Using Cognitive-Behavioral Therapy to Reduce Suicidal Thoughts and Actions

Penn Medicine researchers found that patients who did not respond to cognitive-behavioral therapy (CBT) for anxiety in childhood had more chronic and enduring patterns of suicidal ideation 7 to 19 years after treatment, according to a study in the Journal of the American Academy of Child & Adolescent Psychiatry.

The relationship between anxiety disorders in children and adolescents, and the emergence of later depressive disorders, is well established. However, few studies have established evidence for an independent relationship between anxiety and the range of suicidal behaviors, including suicidal ideation, plans, attempts, and completed suicides, or the impact of CBT for anxiety in childhood and adolescent years on later suicidality.

The study included 66 patients who were treated for anxiety as children and agreed to be followed for years after treatment. Forty patients were classified as responding successfully to CBT in childhood and adolescent years (i.e., primary anxiety disorder not clinically significant after 16 weeks of treatment), whereas 26 were treatment nonresponders.

Seven to 19 years after treatment, treatment response was found to significantly predict lifetime suicidal ideation; treatment nonresponders were more likely to have experienced suicidal ideation. Patients who reported thinking about suicide in the past 12 months or 2 weeks were among those who had not responded to CBT. Eighteen of these patients reported experiencing suicidal ideation, nine reported having made one or more suicide plans, and six described making one or more suicide attempts in their lifetime. All instances of suicidal plans and attempts reported occurred after the age of initial treatment.

This is the first study to demonstrate the protective function of successful evidence-based treatment for childhood anxiety disorders on suicidal ideation in late adolescence and adulthood.

New Algorithm Identifies Ways Individuals are at Risk for Posttraumatic Stress Disorder

Researchers have built a new computational tool that identifies 800 different ways people are at increased risk for posttraumatic stress disorder (PTSD), permitting (for the first time) a personalized prediction guide.

Clinicians have had to work with computation methods capable of calculating the average risk for entire groups of survivors, which have proven to be insufficient as individual risk prediction tools. The new algorithm applied risk prediction tools currently used to predict the growth of cancer to predict PTSD.

The study set out to uncover interchangeable, maximally predictive sets of early risk indicators and build a Target Information Equivalence Algorithm. The algorithm showed that, when applied to data collected within 10 days of a traumatic event, it can more accurately predict who is likely to develop PTSD despite the many ways in which traumatic events occur. Data put into the algorithm include variables on type of event, early symptoms, and emergency department findings.

The research team has already received datasets from 19 other centers worldwide to produce a comprehensive predictive algorithm.

Examining Prior Policies for Antipsychotic Prescribing to Children

With a concern about inappropriate prescribing of antipsychotic medications to children, 31 states have implemented prior authorization policies for atypical antipsychotic medication prescribing, with most applying policies to children younger than 7, according to
a study in the *Journal of the American Medical Association*.

Antipsychotic medication prescribing to youth (age <18) was estimated to have increased from 0.16% (1993-1998) to 1.07% (2005-2009) in office-based physician visits. Antipsychotic drug use is also five-fold greater in Medicaid-insured than privately insured youth and occurs mostly for indications not approved by the U.S. Food and Drug Administration. In light of antipsychotic treatment-emergent cardiometabolic adverse events, government reports called for efforts to improve pediatric psychotropic medication oversight in state Medicaid agencies. Such efforts have included age-restricted prior authorization policies, which require clinicians to obtain preapproval from Medicaid agencies to prescribe atypical antipsychotic drugs to children younger than a certain age as a condition for coverage.

Researchers reviewed antipsychotic drug-related Medicaid prior authorization policies for youth in 50 states and the District of Columbia between June 2013 and August 2014, and characterized these policies according to age-restriction criteria and whether a peer review process was present.

Potential unintended consequences of these restrictive policies include inadequate treatment; substitution of potentially inappropriate, off-label psychotropic medication classes (e.g., anticonvulsant mood stabilizers, antidepressant drugs); and administrative burden on prescribers.


