid-acting medications like esketamine that decrease suicide risk.

The 2020 Strategic Plan for Research is not a static document like its predecessors. This version will be a living, web-based document that the institute will update regularly as new priorities, new challenges, and/or new opportunities materialize.

As part of this shift online, NIMH has created “progress pages” for each of the four key research goals, which will highlight key findings by researchers funded by NIMH. Gordon stated that these pages will enable researchers and the public to see for themselves how well NIMH is following its plan, reinforcing the institute’s commitment to transparency and accountability.

VIEWPOINTS

Defund the Police and Mental Illness

BY KENNETH P. ROSENBERG, M.D.

Before the COVID-19 pandemic and before protesters spilled onto streets around the globe calling for police reforms and an end to systemic racism, the United States was in the midst of a mental health crisis. As a consequence of deinstitutionalization and a lack of coherent mental health policy, we’ve turned our police departments into the nation’s largest psychiatric outreach team. This historic mistake has cost tremendous amounts of money—and a shocking number of lives.

The call to defund the police, with all the slogan’s different interpretations, has highlighted the enormous amount of taxpayer dollars invested in a failed—and sometimes deadly—system for dealing with many community safety issues, including mental health. Demonstrators are calling for redistribution of funds from police budgets into service functions that will take better care of communities and create a more stable and sustainable society. It is vital that having medical professionals intervene with people in psychiatric crisis be a part of any police reform or replacement plan.

The police are indeed helpful to us. They SAVE lives. They PROTECT and SERVE our loved ones and our communities. But their major role in mental health care, particularly when there is no threat to public safety, is a historical accident that should be corrected.

I am a psychiatrist who has studied the struggles of those with serious mental illness and the brother of a white woman who died of complications from schizophrenia (see Psychiatric News, https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2019.12a221). I know how ill equipped the police are to help people in mental health crisis. I also recognize the particular threat the current system poses to people of color, including those with mental illness. Mental health crises are the only health emergencies in which law enforcement officers are the first responders, and this misallocation of community resources has had disastrous consequences.

Consider these statistics, gathered through a national survey of law enforcement departments that tallied the 10 million annual emergency transports of people with mental illness in 2017. Twenty-one percent of all arrests made by two of the 34 American law enforcement agencies in the survey were with people in psychiatric crisis, including those with serious mental illness. Twenty percent of all law enforcement officers were white; 21% were black; and 10% of their overall budgets was spent on mental health transports, and 10% of their overall budgets was spent on responding to or transporting people with mental illness. This amounted to a staggering total of $918 million spent nationwide. The outcomes continued on facing page
Experts share advice on how you can cope effectively with the trauma and uncertainty associated with the COVID-19 pandemic and help others to do likewise.

BY GRACE W. GENGOUX, PH.D., AND DEBRA KAYSEN, PH.D.

The COVID-19 pandemic is affecting all of us in different ways. Many are feeling anxious about potential risks to themselves or to loved ones. Others are feeling anxious because of the constant flow of — and often conflicting — information. Some are overwhelmed by caregiving demands, feelings of social isolation, economic impacts, and worries about an uncertain professional future. COVID-19 is affecting some people as a traumatic event, either because of the direct and severe effects of the illness itself, because of the deaths of loved ones, or because of professional duties that require impossible decisions in difficult situations. It is important to note that most individuals who are exposed to stressors or traumatic events are resilient. Nevertheless, now more than ever, mental health professionals and others in caregiving roles need support, tools, and resources to help bolster their natural resilience.

During this extraordinary time, it can be useful to tap into resources known to help individuals deal with acute traumatic events. The principles of Psychological First Aid (PFA) can help you respond to others in a constructive and supportive way and take care of yourself during this sustained and stressful time.

What Is Psychological First Aid?

PFA was developed by the National Child Traumatic Stress Network and the National Center for Post-Traumatic Stress Disorder to manualize practices from disaster mental health and provide the mental health field with a framework within which to respond following acute trauma. This modular approach was designed to support individuals in the first few days after a traumatic event. The approach is informed by up-to-date evidence regarding risk and resilience following trauma, with an emphasis on a framework that is culturally informed, applicable across the lifespan, and deliverable in field settings. PFA was adapted by the World Health Organization during the Sierra Leone Ebola outbreak as an intervention to mitigate the mental health effects of the epidemic. At its core, PFA is a humane response that provides support to individuals who are suffering. One of the first principles of PFA is the recognition that a wide range of reactions is normal. Even though initial responses can seem overwhelming, most people who are exposed to potentially traumatic experiences do not develop long-term problems. The core actions of PFA listed in Figure 1 are designed to increase a sense of safety, connection, calmness, and hope during distressing times.

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Communicating with others in distress, you can incorporate PFA constructs by focusing on the following:
- Communicating with calmness to convey safety and respect.
- Listening with compassion to what an individual wants to share.
- Respecting and incorporating cultural customs or rituals.

Figure 1. Psychological First Aid Techniques

1. Contact and engagement
2. Safety and comfort
3. Stabilization
4. Information-gathering
5. Practical assistance
6. Links to Social Supports
7. Information on coping
8. Links to services

Source: Adapted from Brymer et al., 2006

Can Hormonal Treatments Help Your Patients?

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Level of Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mifepristone</td>
<td>Moderate evidence of efficacy at treating major depression with psychotic symptoms.</td>
</tr>
<tr>
<td>Thyroid hormone T3</td>
<td>Moderate evidence of efficacy as a therapy for treatment-resistant depression; strong evidence that as an adjunct, it can accelerate the effects of tricyclic antidepressants, but no evidence of accelerating SSRIs.</td>
</tr>
<tr>
<td>Estrogen replacement therapy</td>
<td>Moderate evidence of ability to treat perimenopausal women with major depression and physical menopause symptoms; weak evidence of efficacy in preventing depression in perimenopausal women or in treating depression in postmenopausal women.</td>
</tr>
<tr>
<td>Oral contraceptives</td>
<td>Moderate evidence that drospirenone-containing oral contraceptives can improve symptoms of premenstrual dysphoric disorder, but weak evidence for other oral contraceptives.</td>
</tr>
<tr>
<td>Testosterone therapy</td>
<td>Strong evidence of efficacy in treating depressive symptoms in men with clinical hypogonadism; no evidence for an effect on major depression in men without hypogonadism, but some preliminary evidence of efficacy in men with subthreshold depression.</td>
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</tbody>
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Source: Jennifer B. Dwyer, M.D., Ph.D., et al., AJP in Advance, May 27, 2020

Supportive Psychotherapy

**BY ARNOLD WINSTON, M.D.**

Supportive psychotherapy was developed in the early 20th century as a treatment approach with more limited objectives than psychoanalysis, which had previously been the only psychological treatment in the field of medicine. Personality change and exploration of unconscious conflicts were the focus of psychoanalysis and expository or exploratory psychotherapy. The objectives of supportive psychotherapy were not to change a patient’s personality or to explore conflicts, but rather to help a patient cope with symptoms, to prevent relapse of a serious psychiatric illness, or to help a relatively healthy person deal with a transient problem.

Based on these objectives, the definition of supportive psychotherapy most commonly used, as you’ll see in the new book of which I am co-editor, is “a dyadic treatment that uses direct techniques to ameliorate symptoms and maintain, restore, or improve self-esteem, ego functions, and adaptive skills with a focus on the patient’s overall health and well-being.”

**Therapeutic Alliance**

The key to successful results in all forms of psychotherapy is the establishment and maintenance of a positive therapeutic alliance between the patient and therapist. The therapeutic alliance is the best predictor of outcome in multiple psychotherapy studies. In the presence of a positive patient-therapist relationship, the patient is more likely to see himself or herself as a partner in the psychotherapy process. A positive therapeutic alliance furthers the patient’s interest and commitment to the psychotherapy.

**Psychopathology-Impairment-Psychotherapy Continuum**

The psychopathology continuum and the supportive-expressive continuum are useful ways of conceptualizing the evaluation and treatment process to decide on the appropriate approach for a given patient. The psychopathology-impairment continuum begins with the most impaired patients on the left side of the continuum, moving to moderately impaired patients in the middle, to least impaired on the right (see figure). The supportive-expressive continuum conceptualizes psychotherapy on a continuum beginning with supportive psychotherapy on the left side, moving to supportive-expressive psychotherapy, then expressive-supportive psychotherapy, and finally expressive psychotherapy and psychoanalysis on the right side.

