CHIEF EDITOR DR. SYED MUBIN AKHTAR

# KARACHI PSYCHIATRIC HOSPITAL

## BULLETIN

MAY-2014

(Regd. No. SS-237)

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اسلامی نظام

"وہ اللہ ہی ہے جس نے اپنے رسول صلی اللہ علیہ وسلم
کو ہدایت اور دین حق کے ساتھ بھیجا ہے
تاکہ اُس کو ہر دین پر غالب کردے
خواہ مشرکوں کو کتنا ہی ناگوار کیوں نہ گزرے"۔

(القرآن: سورہ توبہ آیت نمبر ۳۳)

# KARACHI PSYCHIATRIC HOSPITAL BULLETIN

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# SPEAK, MEMORY

**By Richard Noll, PhD**

In the 1980s, thousands of patients insisted they were recovering childhood memories of physical and sexual abuse during Satanic cult rituals. Here: a look back at the moral panic.

Some mass cultural phenomena are so emotionally-charged, so febrile, and in retrospect so causally incomprehensible, that we feel compelled to move on silently and feign forgetfulness.

Historian Alfred Crosby noted these "peculiarities of human memory" in the 1976 first edition of his book, America's Forgotten Pandemic: The Influenza of 1918. "Why have (Americans) so thoroughly forgotten it since?" he asked. Until Crosby's book appeared, even historians had avoided the painful subject for 50 years. Without resorting to psychiatric or psychoanalytic explanations, Crosby speculated that any mass event that had "enormous influence" but that "utterly evades logical analysis" might justify our ignorance of it "because the alternative would be to sink into the quicksand of speculation without any limits."

Just 25 years ago, American psychiatry was infected by a psychic pandemic that originated outside the profession. In 1983 it broke out of a reservoir of religious, legal, psychotherapeutic, and mass media mixing bowls. Children in US day care centers and adults in psychotherapy told 2 distinct versions of their malady. By 1988 some elite members of the American Psychiatric Association (APA) were making it worse. They had become its vectors. Then other elite psychiatrists stepped in to quarantine the profession. Eventually, just like the last wave of the influenza pandemic, after 1994 it ended as suddenly and incomprehensibly as it had started.

As our medical schools and graduate programs fill with students who were born after 1989, we meet young mental health professionals-in-training who have no knowledge or living memory of the Satanic ritual abuse (SRA) moral panic of the 1980s and early 1990s. But perhaps they should. Cautionary tales may prevent the recurrence of pyrogenic cultural fantasies and the devastating clinical mistakes they inspire.

But who should tell this tale? To those of us who are old enough to have been there, that era already seems like a curious relic of the past, bracketed in our memory palaces behind a door we are loathe to open again.

In the 1980s thousands of patients insisted that they were recovering childhood memories of physical and sexual abuse during Satanic cult rituals. In addition to the red or black robes of the abusers and other paraphernalia of devil worship familiar to any horror film devotee, these memories often included the ritual sacrificial murder of children, blood-drinking, cannibalism, bestiality, and incest. Famous believers in SRA ranged from Gloria Steinem to Pat Robertson. A prominent historian of religion has argued that "the emergence of SRA motifs" served as "a kind of feminist and evangelical Christian pornography."

Clinicians who then believed in the factual basis of the claims (and there were many) have probably spent the last 30 years asking themselves, "How could I have been so . . . .?" (fill in the blank). Or perhaps they are still saying to themselves, as the authors of one book suggest in their title, Mistakes Were Made (But Not By Me).

Their silence is understandable. But even many of the most pivotal of the skeptical psychiatrists of that era have not shared their personal memories in a public forum. Why were they so immune and how did they decide that such clinical narratives had no basis in historical truth?

Might historians of psychiatry offer us something here? Unfortunately, like those generations of historians following the 1918 pandemic, they too have repeated the compulsion to dissociate themselves from an ugly cultural and medical disaster. Revulsion is a human reaction we can certainly all understand.

Despite the discomfort it brings, we owe it to the current generation of clinicians to remember that an elite minority within the American psychiatric profession played a small but ultimately decisive role in the cultural validation, and then reduction, of the Satanism moral panic between 1988 and 1994. Indeed, what can we all learn from American psychiatry's involvement in the moral panic?

