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President's Column

Indian Summer, Depression, Social Anxiety and Treatments that Work

David Fogelson, M.D.

Indian Summer, "suggesting inconsistency, infertility, and depleted capabilities, a period of seemingly robust strength that is only an imitation of an earlier season of actual strength." Wikipedia.

When I awakened this morning, autumn seemed to have arrived on a cool brisk breeze, only to give way to warm Indian summer winds in the afternoon. The autumn heat created a languid spirit more conducive to spectator sports than to writing columns. Even spectator sports are challenging to a Southern Californian: The UCLA Bruins and The USC Trojans have struggling football programs, the Dodgers made only a brief post-season appearance as Clayton Kershaw suffered agonizing losses, no NFL team anywhere in sight, and the bright spots in the LA sports firmament are Kings Hockey and Clippers Basketball! Unable to distract myself with sports, I re-dedicated myself to writing this column.

I encourage you, the reader, to read the minutes of our last meeting for an update on the activities the SCPS is undertaking on your behalf and on behalf of your patients. Please visit http://www.psychiatry.org/ for updates on APA activities and advocacy. Please visit http://www.calpsych.org/ for updates on CPA activities and advocacy.

To shake my languid spirit I went cycling this afternoon. I have returned refreshed and energized. My anecdotal experience may generalize to more serious depression and anxiety. A recent review in the Journal of Clinical Psychiatry, 2014 Sep;75(9):964-74, concludes: "Physical activity reduced depressive symptoms in people with mental illness. Larger effects were seen in studies of poorer methodological quality. Physical activity reduced symptoms of schizophrenia and improved anthropometric measures, aerobic capacity, and quality of life among people with mental illness." The findings of this review should encourage us to recommend exercise, both aerobic and non-aerobic, to our patients suffering from depression and other mental illnesses.

With the return of autumn, our leading journals have brought us new findings in the artful application and combination of pharmacotherapy, cognitive therapy, and psychodynamic therapy in the treatment of depression and social anxiety disorder. I will briefly review three articles and then comment upon their relevance

(Continued on page 2)

In This Issue...

to our practices.

The first article is: Effect of Cognitive Therapy With Antidepressant Medications vs Antidepressants Alone on the Rate of Recovery in Major Depressive Disorder: A Randomized Clinical Trial. By Hollon SD, DeRubeis RJ, Fawcett J, Amsterdam JD, Shelton RC, Zajecka J, Young PR, Gallop R. in JAMA Psychiatry. 2014 Oct 1;71(10):1157-64. This was an adult outpatient study involving 452 patients with chronic or recurrent depression who were treated with antidepressant medication (ADM) with or without cognitive therapy (CT). Rates of remission and recovery were examined. Remission was defined as a Hamilton Depression Score of 8 or less and recovery was defined as six months without relapse following remission. Combined treatment enhanced the rate of recovery only in patients with severe non-chronic depression. 81% v. 51%. Combined treatment decreased the drop-out rate, 19% v. 27%. Remission rates did not differ between groups as a main effect of treatment or as an interaction with severity or chronicity. Combined treatment decreased the rate of reported adverse events, thought to be related to less time spent in a major depressive disorder (MDD) episode. The advantage of combined treatment in this study was limited to patients with severe non-chronic depression.

The second article is: Sequential Treatment With Fluoxetine and Relapse-Prevention CBT to Improve Outcomes in Pediatric Depression by Kennard BD, Emslie GJ, Mayes TL, Nakonezny PA, Jones JM, Foxwell AA, King J. in the Am J Psychiatry. 2014 Oct 1;171(10):1083-90. This was a child and adolescent study involving 200 youths age 8-17 with major depression who were treated with fluoxetine. 144 patients experienced a 50% reduction in depressive symptoms and were randomized to continuation treatment with ADM with or without CT for six months. Primary outcome measures were time to remission and rate of relapse. Time to remission did not differ between groups, mirroring the findings in the adult study by Hollon et al. The combined treatment group had a lower rate of relapse by week 30, 9% v. 27%. This non-chronic sample of youths mirrored the findings in adults.