Supportive psychotherapy is indicated for patients on the left side of the continuum (higher impairment levels), whereas expressive psychotherapy is better suited for patients on the right side of the continuum (healthier patients). However, it has been shown that healthy patients can significantly benefit from supportive psychotherapy.

**Evaluation Process**

The evaluation process is a critical beginning to the psychotherapy process. Using the psychotherapy continuum, the initial determination as to...
Psychosocial Therapy May Improve Immune Function

A meta-analysis combining 56 studies shows that psychosocial interventions, such as cognitive-behavioral therapy, can enhance immune system function. BY NICK ZAGORSKI

Psychiatry now shows that psychosocial interventions might also improve the immune system. What’s more, the study suggests that the immune benefits of psychosocial therapies persist for months after treatment ends.

This finding could have significant global implications, said senior study investigator George Slavich, Ph.D., an associate professor of psychiatry and biobehavioral sciences at the University of California, Los Angeles. A poorly functioning immune system can lead to chronic inflammation, which is associated with diseases both physical (such as diabetes and cardiovascular disease) and mental (such as schizophrenia and Alzheimer’s disease). The findings are also timely in the era of COVID-19, as people with weaker immune systems are at risk of worse outcomes if infected.

Medications ranging from the over-the-counter anti-inflammatory drug ibuprofen to the potent immune system suppressor infliximab are commonly prescribed to reduce inflammation. However, some of these drugs can be expensive, and all of them—even store-bought pills—come with a risk of side effects. Psychosocial therapies can offer a less risky and more holistic option for immune health, Slavich said.

Slavich and colleagues combined data from 56 clinical studies that assessed the effects of a psychosocial intervention on some measure of immune health. Most of the studies involved participants with chronic conditions such as cancer or HIV.

These 56 studies encompassed eight types of interventions: behavior therapy (which seeks to help patients understand and change problematic behaviors), cognitive therapy (which teaches patients how to change negative thoughts or mindset), CBT (which incorporates behavioral and cognitive elements), CBT plus additive support (such as telephoned follow-ups, bereavement group support, or supportive therapy), psychoeducation, other psychotherapy (such as stress management), and multiple or combined interventions. The studies also looked at seven immune system biomarkers that are commonly assessed in patients: proinflammatory cytokine levels, anti-inflammatory cytokine levels, antibody levels, white blood cell counts, white blood cell activity, viral load (for example, HIV levels), and other outcomes (for example, number of postoperative infections).

Overall, the participants who received any psychosocial intervention experienced a 14.7% increase in positive immune outcomes (for example, lower viral loads) and an 18.0% decrease in harmful outcomes (for example, proinflammatory cytokines) compared with those who did not receive a psychosocial intervention. The benefits of psychosocial intervention were similar regardless of patient age, sex, or duration of therapy; improvements were noticeable up to six months after the last therapy session.

As a comparison, the authors noted that the observed level of improvement in measures like cytokine levels following infliximab treatment was similar to what has been reported for patients receiving infliximab monthly to treat their rheumatoid arthritis—a treatment regimen that runs about $25,000 a year.

Slavich cautioned that the meta-analysis did not examine associations between immune biomarker improvements and patients’ health outcomes.

“We need additional research to address the important question of whether these psychosocial interventions are directly related to better patient health,” he told Psychiatric News.

“We also need to understand the mechanisms that underlie psychosocial intervention–related improvements in immunity,” Slavich continued. “Are psychosocial interventions helpful because they get people to eat better, sleep better, and/or exercise more often? Or maybe psychotherapy is helpful for the immune system because it changes how individuals think and feel.”

The meta-analysis revealed clues about the potential benefits of group therapy: Patients who received group-based therapy had marginally better improvements than those receiving individual care. “A group setting presents the patient with an opportunity to interact with affected peers and benefit from a variety of group-specific therapeutic factors, such as the instillation of hope, universality, altruism, interpersonal feedback, and cohesion,” wrote Veronika Engert, Ph.D., of the Institute of Psychosocial Medicine and Psychotherapy at Jena University Hospital in Germany and colleagues in an editorial accompanying the study.

The possible importance of a group element is also relevant in the current era when tele-mental health is now the norm and group sessions have a different dynamic. The meta-analysis did not compare in-person versus online interventions, and the impact of online psychotherapy on the immune system needs to be evaluated as well.

This analysis was supported by a Society in Science–Branco Weiss Fellowship, a Young Investigator Grant from the Brain & Behavior Research Foundation, and a grant from the National Institute of Mental Health. PN

“A Psychosocial Interventions and Immune System Function. A Systematic Review and Meta-analysis of Randomized Clinical Trials” is posted at https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2766707. The editori-

al, “Psychosocial Factors in Disease and Treatment—A Call for the Biopsychosocial Model,” is posted at https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2766705.
Pluripotent Stem Cells May Unlock How Genetic Variants Result in Mental Disorders

Stem cell–derived brain cells are helping psychiatric researchers understand how genes influence neurodevelopment and thereby impact risk for psychiatric disease.

BY SAMUEL POWELL, B.SC. (M.D., PH.D. CANDIDATE); ALEX YU, B.SC. (INCOMING MEDICAL STUDENT); CRAIG KATZ, M.D.; AND KRISTEN J. BRENNAND, PH.D.

S cientists in a variety of disciplines have been exploring the biological basis of mental illness for more than a century. However, meaningful progress has been hampered by the complexity of the brain and the limited accessibility of live human brain tissue for experimental study. In medical disciplines such as dermatology, infectious disease, and oncology, doctors take biopsies or other tissue samples to study what has gone wrong to cause disease. Scientists working in these fields can even culture disease-relevant cells to better understand the molecular pathways driving various disorders.

For obvious reasons, psychiatrists do not take brain biopsies from patients. Advances in brain imaging techniques have partially filled the gap, but brain imaging is still limited with respect to its resolution and to the specificity of functional activities it can depict. Postmortem brain studies, while informative, also have limitations: They do not contain living, functional brain tissue, which precludes experiments on whether or not a particular manipulation leads to a predicted response.

This highlights the fundamental problem that has hindered research on psychiatric illness: There is only so much that scientists can do to study the brain without performing experiments on the people to whom the brains belong. Without a doubt, much has been learned about the mind by studying how the brain responds to different psychological and chemical stimuli, but many types of experimental approaches—such as drug screens and genetic manipulations—would require gross ethical violations if they were performed on the brains of living people.

This is why the generation of human brain tissue through human-induced pluripotent stem cells (hiPSCs) is a potential game changer. Scientists can now create human brain tissue from readily accessible cells from skin and blood. These stem cell–derived brain cells can include relatively homogeneous populations of neural cells or more physiologically relevant three-dimensional “mini-brains” termed organoids that allow investigators to study more complex aspects of neurodevelopment and circuits. These techniques enable scientists to study mental illness in new ways, focusing on how genes influence neurodevelopment and thereby impact risk for psychiatric disease.

hiPSCs Link Genetic Variants to Disease Pathways

The Psychiatric Genomics Consortium has identified hundreds of genetic variants that are associated with either an increase or decrease in risk for psychiatric disorders. Importantly, these variants appear to be overrepresented in pathways previously connected to brain disorders, including brain development, synapse formation, neurotransmitters, learning and memory, and the immune system.

Although relying on genomics alone has important limitations for the following reasons:

• Psychiatric disorders are highly heritable, and this genetic risk is “polygenic,” reflecting inherited risk impacting multiple genes.

• With the exception of rare cases, the genetic variants associated with disease risk have small effect sizes individually, making it incredibly difficult to identify traditional “candidate genes” for mental illnesses.

• There is significant overlap in the polygenic risk for psychiatric conditions. For instance, schizophrenia and bipolar disorder share many common risk variants.

• Finally, psychiatric risk variants are highly overrepresented in parts of the genome that do not code for proteins, making the identification of the affected molecular pathways even more challenging.