### Analyzing Addiction Treatment Policy Implications

The National Association of Psychiatric Health Systems commissioned an independent health care policy and economics consulting firm to define the substance use disorder population and appraise existing policies regarding the coverage, funding, and delivery of addiction treatment. Findings are based on a focused review of the relevant literature, as well as information from a series of informant interviews with clinical, policy, and other substance use experts.

The report notes that transformative policies (namely, the federal Mental Health Parity and Addiction Equity Act [MHPAEA] and Affordable Care Act [ACA]) have sought to improve patient access to treatment by reforming prior insurance coverage restrictions. Yet, significant coverage gaps persist.

To better respond to the needs of individuals with substance use disorders, the analysis makes several policy recommendations, including:

- full implementation of the federal MHPAEA and ACA laws;
- coverage of benefits and services across the full continuum of care;
- focus on long-term patient engagement and treatment of substance use disorders as chronic diseases;
- modification of the Medicaid Institutions for Mental Disease exclusion;
- modernization of Medicare (to cover a full range of benefits, including residential treatment services);
- better integration of addiction treatment with existing behavioral health and medical care systems; and
- more research to collect national outcomes measures.


### Enhancing Therapeutic Relationships Through Understanding Ruptures and Repairs

Current research suggests that the healing relationship between client and therapist, called *therapy alliance*, is the strongest predictor of a positive outcome in therapy. Moments of difficulty in this therapeutic alliance are called *ruptures*, whereas subsequent attempts to fix the alliance are called *reparations*. Alliance might rupture when therapists make a mistake (e.g., a failure of empathy) or in couples or family therapy when therapists spend too much time and energy on one client’s issues at the expense of others’ needs. It could also rupture when therapists push too hard or too quickly in a difficult area, leaving clients feeling exposed or misunderstood.

The Epstein Center recently conducted the first study of rupture-repair in individual, couples, and family therapy. The research found that different ruptures occurred with different
frequency in various types of therapy. However, ruptures posed a significant threat in all types of therapy; they occurred at the beginning, middle, and end of treatment, but the majority were successfully repaired.

A better understanding of the processes of rupture and repair shows therapists not only how to look for them but also how to fix them, allowing for an enhanced therapeutic relationship.


Domestic Violence and Women’s Mental Health

In addition to physical injuries, women who are victims of domestic violence are also at greater risk of mental health problems, such as depression and psychotic symptoms, according to recent findings of a study published in Depression and Anxiety.

Mothers (N = 1,052), with no history of depression, who participated in the Environmental Risk Longitudinal Twin Study over 10 years were interviewed multiple times by study researchers to determine whether they had experienced violence from their spouses and if they had any mental health disorders.

Results included the following:
• More than one third of the women reported enduring violence from their spouses (i.e., being pushed or hit with an object).
• Participants had a more extensive history of childhood abuse, abuse of illicit substances, economic poverty, early pregnancy, and an antisocial personality.
• These women were twice as likely to have depression.
• Domestic violence had an effect on mood as well as other mental health aspects. These women had a three times higher risk of developing schizophrenia-like psychotic symptoms; this risk doubled for women who were victims of childhood abuse.

Domestic violence causes not only physical injuries, but psychological ones as well, increasing the risk of depression and psychotic symptoms.


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Pay Gap Not Narrowing Between Male and Female Nurses

An analysis of the trends in salaries of RNs in the United States from 1988 through 2013 found that male RNs outearned female RNs across settings, specialties, and positions, with no narrowing of the pay gap over time, according to a study in the Journal of the American Medical Association.

Researchers examined salaries of males and females in nursing over time using nationally representative data from the last six quadrennial National Sample Survey of Registered Nurses (NSSRN) and data from the American Community Survey (ACS). The NSSRN sample included 87,903 RNs, of whom 7% were men; the ACS sample included 205,825 RNs, of whom 7% were also men. The surveys showed that male RN salaries were higher than female RN salaries during every year. No significant changes in female versus male salary were found over time.

The analysis estimated an overall adjusted earnings difference of $5,148. The salary gap was $7,678 for ambulatory care and $3,873 for hospital settings. The gap was present in all specialties except orthopedics, ranging from $3,792 for chronic care to $6,034 for cardiology. Salary differences also existed by position (e.g., middle management, nurse anesthetists).