The third article is: Long-term outcome of psychodynamic therapy and cognitive-behavioral therapy in social anxiety disorder by Leichsenring F, Salzer S, Beutel ME, Herpertz S, Hiller W, Hoyer J, Huesing J, Joraschky P, Nolting B, Poehlmann K, Ritter V, Stangier U, Strauss B, Tefikow S, Teismann T, Willutzki U, Wiltink J, Leibing E. in Am J Psychiatry. 2014 Oct 1;171(10):1074-82. This was an adult outpatient study involving 207 patients with social anxiety disorder who were treated with 25 sessions of CT or psychodynamic therapy. They were assessed 6, 12, & 24 months after treatment for rate of remission and response. The response rates, 70%, and remission rates, 40%, did not differ between groups.

The main findings of the Hollon study support advantages to combined treatment with ADM and CT primarily in those patients with severe non-chronic depressions. Patients with milder depressions, chronic depressions, or depression complicated by personality disorders fared no better with combined therapy compared to ADM alone. These findings mirror prior meta-analyses supporting the superiority of combined treatment in severe depression. The main findings of the Kennard study demonstrated that 144/200 (72%) youths who responded to initial treatment with fluoxetine fared better when randomized to adjunctive treatment with CT compared to treatment as usual. This study, like the Hollon study, supports prior literature demonstrating the beneficial role of CT in relapse prevention.

There is now robust evidence for the value of CT in the management of patients with MDD, yet CT remains underutilized. I encourage you to take advantage of the wonderful CBT manuals available at Oxford University Press under the series, *Treatments that Work.* This series includes manuals for the treatment of MDD and Social Anxiety Disorder. If you do not wish to perform CT with your patients, find competent CT practitioners in your community to whom you may refer.

The article by Leichsenring reminds us that psychotherapies expertly applied may be equally effective. Psychodynamic therapy was found to be equal to CT in preventing relapse in the treatment of Social Anxiety Disorder.

One wonders if they might have found similar effectiveness of treatments if they had done a MDD study. The possibility remains that relapse prevention may be enhanced not only by CT combined with ADM but by expert psychotherapies combined with ADM in the treatment of MDD as well as Social Anxiety Disorder. So on second thought; maybe do not rush to refer your patients who suffer from MDD for CT before providing them with your usual expert psychotherapy. If they fail psycho-dynamically oriented psychotherapy plus ADM, please consider a referral for CT.

By the time you read my next column, you will be working off the pounds put on at your Thanksgiving repast! Happy Thanksgiving to all!

Letter from the Editor

Was Blind, But Now I See

Colleen Copelan, M.D.

Truly amazing to see again—clearly near and far, in true colors, and without that dazzling, wagonwheel glare. Yes, I had cataracts removed and replaced with IOL. That's an IntraOcular Lens, for those of you under 40.

But my story goes back a year or two. Slowly, quietly, imperceptibly, the fog comes on little cat feet. You don't really notice the cloudiness but eventually you do clean the windshield and turn on the defroster, and keep buying stronger reading glasses—all to no avail. The halos and the multi-spoked glare of headlights eventually limit you to daytime driving. The glass window next to the door can look like the door, but it doesn't open when you push it. By now I've given up driving all together.

Teenage clerks in grocery stores lose patience with my hesitant search for icon on the credit card swiper. Every store has the icons in a different place! And every clerk treats you like a doddering imbecile.

It was a humbling experience, and a taste of what it's like to live with a disability.

Maybe it was the way the fog crept up on me so slowly, or maybe stubbornness or denial—or all three—but I waited unnecessarily long to see the ophthalmologist, who said I was "close to legally blind" in my bad eye. The diagnosis made it worse! No more denial.

Now the terror of submitting to a knife in the eye. I didn't know which was worse; submit or go blind! But reason prevailed. I'm happy to say, and delighted to see. cocopelan@aol.com

Council Highlights
October 9, 2014

Erick Cheung, M.D., *Secretary*

The meeting was called to order with quorum by Dr. Fogelson at 7:02PM.

Minutes from the 9/18/14 meeting were approved by council.

President's Report (Dr. David Fogelson):

Resumed discussion of funding support of CPPPH, an organization that provides education resources and services for impaired physicians (in the absence of medical board diversion program). Teleconference was held with Dr. Randall Hagar and Sandra Bressler from CPPPH. CPPPH is a jointly supported organization, functions of CPPPH include: role as an "oversight board", educational outreach, service to physician wellbeing committees, provides guidelines for physicians treating other physicians, improve quality of physicians who perform evaluations (provides certificates of completion), advocacy and lobbying efforts. Does not receive direct referrals for impaired physicians. Does not provide direct assessment or monitoring of physicians. Does provide referrals.