The question remains: Exactly how do genetic variants lead to psychiatric disease? This is where in vitro models can be transformative. Increasingly, patient-specific hiPSC-derived brain cells are providing a new avenue to link specific variants to the genes and molecular pathways they affect.

Much of this work involves the use of CRISPR-based genome engineering. CRISPR (Clustered Regularly Interspaced Short Palindromic Repeats) enables scientists to precisely edit the DNA of any genome.

Studies of rare, highly penetrant variants implicated in small numbers of psychiatric patients are revealing key insights into disease biology. In some cases, investigators studied hiPSC-derived brain cells from patients harboring rare variants and from unaffected controls; in others, genetic engineering approaches using CRISPR have been used to introduce a particular variant into healthy donor lines and compare neurons made from these edited and unedited hiPSCs. In one pioneering example published in Nature in August 2014, Zhexing Wen, Ph.D., and colleagues at Johns Hopkins engineered hiPSCs to contain a mutant copy of the Disrupted in Schizophrenia 1 (DISC1) gene that was identified in a family containing high rates of mental illness. Upon differentiation of the hiPSC into neurons, investigators observed several abnormalities in synaptic functioning, thus linking a specific disease-associated mutation to relevant dysfunction in neural tissue.

An alternative method is to use CRISPR to edit different versions of a risk variant into the same donor line, then compare otherwise identical (or “isogenic”) neurons according to their variant-containing line to control for differences in genetic background between individuals. They found that conversion of a noncoding single nucleotide polymorphism (SNP) resulted in significant changes in gene expression, neuronal morphology, and neuronal activity.

In the same study, the investigators also simultaneously manipulated small numbers of risk genes and observed synergistic effects that suggest important interactions between risk variants above and beyond the simple additive effects alone. Overall, this work highlights the promise of hiPSC models to pinpoint not just the cell-type–specific impact of individual risk variants but also the interactions between them. Many common variants associated with psychiatric disorder risk are believed to regulate gene expression, but it remains unclear which genes are targeted by each variant and the mechanisms by which each variant alters gene expression. By integrating CRISPR techniques with hiPSC-based models, scientists in a variety of disciplines have been exploring the biological basis of mental illness for more than a century. However, meaningful progress has been hampered by the complexity of the brain and the limited accessibility of live human brain tissue for experimental study. In medical disciplines such as dermatology, infectious disease, and oncology, doctors take biopsies or other tissue samples to study what has gone wrong to cause disease. Scientists working in these fields can even culture disease-relevant cells to better understand the molecular pathways driving various disorders.

For obvious reasons, psychiatrists do not take brain biopsies from patients. Advances in brain imaging techniques have partially filled the gap, but brain imaging is still limited with respect to its resolution and to the specificity of functional activities it can depict. Postmortem brain studies, while informative, also have limitations: They do not contain living, functional brain tissue, which precludes experiments on whether or not a particular manipulation leads to a predicted response.

This highlights the fundamental problem that has hindered research on psychiatric illness: There is only so much that scientists can do to study the brain without performing experiments on the people to whom the brains belong. Without a doubt, much has been learned about the mind by studying how the brain responds to different psychological and chemical stimuli, but many types of experimental approaches—such as drug screens and genetic manipulations—would require gross ethical violations if they were performed on the brains of living people.

This is why the generation of human brain tissue through human-induced pluripotent stem cells (hiPSCs) is a potential game changer. Scientists can now create human brain tissue from readily accessible cells from skin and blood. These stem cell–derived brain cells can include relatively homogeneous populations of neural cells or more physiologically relevant three-dimensional “mini-brains” termed organoids that allow investigators to study more complex aspects of neurodevelopment and circuits. These techniques enable scientists to study mental illness in new ways, focusing on how genes influence neurodevelopment and thereby impact risk for psychiatric disease.

hiPSCs Link Genetic Variants to Disease Pathways

The Psychiatric Genomics Consortium has identified hundreds of genetic variants that are associated with either an increase or decrease in risk for psychiatric disorders. Importantly, these variants appear to be overrepresented in pathways previously connected to brain disorders, including brain development, synapse formation, neurotransmitters, learning and memory, and the immune system.

Although relying on genomics alone has important limitations for the following reasons:

• Psychiatric disorders are highly heritable, and this genetic risk is “polygenic,” reflecting inherited risk impacting multiple genes.

• With the exception of rare cases, the genetic variants associated with disease risk have small effect sizes individually, making it incredibly difficult to identify traditional “candidate genes” for mental illnesses.

• There is significant overlap in the polygenic risk for psychiatric conditions. For instance, schizophrenia and bipolar disorder share many common risk variants.

• Finally, psychiatric risk variants are highly overrepresented in parts of the genome that do not code for proteins, making the identification of the affected molecular pathways even more challenging.

The question remains: Exactly how do genetic variants lead to psychiatric disease? This is where in vitro models can be transformative. Increasingly, patient-specific hiPSC-derived brain cells are providing a new avenue to link specific variants to the genes and molecular pathways they affect.

Much of this work involves the use of CRISPR-based genome engineering. CRISPR (Clustered Regularly Interspaced Short Palindromic Repeats) enables scientists to precisely edit the DNA of any genome.

Studies of rare, highly penetrant variants implicated in small numbers of psychiatric patients are revealing key insights into disease biology. In some cases, investigators studied hiPSC-derived brain cells from patients harboring rare variants and from unaffected controls; in others, genetic engineering approaches using CRISPR have been used to introduce a particular variant into healthy donor lines and compare neurons made from these edited and unedited hiPSCs. In one pioneering example published in Nature in August 2014, Zhexing Wen, Ph.D., and colleagues at Johns Hopkins engineered hiPSCs to contain a mutant copy of the Disrupted in Schizophrenia 1 (DISC1) gene that was identified in a family containing high rates of mental illness. Upon differentiation of the hiPSC into neurons, investigators observed several abnormalities in synaptic functioning, thus linking a specific disease-associated mutation to relevant dysfunction in neural tissue.

An alternative method is to use CRISPR to edit different versions of a risk variant into the same donor line, then compare otherwise identical (or “isogenic”) neurons according to their variant-containing line to control for differences in genetic background between individuals. They found that conversion of a noncoding single nucleotide polymorphism (SNP) resulted in significant changes in gene expression, neuronal morphology, and neuronal activity.

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Can hiPSCs Advance Precision Medicine in Psychiatry?

The ultimate allure of hiPSC-based models of psychiatric disease is the promise of improved treatments and tailoring them to individual patients. In the first proof-of-concept report of hiPSC neurons generated from patients with schizophrenia published in *Nature* (April 2011), Brennand, Fred Gage, Ph.D., and colleagues were able to partially improve synaptic deficits observed in patient-derived neurons with the antipsychotic loxapine.

Could hiPSC models be the breakthrough that finally enables biologically informed treatment discovery? As an example, in an article in *Nature Communications* (October 2018), Brennand, Benjamin Readhead, Ph.D., and colleagues performed a drug screen on hiPSC-derived neural cells from schizophrenia patients and control patients and on eight unrelated cancer cell lines. Across these various cell types and donor lines, several thousand “transcriptional signatures” corresponding to drug response were derived. Using these gene expression–based readouts, the investigators found several drugs that reversed transcriptional abnormalities previously observed in postmortem studies of schizophrenia.

In the future, similar approaches may be used to link genetic information to predictions of differential treatment response, enabling clinicians to precisely match treatments to individual patients.

Use of patient-specific brain cells from hiPSCs is a transformative innovation that may one day yield new therapies for patients with psychiatric disorders. By studying patient-specific neurodevelopment and activity with hiPSC-based models, scientists are uncovering how genetic factors impact neuronal function, thus revealing key mechanisms of psychiatric disease.

Our hope is to one day tailor psychiatric medicine to biologically informed treatments and bring relief to those suffering from mental illness.

**Photo** By f.m.k. via Getty Images

Phenotypic changes in the postpartum “blues,” which typically go away within a few weeks of childbirth.

“Synaptic Dysregulation in a Human Ips Cell Model of Mental Disorders” is posted at https://www.nature.com/articles/nature23716.

“Synaptic Dysregulation in a Human Ips Cell Model of Mental Disorders” is posted at https://www.nature.com/articles/s41586-019-0497-5.

“Modeling Schizophrenia Using Human Induced Pluripotent Stem Cells” is posted at https://doi.org/10.1038/nature09915.

“Expression-Based Drug Screening of Neural Progenitor Cells From Individuals With Schizophrenia” is posted at https://www.nature.com/articles/s41467-018-06515-4.

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ast March, the Food and Drug Administration (FDA) approved brexanolone (Zulresso) as the first medication specifically designed to treat postpartum depression (PPD). The advent of this potentially game-changing drug has sparked new interest in better understanding optimal treatment approaches for PPD and whether other novel therapeutics may similarly hold promise for recovery.

**A Fast and Effective Discovery**

Approximately 1 in 8 women in the United States will experience PPD—the constellation of severe and debilitating sadness, loss of interest in normally enjoyed activities or relationships, and other mood-related symptoms that can lead to adverse outcomes including suicide.

“Symptoms can begin during pregnancy or after delivery and can last several months to a year or more,” said Kristina M. Deligiannidis, M.D., an associate professor of psychiatry and obstetrics/gynecology at the Feinstein Institutes for Medical Research and the Zucker School of Medicine at Hofstra/Northwell. Symptoms of PPD differ from the postpartum “blues,” which typically go away within a few weeks of childbirth.

Without treatment, PPD can detrimentally impact both the mother and infant, underscoring the importance of timely and efficient therapeutics.

Although evidence suggests antidepressants approved for the treatment of major depression are more effective than placebo at reducing symptoms of PPD, few studies have examined which antidepressants or psychological treatments are most effective.

“There are evidence-based psychotherapies and traditional antidepressants that can be helpful. But there are a sizable number of women who wouldn’t benefit from traditional therapies or the length of time between initiating these therapies and seeing benefits would be too long—taking weeks to months,” said Samantha Meltzer-Brody, M.D., M.P.H., chair of the University of North Carolina (UNC) School of Medicine’s Department of Psychiatry and director of the UNC Center for Women’s Mood Disorders. “For many women, that’s problematic because the onset of symptoms is severe and there is a need for fast-acting treatment that works within hours to days.”

Additionally, studies show that only about 16% of women with PPD receive treatment, and many in treatment continue to experience symptoms, says Kristina M. Deligiannidis, M.D., and their colleagues that was published in 2018.

Of 209 women randomized to treatment or placebo, those receiving a brexanolone infusion exhibited significantly greater rates of depression remission (Hamilton Depression Rating Scale [HAM-D] total score ≤7); at hour 60, approximately 50% of the women who received brexanolone remitted versus approximately 23% of those who received placebo. Treatment was also associated with greater chances of achieving depression response (≥50% reduction in HAM-D score) by hour 60 (approximately 75% of the brexanolone group versus 55% of the placebo group). The reduction in depression severity and speed at which the reduction was achieved were both greater with brexanolone than what has been seen in traditional oral antidepressant clinical trials. Severity improvements were also maintained during the 30-day study. Adverse effects were non-life threatening (for example, sedation and dry mouth), but some women required dose reduction.

“I can’t emphasize enough how amazing it is to see someone who has battled PPD with severe symptoms have a marked response and feel so much better within hours to days of the 60-hour infusion,” said Meltzer-Brody. “That’s a huge step forward in the field—our ability to treat someone that quickly.”

**Flexible, Team-Based Approaches**

Despite the optimism surrounding brexanolone, Meltzer-Brody noted that certain barriers exist that may impact patient access and benefit—see *Postpartum* on page 17.

**Photo** By f.m.k via Getty Images

Only about 16% of women with postpartum depression receive treatment, and many in treatment continue to experience symptoms, says Kristina M. Deligiannidis, M.D., have a marked response and feel so much better within hours to days of the 60-hour infusion, said Meltzer-Brody. “That’s a huge step forward in the field—our ability to treat someone that quickly.”

**Photo** By f.m.k. via Getty Images

Flexible, Team-Based Approaches

Despite the optimism surrounding brexanolone, Meltzer-Brody noted that certain barriers exist that may impact patient access and benefit—see *Postpartum* on page 17.
A placebo-controlled study suggests the gonadotrophin receptor inhibitor degarelix may reduce the risk that men with pedophilic disorder commit child sexual abuse. **BY NICK ZAGORSKI**

A testosterone-suppressing drug may rapidly reduce pedophilic thoughts in men diagnosed with pedophilic disorder, reports a study published in *JAMA Psychiatry*. Though the study observed only the effects of the medication for a two-week period, experts said the findings represent a critical advancement in treating pedophilic disorders.

Pedophilic disorder is characterized by recurrent sexual attraction to prepubescent children, according to *DSM-5*. Some testosterone-suppressing medications are currently provided as a pedophilia treatment (an intervention known as chemical castration) but are mostly limited to forensic settings like prisons. A major reason is that these drugs—known as gonadotropin-releasing hormone agonists—induce a short-term surge in testosterone production before suppressing it over a course of weeks or even months. During that surge period, the individual has an increased risk of acting on sexual impulses and therefore providing such drugs to people outside of an enforced setting is dangerous.

In this study, researchers at Sweden’s Karolinska Institutet and University of Gothenburg tested a gonadotropin-releasing hormone antagonist called degarelix, which blocks gonadotropin-releasing hormone receptors from receiving signals and suppresses testosterone quickly without an initial surge. (This medication is approved by the Food and Drug Administration for prostate cancer.)

The researchers recruited 52 men aged 18 to 66 years with pedophilic disorder who had reached out to a national helpline for unwanted sexual thoughts. All the participants were considered to be at low-to-moderate risk of sexual abuse based on their responses to assessments of their sexual preoccupation, self-regulation, cognitive empathy, and antisocial traits. The participants were randomly given an injection of degarelix or placebo each week for two weeks.

After two weeks, the participants taking degarelix reported significantly fewer pedophilic thoughts and overall sexual thoughts than those given placebo. There were no statistically significant differences between the two groups in self-regulation and empathy scores. The individuals who took degarelix maintained their improvements in unwanted sexual thoughts at a follow-up visit eight weeks later.

The participants also provided interim views at the end of the study describing their experiences, and most had a favorable attitude toward the treatment. Side effects were primarily skin reactions at the injection site, but two adults in the degarelix group had to be hospitalized for suicidal ideation.

“Only one participant was lost to follow-up, and 58% of those randomized to receive degarelix wished to continue treatment, which indicates to us a potential role for long-term treatment along with psychosocial support,” wrote lead author Valdemar Landgren, M.D., and colleagues. “In view of the participants’ wishes and effects expressed in the self-reports, we believe degarelix should be considered for help-seeking individuals with pedophilic disorder.”

Richard Krueger, M.D., the medical director of the Sexual Behavior Clinic at the New York State Psychiatric Institute, cautioned that this study focused on only a few specific risk behaviors over a short, two-week period. Since scores for empathy and self-control did not differ between participants in the degarelix and placebo groups, Krueger suggested that the observed improvements may have been due to a drop in general sexual function and not a drop in pedophilic desire per se.

“Before this drug can have any application, what needs to be done is a study of low- and high-risk pedophiles in a field that has virtually none.”

—Richard Krueger, M.D.

**“Researchers completed a scientifically valid randomized study in a field that has virtually none.”**

**COVID-19: From Psychological Distress To Neuropsychiatric Manifestations**

The neuropsychiatric picture of COVID-19 is not fully known yet. Better understanding and prospective monitoring of the neuropsychiatric manifestations related to COVID-19 can inform early detection and treatment planning. **BY FARAH ZAIDI, M.D.**

In the six months since COVID-19 has transformed life across the globe, there has been a marked increase in psychological distress stemming from fear of this viral illness and the stigma associated with it, challenges related to sheltering in place and physical distancing, financial strain, isolation, and exacerbation of mental illness (including increased risk of death by suicide) and new barriers to care. Shelter-in-place rules have also raised alarms about domestic violence and child abuse.