The motion was made, seconded, and approved to contribute $1,000 to CPA in specific support of the CPPPH organization. An amendment was made, seconded, and approved to increase the support of CPPPH to $1,500.

Discussed APA Engage 2014, and council was referred to the recent newsletter for more details.

The 2014 NAMI walk at Grand Park on 10/11/14 was again announced and all were encouraged to attend.

Council reviewed the SCPS executive director's annual evaluation. Council members expressed high satisfaction and appreciation of the executive director's work.

Council discussed current district branch ethics committee procedures and guidance (or lack thereof) regarding review of extrinsic evidence cases. A motion was made, seconded, and approved to review the DB and APA bylaws to determine the district branch's obligation to perform ethics activities, to request the bylaws committee to confer with the chair of the ethics committee regarding this subject, and to report back to council.

President Elect's Report (Dr. Heather Silverman): Nominating committee members were appointed. Reported on CPA discussions regarding concerns over psychologist prescribing laws and some cases of misrepresentation of medical degrees.

Membership Report: The following individuals were recommended for approval to join APA membership:
New MIT: Natasha Dasig, Jason Jalil, Han Luong, Kirsten Thompson

New general members: Rebecca Kornbluh, Lauren Ozbolt

A motion was made to accept the membership committee's recommendations, seconded, and approved.

Treasurer's Report (Dr. Duriez): A review of current financial status of the organization was presented. A motion was made, seconded, and approved to accept the treasurer's report.

Program Committee Report (Dr. Gales): Discussed potential opportunities for future meetings. Council dis-

cussed the value and opportunity for a meeting regarding education about internal medicine issues for psychiatrists and consultation/liaison topics.

The art of psychiatric medicine report (Dr. Furuta): Provided an update on the artistic aspects of practicing psychiatry. Discussed last meeting that focused on musical aspects of psychiatry and personal identification. Discussed next ideas for a documentary on oral history taking.

Legislative Report (Dan Willick): Discussed possible scope of practice legislation in the upcoming year.

New Business: Dr. Furuta announced the New Global Health Fellowship at UCSF, and their desire to have psychiatrists involved in the development of the program. Council was directed towards the weblink: Healinitiative.org
Council recommended ongoing discussion regarding global mental health at future council meetings.

Old Business: none

The meeting was adjourned by Dr. Fogelson at 9:52 PM.

On Tuesday, October 7th, SCPS members and members of the Southern California Society of Child and Adolescent Psychiatry came together at the home of William Arroyo, M.D., for a two-hour CME meeting on the medical and social implications of legalized marijuana. The speakers were Charles Grob, M.D., who spoke about Medical and Psychiatric Implications of Marijuana Legalization and Mark Kleiman, Ph.D., a professor fo Public Policy who spoke on How Legal Should Marijuana Be?

The meeting was well attended and appreciated.

If you are interested in this topic, please note that there will be a presentation by Itai Danovich, M.D., at the Psychopharmacology Update 26 entitled: **Pharmacological Implications of Marijuana: Therapeutic Agent or Target for Therapeutics?**

From Eleanor Lavretsky, M.D., Ph.D.
RE: California Carrier Advisory Committee (CAC) Meeting, CMS/MEDCARE/NORIDIAN

This is my report on important issues for psychiatry discussed during CAC meeting organized by NORIDIAN Healthcare Solutions, the new Medicare Contractor in California.
I represent CPA in CAC and attend meetings which used to be scheduled every Quarter in January, April, July and October of each year. Noridian changed the Schedule. The most recent meeting took place on September 17, 2014 at the Hilton Los Angeles Airport from 10:00 A.M. to 2:00 P.M.
Attendees included Noridian Staff, CMS Regional Staff, representatives of all California Medical Professional Associations, State Medical Society, CERT.

Most issues discussed are related to other medical professions – ophthalmology, oncology, radiology, laboratory, pain medicine. However, several topics are important to all medical specialties including psychiatry.

ICD10. There are now CMS Webcast and CMS.GOV/ICD internet sites for information and education.

Recovery Audits. Many physicians including psychiatrists used to be audited by Medicare or audit contractor Health Data Insight (HDI), required to submit records and their charges for services were denied or delayed.

Award of all new recovery audits contractors are now on hold due to ongoing legal problems. Only automated reviews are occurring at this time. Records are not being requested.