A growing literature is helping us to better understand the virus and its impact beyond the respiratory system, neurotropic potential, and possible mechanisms of underlying pathology. The volume of the National Institutes of Health’s LitCovid has increased from 40 publications in late January 2020 to approximately 1,970 publications in early July. LitCovid is a curated literature site of the National Institutes of Health and the National Center for Biotechnol-
The Perils of a Pandemic: Challenges Faced by Addiction Services

Psychiatrists who treat people with substance use disorders have been helped by relaxed treatment regulations, but that’s not enough. BY SANYA VIRANI, M.D., M.P.H., AND SOUPARNO MITRA, M.D.

The coronavirus pandemic engulfed New York City’s health care system for a number of months. The downstream effects not only became evident across hospitals that found it necessary to redeploy several physicians to critical care units but also in outpatient services continued from facing page

Anosmia Reporting Tool. The tool is designed to submit data confidentially to AAO-HNS for anosmia and dysgeusia related to COVID-19. Preliminary findings collected from this tool showed that “anosmia was noted in 73% of patients prior to COVID-19 diagnosis and was the initial symptom in 26.6%.” Based on these findings, it appears that anosmia may be a presenting symptom in COVID-19 before other more commonly known symptoms appear.

Proposed mechanisms for pathogenesis of neurological and neuropsychiatric manifestations related to COVID-19 include hypoxic brain injury; interaction of the COVID-19 virus spike protein with ACE-2 receptors of the cerebral capillary endothelium, resulting in damage to the endothelial lining and access to brain; cerebral edema; post-infectious autoimmunity; and immunomodulatory treatments.

As the global community continues to learn about and adjust to many emerging aspects of COVID-19, its multisystem impact is increasingly known. Awareness about neuropsychiatric manifestations related to COVID-19 could prepare the psychiatric community in managing at-risk populations. PN

Postpartum continued from page 15

namely, the need for health care professionals to alter how they implement PPD treatment. Specifically, brexanolone is a 60-hour intravenous (IV) infusion, which is vastly more complicated than taking an oral pill. Effective delivery must be multidisciplinary, relying on clear communication and coordination among a team of physicians (including psychiatrists, specialists, nurses, and pharmacists who prescribe, verify dosing, administer the drug, monitor for interactions, and track response and outcomes).

Also, brexanolone is approved under the FDA’s Risk Evaluation and Mitigation Strategies program because in clinical trials, there were reports of increased sedation and a potential for risk of loss of consciousness if overly sedated. Thus, patients must be monitored in a hospital setting—yet another aspect of the treatment paradigm that needs to be sorted out.

Additional trials of other potential PPD medications are underway, which too may mean adopting new approaches to patient care. Deligiannidis and colleagues are currently examining oral SAGE-217 (Zuranolone) for severe PPD. Other researchers are looking at the effects of ketamine and of oral and IV ganaxolone. And the early success of brexanolone—a neuroactive steroid antidepressant—has sparked interest in other drugs within the same class, given their potential to positively modulate GABA A receptors.

“The FDA approval of a neuroactive steroid as an antidepressant is extremely exciting to our field as it is the first medication of its kind,” said Deligiannidis. “The research field is now wide open to discover how GABAergic agents work at the molecular and neurocircuitry levels. That research may lead to additional treatment targets.”

Meltzer-Brody similarly expressed optimism at the wave of potential new treatments for PPD but warned that psychiatrists must be prepared to think about new approaches to care rather than relying solely on traditional treatments.

“The postpartum period is such a vulnerable time, and there’s a great need for effective treatments that can work quickly,” she said. “We need to be open to figuring out new ways of delivering care so we can decrease suffering in patients. And something that can work very rapidly and have efficacy can be very appealing.” PN

Suicidal Thoughts Begin Early for Some Youth

In addition to alarming data showing that over 8% of 9- and 10-year-olds had suicidal thoughts, this new analysis of national data highlights high discordance between child and parent suicide screens. BY NICK ZAGORSKI

Using data available from a nationwide study of children, researchers have calculated the first robust estimate of the prevalence of suicidal behaviors (including thoughts, plans, and attempts) among 9- and 10-year-olds in the United States. This analysis, which was published in Lancet Psychiatry, also identified key factors that both increase suicidal behaviors and help protect against them.

In that latter category, both positive parental engagement with children and having a positive school experience helped reduce the risk of suicidal behaviors by about 20%, while family conflicts and child psychological problems were associated with elevated risk of suicidal behavior.

These are not genetic risk factors or broad environmental risks that are difficult to modify, noted senior study author Sophia Frangou, M.D., Ph.D., a professor of psychiatry at the Icahn School of Medicine at Mount Sinai. “These are actionable items that are relevant to everyone and could lead to immediate results.”

Frangou and colleagues analyzed baseline data available from the National Institutes of Health–funded Adolescent Brain and Cognitive Development (ABCD) study. This study has enrolled over 10,000 children aged 9 and 10 from across the United States and is monitoring them for a decade to study teen brain development. As part of the baseline ABCD assessments, child participants and their parents separately completed a variety of questionnaires related to physical and mental health, including a survey on the child’s current or past suicidal behaviors. Complete data for both child and parental suicidality reports were available for 7,994 ABCD study participants.

Among children, 673 (8.4%) reported any past or current suicidal thoughts, 75 (0.9%) reported any past or current suicidal plans, and 107 (1.3%) reported past or current suicidal attempts. A total of 650 parents (8.1%) reported suicidal thoughts in their children, 46 (0.6%) reported suicidal plans, and 39 (0.5%) reported suicidal attempts. Though the overall rates look similar, Frangou highlighted that there was very little overlap between the child and parent reports; for example, only 198 children who reported suicidal thoughts were also identified as having these thoughts by their parents.

“This level of disagreement is concerning and suggests communication between caregivers and children about suicide is lacking,” Frangou told Psychiatric News. “From a clinical standpoint, the discordance also reinforces that just using parent reports on suicidal thoughts and behaviors in their children is not advisable.”

The research team then analyzed data from other family assessments and found that the presence of problem behaviors in children (such as aggression or antisocial behavior) and family conflicts reported by children were associated with an increased risk of suicidal behaviors in both boys and girls. Frangou stressed that the problem behaviors did not have to rise to the level of a psychiatric disorder to influence suicidality risk.

In contrast, more parental engagement and more positive school experiences were both associated with reduced risk of current or past suicidal behaviors in children. “Based on the reports, it was not just the absence of bullying that was important; what was protective was the children’s experience of their school as engaging and interesting,” Frangou said.

Frangou noted the significance of the findings in light of the COVID-19 pandemic, which has left millions of children nationwide out of school. “Experience from previous pandemics and emerging evidence from the current one point to increased domestic friction and spousal and child abuse when people are confined at home for extended periods,” she said.

The circumstances of this pandemic are amplified by the anxiety and uncertainty many families have over their immediate health and long-term financial prospects. It’s a volatile mix, but this study points to the important role that parents play in a child’s well-being.

“If parents can make the home environment engaging for children during this challenging time, it could also lead to positive outcomes.” PN


Hormones

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Inhibiting CRF or its receptors have not produced meaningful results in human trials.

“The CRF studies are a strong cautionary tale in the field of endocrine research,” said Jennifer Dwyer, M.D., Ph.D., an assistant professor of psychiatry at Yale University and lead author on the task force report. “The prernatal data were so clear and convincing but did not pan out. It illustrates the complexity of these hormonal systems.”

As Dwyer told Psychiatric News, all three of the systems reviewed feature sophisticated feedback mechanisms (in which the final hormone products regulate their own production) to ensure concentrations stay in a narrow range. Breaking that feedback loop to adjust hormone levels without causing unintended damage can be tricky.

Also as highlighted in the report, these hormones exert dramatically different effects depending on the patient’s age and the severity of his or her depression. While estrogen therapy is effective for depression in women during menopause, for example, there is no evidence it works in postmenopausal women. And in men without hypogonadism, testosterone has shown some efficacy to improve mild depression but has no effect in men with major depression.

Dwyer and colleagues on the task force underscored that with the exception of brexanolone’s indication for postpartum depression, none of these hormone formulations or hormone-targeting medications has been approved for any depressive disorder.