RECOVERY AUDITS MAY START AGAIN, after legal questions are resolved in court.

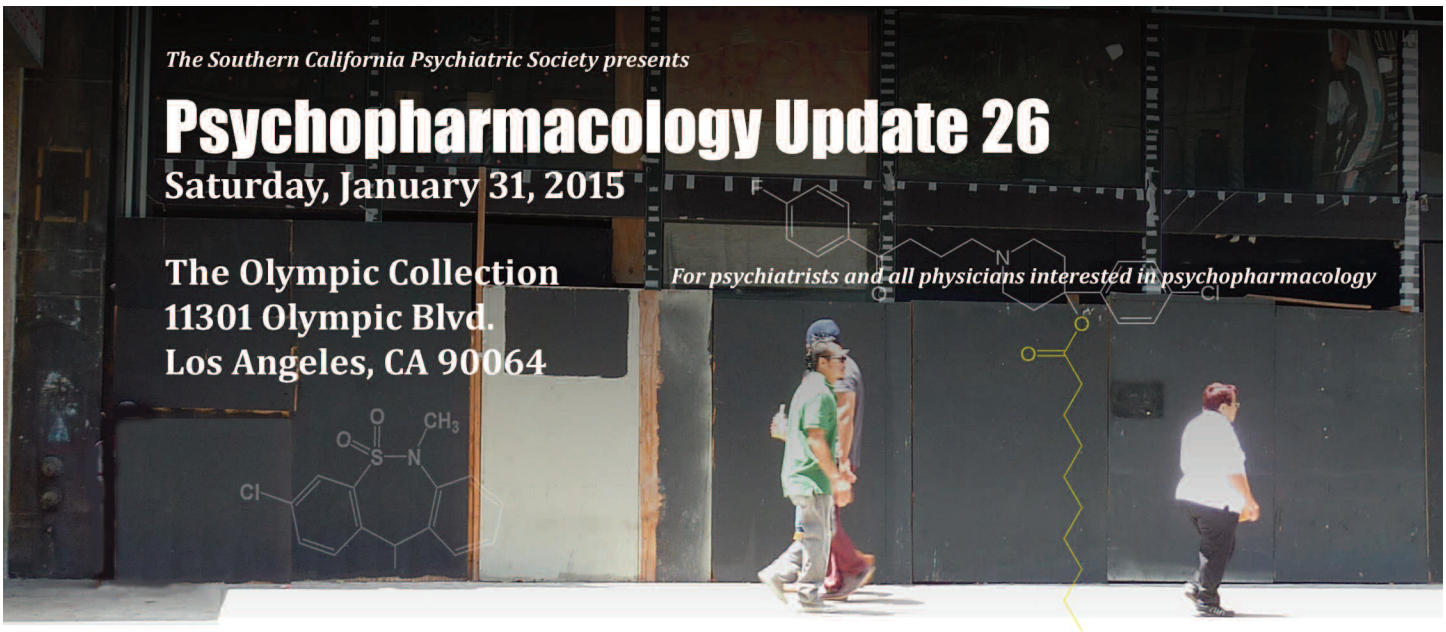
Hospital services. There is now requirement of two midnights hospital stay in order to consider this as inpatient service. If the patient is in the hospital less than 2 midnights, then it is considered outpatient service. The physician that is responsible for this patient is obligated:

a) To order specifically for admission by a physician or a proxy;
b) There must be a certification by an MD, DO or a Podiatrist;
c) The Certification must state the expected length of stay and reasons for this stay.

Electronic Health Records. Meaning Use stage continues. Incentive program has more flexible requirements.

There are PQRS (Physician Quality Reporting System) measures, which are supposed to better evaluate the physician's performance and make more justified decision about payments by Medicare.

It is important that all interested physicians review the proposed and now implemented Quality of Care Assessment System. Not everybody agrees with offered measurements and informative value of new PQRS requirement.



The 2014 LA NAMIWalk was a huge success! It was held on Saturday, October 11th at Grand Park in downtown LA. The SCPS booth was a popular stop for everyone there. SCPS members, Robert Burchuk, M.D., David Fogeslon, M.D., Lawrence Gross, M.D., Heather Silverman, M.D., and Roderick Shaner, M.D. volunteered at the booth and provided information about mental illness to the public. Here are photos from the event.