“Over the next several years, the field will have a better sense of whether these exciting preliminary findings can be replicated in larger samples and applied to clinical practice,” they concluded. PN

Low-Dose Testosterone No Better Than Placebo for Women With Depression

Though the APA Task Force review on hormonal depression treatments included a section on the use of testosterone to reduce depression in men, there were limited data on the benefits of this therapy on women. A report in AJP in Advance published in July suggests combining low-dose testosterone therapy with an antidepressant regimen shows no benefit over placebo in women with treatment-resistant depression.

“Based on our findings and the results of several other recent clinical trials, we conclude that the addition of low-dose testosterone to ongoing, ineffective antidepressant medications should not be recommended for women with major depression,” Laura E. Dichtel, M.D., of Massachusetts General Hospital and Harvard Medical School and colleagues wrote.

The researchers randomly assigned 101 women with treatment-resistant depression to use low-dose testosterone cream (starting at 10 mg/day) or placebo cream along with their regular antidepressant for eight weeks. While the low-dose testosterone was well tolerated, both groups reported similar improvements in overall severity of depression, fatigue, and sexual dysfunction, the authors reported. They noted that 49% of the placebo group reported significant depression improvements; this unusually high placebo response may have masked testosterone’s benefits.

“High placebo response rates may challenge underlying assumptions when designing trials using current methods, and several initiatives have focused on novel strategies to reduce placebo response in depression studies,” the authors wrote. “Studies implementing these strategies may produce better quality data, with greater separation rates between active treatment and placebo in cases where the drug is truly effective.”


America’s First Asylum for African Americans Marks 150th Anniversary

The history of Central State Hospital in Petersburg, Va., is tied to the history of American psychiatry and APA. By King Davis, Ph.D.

At APA’s 2019 Annual meeting in San Francisco, where the Association marked its 175th anniversary, thousands of members and guests were invited to celebrate APA’s historic origins in Philadelphia in 1844. An important feature of the celebration was a wall display of large photographs, including those of the first two public asylums opened in the United States in the 18th and 19th centuries.

As a former commissioner of the Virginia Behavioral Health System, I was pleased to see the pictorial displays and history of the first two state hospitals in Virginia (Eastern State and Western State) and their medical superintendents (Drs. John Galt and Francis Stribling, respectively, both co-founders of the Association of Medical Superintendents of American Institutions for the Insane, the fore-runner of APA). However, the display made no mention of Central Lunatic Asylum for Colored Insane, which opened in 1870; it was the first state asylum in the nation created for newly freed slaves. It was renamed Central State Hospital in 1894.

Eastern, which opened in 1773, was the first public mental institution in the United States and admitted one free African American a year until the end of the Civil War. Western, which opened in 1825, remained racially segregated until 1967. The idea for such a hospital was proposed and sanctioned by an APA commission chaired by Galt; Stribling; and another co-founder of APA, William Awl of Ohio. It influenced the policy direction of public psychiatric hospitals throughout the nation for the next 100 years.

Although Central State’s obscurity in conferences, research, and literature in the 21st century is troubling, I propose its historiography is tangential to understanding current discussions and massive street demonstrations that seek to finally eliminate America’s long racist history, vestiges and symbols of white supremacy, and acceptance of continued discrimination. These forces constitute the most virulent social determinants of health, which cause and sustain racial inequality and disparities in individuals, communities, and state hospitals.

continued on next page
 Patients engage in diversional occupation, which consists of leisure and recreational activities to promote mental and physical health. This photo appears in the 45th Annual Report of Central State Hospital.

“Segregated state hospitals were often underfunded, overcrowded, unrepaired, understaffed, and dependent on uncompensated patient labor often masqueraded as effective treatment.”

and practices proliferated throughout the South, while segregated wards and buildings were ubiquitous in the North. Stribling's stance on segregated patient care was adopted as public policy throughout the Southern states and as de facto policy of APA. Segregated state hospitals were often underfunded, overcrowded, unrepaired, understaffed, and dependent on uncompensated patient labor often masqueraded as effective treatment. Much of the care they provided was substandard as shown in a review of treatment records.

The 1964 Civil Rights Act compelled racial integration in public mental health systems; however, recent studies showed that implicit bias has influenced the design and delivery of psychiatric assessment and treatment. The first federal publication that sought to shed light on such bias in mental health care was Surgeon General David Satcher’s 2001 report, “Mental Health: Culture, Race and Ethnicity.” The report identified numerous gaps in research, knowledge, practice, and policy. Since it was issued, several contemporary research studies documented the continuation of implicit bias and disparities in mental and physical health owing in part to a host of social determinants that are at the heart of current civil demonstrations. We lack solutions.

Quest for Freedom Pathologized

Although Galt believed that integrated psychiatric treatment could take place if African Americans had a history of freedom, in 1845 Stribling successfully proposed to the Virginia legislature that a separate psychiatric facility had to be created for African Americans based on their differences from white individuals. Virginia legislators agreed that racial segregation of psychiatric patients and sterilization (1840-1870) series of military, legislative, and medical debates, negotiations, and data analysis that inflated the impact that freedom would have on increasing the rates of insanity, violence, and crime in the newly freed African American population. The 1840 census falsely reported that free African Americans in Northern states had a rate of insanity 10 times greater than that represented by the number of Black individuals in asylums in the Southern states. These biased findings failed to indicate that only Galt’s hospital at Williamsburg admitted free Blacks prior to the mid-1800s. The false prediction that rates of insanity would substantially increase if enslaved individuals were freed from bondage was counter to the belief that Black individuals were immune from the risk of insanity and other ills prior to 1840.

The directors of Virginia’s two 19th-century asylums raised concerns with medical directors from other states about the need for a national policy to respond to predictions based on the 1840 census that mental illness in African Americans would greatly increase. In 1844, Galt, Stribling, and Avl formed a committee to recommend a national policy on asylums for African Americans. Galt and Stribling strongly disagreed on whether to integrate their own state hospitals by race and servitude when the legislature gave them this opportunity. Galt stated that there was no medical reason that Blacks and whites could not be served in the same facility, but he demurred when it came to admitting
The enslaved. He believed the enslaved were situationally immune from these illnesses because they did not own or manage property or engage in civic affairs, the sources of stress.

In 1845, Virginia passed laws enabling free and enslaved African Americans to gain access to state asylums based on the discretion of the individual directors and the willingness of slave owners to pay for their care. However, Stribling argued persuasively for a policy of racial separation that exempted Western State Hospital. Both Galt and Stribling were influenced by the prevailing hypothesis derived from the census that freedom was inimical to the mental well-being of those with a history of enslavement.

At the end of the Civil War, Union Gen. E. R. S. Canby confiscated all Confederate and private hospitals in Virginia. He chose an annex at Howard's Grove Hospital, a former Confederate hospital located just outside of Richmond, for the treat-

ment of African Americans. From 1865 to 1870, the federal government leased Howard's Grove Hospital and converted the annex into an all-purpose hospital for formerly enslaved African Americans weighed down with conditions of insanity, physical disease, dislocation, homelessness, old age, violence, alcoholism, criminal behavior, and poverty.

The Commonwealth of Virginia extended the lease agreement from 1870 to 1885 and made substantial improvements to the temporary structures at Howard's Grove. Howard's Grove was inadequate as a medical facility, however, lacking sanitation, potable water, cooking space, and safe accommodations for individuals with disabilities. However, questions of legal ownership of new structures built by the state at the termination of the lease forced the Virginia legislature to abandon Howard's Grove as a permanent psychiatric hospital for African Americans.

Virginia Establishes Central Lunatic Asylum for Colored Insane

The legislature was responding to Canby's binding order that the state could utilize Howard's Grove only as a temporary psychiatric hospital, suggesting clearly that a permanent hospital was required. In his order, Canby wrote, "The use of public build-
ings at Howard Grove Hospital, until the Legislature shall otherwise provide, are turned over to the State of Virginia for the purpose of establishing a temporary lunatic asylum" for the "colored insane." By June 1870, the Virginia legislature and Gov. Gilbert Walker passed legislation accepting responsibility for the newly created asylum exclusively for freedmen and formerly enslaved individuals. However, the inadequate annex was rented and used for the next 15 years. In 1882, the Virginia "Asylum Committee" proposed that a new facility would be constructed on the 584-acre Mayfield plantation in Dinwiddie County. The former plantation had been purchased by the Petersburg City Council for $15,000 and given to the commonwealth for development of a new mental hospital for African Americans. The facility—Central Lunatic Asylum for Colored Insane—opened in 1885.

The number of admissions swelled throughout the 1870s, exceeding the hospital's capacity. These numbers were evident in the first annual report published in 1870. From 1865 to 1870, only 80 African American psychiatric patients were admitted to Central Lunatic Asylum, an average of 16 a year. However, the number of psychiatric patients admitted was considerably fewer than that of individuals with primary medical care, economic, and housing needs and fear of racial assaults and violence from whites. By 1885, when the new asylum was completed, the census of Central Lunatic Asylum exceeded 373 psychiatric patients. A relatively small number of psychiatric patients were transferred from Eastern Lunatic Asylum, local jails, and a private hospital in Richmond. However, the census doubled in size almost every decade, reaching a total of 5,000 patients in 1950. From 1870 to 1968, the rate of hospitalization was twice that of the African American proportion of the state's population.

The hospital was renamed Central State in 1894 and was racially integrated in 1967 in response to the Civil Rights Act of 1964. It is fully accredited.

APA has been intimately involved in determining the typology and quality of services available to African Americans in the United States since the mid-19th century. Its most prestigious psychiatric leaders have used their considerable influence and knowledge to convince state and local governments about policy directions and funding for mental health research, education, and effective treatments. Their hypotheses have ranged from consideration that African Americans had situational immunity prior to the end of slavery to predictions of exponential rates of illness born out of a purported inability to manage veiled freedom. Nonetheless, only rarely has the field questioned the pathology of racism. Central Lunatic Asylum sprung from intense debates over racial integration and the ability to provide services across racial lines that were more politically than medically determined. In each era there has been a need for assertive leadership to identify how change could occur. That time is here again. At this point in the 21st century, the field of psychiatry must view the current national and international unrest as an opportunity to provide guidance to state and federal governments and the American population about issues of race and how to mitigate the deleterious effects of bias, racism, violence, discrimination, and harm that have marked the country since these issues arose in the 18th century.
Feeling Young May Protect Seniors From Loneliness During Pandemic

Older adults who experience loneliness due to physical isolation during the COVID-19 pandemic are at higher risk of developing psychiatric disorders, but only if they feel old, suggests a study in the American Journal of Geriatric Psychiatry.

The findings were based on a survey of 277 adults aged 60 and older in Israel who were asked to rate their general health, subjective age (whether they felt younger or older than their age), exposure to COVID-19, loneliness, depression, anxiety, and distress.

After adjusting for age, demographics, and COVID-19–related variables, the researchers found that adults who reported feeling lonely and older also reported higher depression, anxiety, and distress symptoms.

“The current preliminary findings may inform screening and interventions with older adults both during the COVID-19 pandemic and probably in assisting with post-COVID-19 damage control,” the investigators wrote. Screening for subjective age might identify older adults at high risk of the detrimental effects of isolation, they noted. They also suggested that online or telephone interventions targeting loneliness could incorporate tools to improve age identity to help bolster the therapeutic effect.

Cariprazine Found To Interfere With Fetal Brain Development

A study published in Molecular Psychiatry suggests that exposure to the antipsychotic cariprazine in utero might compromise brain development in rare cases.

Cariprazine exerts its antipsychotic effects via interactions with dopamine and serotonin receptors, but research has shown it can also inhibit the enzyme 7-dehydrocholesterol reductase (DHCR7), a key component of the pathway that makes cholesterol. And since cholesterol cannot pass the blood-brain barrier, dietary cholesterol cannot overcome DHCR7 deficiencies in the brain.

For the study, researchers at the University of Nebraska Medical Center and Vanderbilt University assessed the effects of cariprazine exposure on the offspring of female mice with two copies of the Dhcr7 gene and female mice missing one copy of the Dhcr7 gene.

They found that mice born to mothers exposed to cariprazine had higher levels of cholesterol precursor molecules in multiple tissues, particularly brain tissue, relative to mice whose mothers had no exposure; these molecules were elevated to potentially toxic levels in mice born to females with one copy of the Dhcr7 gene.

The investigators, who had previously discovered arisiprazole interferes with cholesterol production, noted that 1% to 3% of people have variants in their Dhcr7 genes that reduce enzyme activity. The authors advised that women with Dhcr7 mutations who are nursing, pregnant, or plan to become pregnant should not be prescribed cariprazine or arisiprazole.

Family History May Predict Symptoms in Patients With Bipolar Disorder

Patients with bipolar disorder who also have a family member with a psychiatric disorder appear to have more severe symptoms than bipolar patients without a family history of psychiatric disorders, according to a study published in the Journal of Affective Disorders.


Structural racism affects everyone, consciously or otherwise. While Dr. Geller’s initial goal is to get APA on a better trajectory with Black members, the task force is cognizant of how matters that affect Black psychiatrists affect other groups and how the actionable changes the task force ultimately proposes to the Board will benefit minority psychiatrists in terms of making opportunities accessible in organized psychiatry, improving relationships with their colleagues, increasing health equity for psychiatric patients, and fulfilling the third goal of APA’s Strategic Initiatives: increasing diversity and inclusion in organized psychiatry and psychiatric practice.

I have encouraged leaders of the M/UR caucus groups to expand on the mission of the task force by designing their own projects, in parallel with the task force, that will illuminate how structural racism affects their patients, practices, and organized psychiatry. These groups have the capacity to propose recommendations that are conducive to improving psychiatry for patients, psychiatrists, and others. Their projects may lead to a Diversity and Health Equity Track being considered by the APA Annual Meeting Program Committee.

I look forward to learning from the endeavors of the M/UR groups—and all APA members. PN
First Aid

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- Providing accurate information.
- Assisting with access to individualized resources.
- Revisiting coping strategies that have helped in the past.

What Is Healthy Coping During COVID-19?

The uncertain timeline of the COVID-19 pandemic raises unique questions about how to best sustain healthy coping. Unlike many traumatic events that last minutes, hours, or several days, this stressor is lasting for many months and the extended period can cause irritability and exhaustion. Physical isolation from loved ones makes gaining social support particularly challenging. Even our normal grief processes are interrupted, and feasible alternative rituals must be identified. In addition, unlike past epidemics, where the effects have been more localized, this pandemic is affecting people overwhelmingly and on a vast scale, depleting support networks and creating tremendous economic stresses.

During this unprecedented global event, extra attention to the human health basics is critical. Healthy coping may include consistent sleep, nutritious food, regular exercise, social connection (even if remote), and self-talk that focuses on compassion. Many people also benefit from extra help managing negative emotions. In both yourself and those you care about, watch out for the tendency to disrupt a regular schedule that was working, withdrawing from interactions, or become overly critical of yourself or others. If there is a need for change, make a plan to address something controllable by listing possible solutions and picking the best one.

Figure 2 lists adaptive coping activities that many people may find useful. It can be particularly helpful to start with coping strategies that have worked in the past because we are all more likely to implement an old successful behavior than to start something new. In addition, these small wins help build a feeling of self-efficacy. If necessary, modify or adapt the old coping strategy to fit into current public health constraints. For example, talk with a friend by phone or video call or adjust your exercise routine in a manner that allows you to wear a mask or practice physical distancing.

A tool you might find useful is the COVID Coach mobile app. The COVID Coach app was created for everyone to support self-care and overall mental health during the pandemic.

Advocacy

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The e4e4 patients were 2.3 times as likely as patients with e3e3 to have a positive COVID-19 test. The investigators found the risk was similar even after factoring in dementia, hypertension, heart disease, and diabetes.