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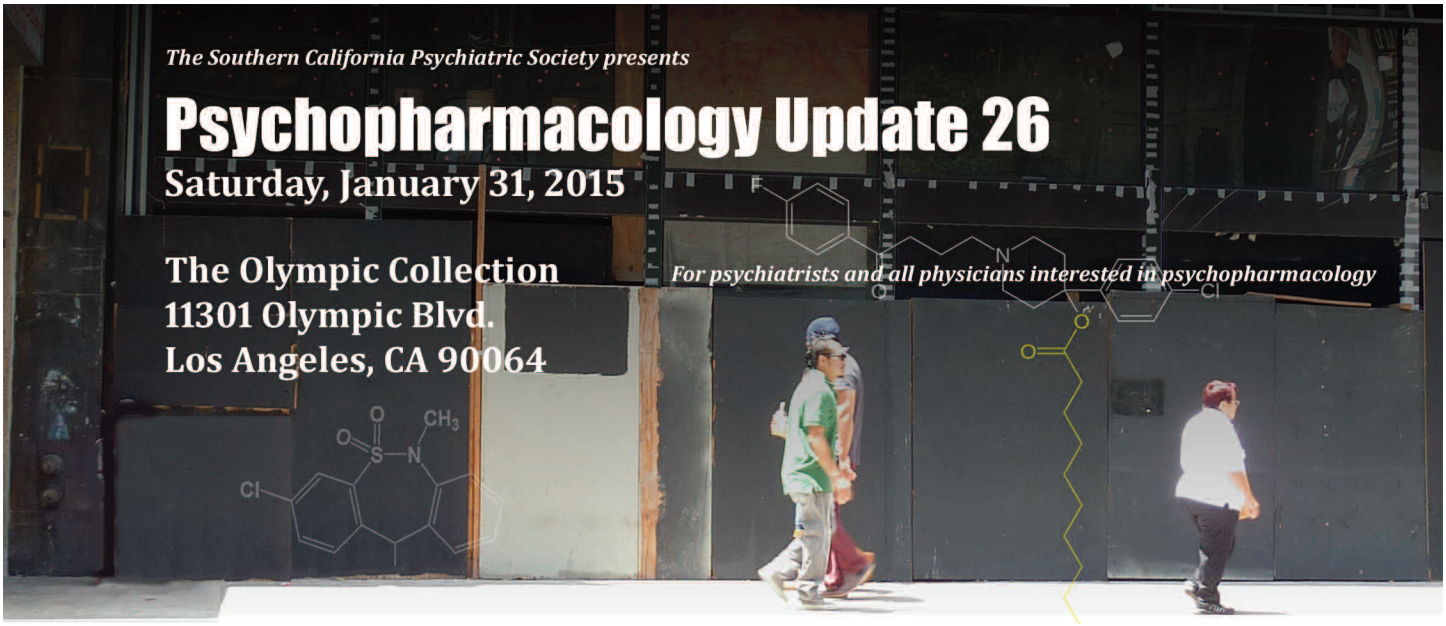

Follow the link for Complete Details and Registration

Schedule: 8:15 A.M. - 3:30 P.M.

Rationale-Based Treatment of Bipolar Disorder
Joseph F. Goldberg, M.D.

Integrated Care
Paul Summergrad, M.D.

Utilization of Pharmacogenomics in Psychiatric Practice
Gerald A. Maguire, M.D.

Pharmacological Implications of Marijuana: Therapeutic Agent or Target for Therapeutics?
Itai Danovitch, M.D.

Eating Disorders: An Update
Joel Yager, M.D.

Click Here for Complete Details and Registration

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SCPS designates this educational activity for a maximum of 5 AMA PRA Category 1 Credit(s)TM. Physicians should only claim credit commensurate with the extent of their participation in the activity. This credit may also be applied to the CMA Certification in Continuing Medical Education.

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Space Available

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Newly remodeled spacious office spaces are available, full time or part time, in an office bldg on Wilshire (Westwood area) as part of established psychiatry/psychology suite. Walking distance to UCLA. Offices are 190 sq. ft., have big windows with views of Los Angeles and the mountains, two waiting rooms, reception area, convenient parking and security. Rent is $1600/month. If interested please contact 310.208.7144.

Services Available

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Happy Thanksgiving!

During this time when we reflect on gratefulness, SCPS would like to thank you for your membership.

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