Though APOE is commonly linked with dementia, this gene is also highly expressed in lung cells, the investigators noted. PNN


Key Takeaway

In sum, it is important to recognize that resilience is not extraordinary; it is the norm. Resilience is also not a trait, but rather can be learned by everyone. Most importantly, resilience is not the absence of distress. Instead, resilience is the ability to manage the distress without breaking. Although the events associated with the COVID-19 pandemic can seem overwhelming, short-term coping skills such as focusing on our physical and emotional health, getting social support, and engaging in the activities we find to be affirming of our values are proven ways to actively build resilience. PNN


Psychologists and psychiatrists are being invited to get involved in advocacy efforts.

“Just as we educate our patients, their families, and the next generation of psychiatrists, we need to educate the public and legislators,” says Alan Levy, M.D. Bhatt and Levy also recommended that members reach out to their local district branch for opportunities to shape policies in their state. “Psychiatrists are in a unique position to educate,” Levy said. “Just as we educate our patients, their families, and the next generation of psychiatrists, we need to educate the public and legislators.” PNN

Information on how to join the Congressional Advocacy Network is posted at https://www.psychiatry.org/psychiatrists/advocacy/congressional-advocacy-network.
Heroes

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Generally, psychiatrists don’t work in those areas, though some do in very busy emergency rooms, and so I haven’t heard of any psychiatrist heroes on public media during these recent months. But we’ve had them. Here are some I’ve known of who either died from the virus or worked at great risk to their health:

The Coronavirus Deaths of Psychiatrists

There are several psychiatrists who I have heard died from complications of COVID-19. Three were elderly and no longer actively working as a psychiatrist: Robert Columbus Lancaster, M.D., Charles Rodney Smith, M.D., and Alyce Chenault Gullattee, M.D.

However, Ricardo Castaneda, M.D., practicing right up until he died in New York on March 25 at age 64. He was a private practitioner and caring for patients near up to when he was infected. When he was hospitalized, he took his computer with him to maintain contact with his patients. His wife texted a last message of his: “I have patients I have to save.” Yet, he couldn’t be saved.

Much of the more detailed information I received on the pandemic and heroism came as an alumni from my medical school, Yale. Most personal to me was the death of Andrew (Drew) Slaby, M.D., M.P.H., Ph.D., from complications of COVID-19 on May 4. Though what he was doing in the pandemic time before his death was not made public, his last official job was in New York. He was renowned for his leadership in developing the field of emergency psychiatry, including his voluminous writing on that and related psychiatric topics. Working in emergency psychiatry has one of the more potentially dangerous subspecialties in which to work, especially as knowledge and standards were only just developing.

One personal connection to Dr. Slaby is that he was from Milwaukee, where I have lived for 30 years. More important is that he was my first mentor when I was a third-year medical student at the Yale Community Mental Health Center, and he was my resident supervisor. He was charismatic, energetic, and a great source of knowledge. I thought I wanted to be like him. On May 4, when he died, I and my co-editors were supposed to be at a book release interview at the renowned 92nd Street Y for our book Anti-Semitism and Psychiatry: Recognition, Prevention, and Interventions. However, of course, that was postponed because of the pandemic. Though that felt unfortunate, it paled before the death of Dr. Slaby on the same day, reminding me of what is most important in life.

These deaths illustrate the importance of the new APA and Psychiatric News project of inviting members to write obituaries about members who have died; the obituaries will be posted on APA’s website. (See https://www.psychiatry.org/psychiatrists/search-directories-databases/member-obituaries.)

High-Risk Work Settings

Also at Yale was Sofia Noori, M.D., a third-year psychiatry resident. She cancelled her wedding date to volunteer to treat patients with COVID-19. That was heroic.

Jeffrey Mufson, M.D., a fourth-year chief resident of the Psychiatric Consultation Service at Yale, volunteered to work on the Step Down Unit and assist with the medical management of both COVID and non-COVID patients. A related challenge to his own health and well-being was distancing from his family.

Many other psychiatrists either volunteered in medical units or were assigned to them. That required an expansion of the scope of practice, which reinforced the importance of our medical training.

Then there were the personal risks of working on psychiatric inpatient units. In my hometown public psychiatric hospital, in April there were reports of several patients with COVID-19, but staff requests to at least use self-obtained protective gear was apparently turned down, leading to the quarantine of two individuals. Being able to manage uncooperative patients, sometimes in a new facility that had to be used temporarily because the prior one was being used for COVID-19 cases, added to the medical risks.

Another Kind of Heroism

Now I am clinically retired and at an age and health status that increase my risk for COVID-19. But, once upon a time, I was designated in 2002 as one of the “Heroes of Public Psychiatry” by the speaker of the APA Assembly. That designation seemed somewhat undeserved as I wasn’t putting my life at risk by working with the poor and underserved, that is, until about 13 years later when I worked part time at a medium security prison.

Perhaps there is a better and broader definition of a hero than courageous acts to help others at personal risk. The psychologist Philip Zimbardo, Ph.D., developed the Heroic Imagination Project for producing “heroes in waiting.” In this conception, heroes can include standing up for what is right and just. That means any psychiatrist who is doing work during the pandemic and afterward, especially for anti-racism, is a hero. PN

Geller

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• Strengthen congressional efforts to prevent suicide.

• Ensure that patients who present in the Emergency Department with suicidal ideation or who have attempted suicide are screened and referred to appropriate mental health treatment.

• Boost resources for call centers, 24/7 mobile crisis units, and crisis stabilization programs.

Geller especially expressed APA’s support for the Telemental Health Expansion Act of 2019 (HR 5201), introduced by Reps. Doris Matsui (D-Calif.) and Bill Johnson (R-Ohio). The legislation would permanently exempt telemental health services from Medicare’s geographic restrictions, such as requiring patients to travel to a qualifying “originating site” for appointments.

“About 65% of [psychiatrists] had not previously used telehealth, and now 85% are using telehealth for about three-quarters of their patients,” Geller told the committee. “The combination of allowing for visual as well as telephone-only services is very important as you have many patients who have no idea how to use any electronic equipment whatsoever.”

He also highlighted the Mental Health Parity Compliance Act (HR 3165), sponsored by Reps. Katie Porter (D-Calif.), Gus Bilirakis (R-Fla.), and Donald Norcross (D-N.J.). This legislation would ensure that health insurance plans comply with the Mental Health Parity and Addiction Treatment Act of 2008.

The COVID-19 crisis has unmasked clear racial disparities and inequities, Geller told the subcommittee. “We cannot begin to remedy systemic issues within health care access and delivery if we do not first have quantifiable data from which to inform our policy proposals,” he said in his written testimony.

During the question-and-answer portion of the hearing, Geller stressed that he believes a campaign is urgently needed to reduce prejudice and discrimination toward people with mental illness and called on Congress to help such an effort.

“We use the word ‘stigma,’ but I think it’s actually an unfortunate word,” he said. “It is prejudice and discrimination to think that if someone has a mental illness, they’re not capable of functioning.”

Geller also addressed the issue of domestic violence and sexual assault potentially increasing as people find themselves required to stay at home while living with a perpetrator of violence. “People are stuck at home together, they’re afraid to report, or they’re afraid to leave home to report,” Geller said. “We have to be cognizant of this phenomenon and specifically address it. It has not been talked about a great deal.”

The only bill addressed during the hearing that APA opposed was the Medicare Mental Health Access Act (HR 884), introduced by Rep. Judy Chu (D-Calif.), which would define psychologists as physicians under Medicare. In his written testimony, Geller noted that the bill “would further fragment care by creating unnecessary and dangerous silos between all health care providers who should be working collaboratively.” APA strongly encourages members to contact lawmakers to express their opposition to this legislation.

Geller testified along with former Rep. Patrick Kennedy, founder of the Kennedy Forum; Arthur C. Evans Jr., Ph.D., CEO of the American Psychological Association; and Arriana Gross, a member of the National Youth Advisory Board of the Sandy Hook Promise Students Against Violence Everywhere Promise Club.

Supportive

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of a psychotherapy session. However, personal boundaries between patient and therapist must be maintained. Supportive psychotherapy can also be combined with cognitive-behavioral therapy, especially to address symptoms of depression and anxiety.

Outcome studies of supportive psychotherapy have found it beneficial for many diagnostic entities, including anxiety and depressive disorders, schizophrenia, bipolar disorder, personality disorders, eating disorders, and physical illnesses. PN