## Dissociation: The celebrity metaphor of the 1980s

The creation of a new category of dissociative disorders in DSM-III (1980) resurrected "dissociation" as a double-duty metaphor for both a causal (defense) mechanism and a descriptive term for the splitting apart of consciousness, complexes within memory systems, and the subjective sense of a unitary self. Disoriented by the loss of a formal Freudian paradigm and the newly energized discourse of biological psychiatry, psychoanalytic clinicians found asylum among the dissociative disorders and their presumed reactive, trauma-induced origins. Within a few short years multiple personality disorder (MPD) would emerge as the most frequently diagnosed entity in this group and would be the subject of several large clinical studies that seemed to validate its existence. The research of 3 psychiatrists in particular caught the profession's attention: Richard P. Kluft of the Institute of the Pennsylvania Hospital in Philadelphia; Frank W. Putnam of the National Institute of Mental Health; and Bennett G. Braun of Chicago's Rush Medical College.

These 3 men were then asked by Robert Spitzer to be new members of the Advisory Committee for Dissociative Disorders for the forthcoming DSM-III-R, which finally appeared in 1987. Other new members were psychiatrists Philip M. Coons and Marlene Steinberg and social worker Janet B.W. Williams. Spitzer was the only holdover from DSM-III.

The DSM-III-R revisions for the dissociative disorders were extensive. The sequence of the disorders in the chapter was changed, with MPD placed first because it "is in many ways both the paradigm and the most pervasive expression of the spectrum of dissociative phenomenology." Severe physical, sexual, and emotional abuse in childhood were its predisposing factors. Described as "apparently extremely rare" in DSM-III, in the years 1984 to 1987 large numbers of cases were reported in the literature by Kluft (200 cases), Putnam (100), Coons (20), and Braun and co-authors (355).

In order to further study the epidemic which they did so much to create, in 1983 they founded the International Society for the Study of Multiple Personality and Dissociation (ISSMP&D). By 1990 there were approximately 2000 members. The ISSMP&D's annual conferences were carnivals of workshops by and for many varieties of mental health professionals. The first, in December 1983, drew more than 300 participants. Beginning in 1986 some taught tales of cults and childhood Satanic ritual abuse.5 In March 1988 the first issue of the peer-reviewed journal Dissociation appeared, with Kluft as the chief editor, Braun as associate editor, and 2 additional assistant editors.

## Psychiatry battles the devil

The DSM-III-R Advisory Committee on Dissociative Disorders was conscious of the historical implications of the MPD diagnosis, noting that MPD "and its attenuated forms are, historically, the secularized descendants of the Judeo-Christian possession syndrome." In other words, they knew they were expanding the jurisdictional boundary of "scientific" psychiatry and colonizing the supernatural. Treatment rationally follows from diagnosis. Psychiatrists soon claimed for themselves superior therapeutic expertise for techniques that had formerly been the province of magico-religious practitioners (exorcists). What they did not anticipate was that the blurring of this boundary would backfire, pulling many of them off into the rip tide of Satanic panic.

Bennett Braun was the first and most fervent DSM-III-R Advisory Committee member to join the crusade against Satan. His public expression of interest in cults and MPD dates at least to 1986. But at an ISSMP&D conference in Chicago in 1988, Braun presented a workshop in which he directly linked the MPD epidemic to the abuse committed against children by devil-worshipping cults. He argued that these Satanic cults were everywhere in the US, internationally organized with a structure similar to communist cells, with local regional, district, national, and international councils. Braun also argued that Satanic cults were transgenerational family traditions that had been going on in secret for at least 2000 years.

At that same conference, Sally Hill, a social worker in private practice in Chicago, and Jean Goodwin, a psychiatrist and professor of medicine at the Medical College of Wisconsin in Milwaukee, presented a paper which attempted to validate Braun's claims by citing historical accounts of allegations of "the Satanic black mass" and other obscene cult behaviors going back to at least A.D. 100. Reproducing these accounts

without regard to context, these clinicians read them as fundamentally true reports of actual events. Professional historians who specialize in those eras tend to interpret such material as a discourse of propaganda aimed at undesirable minority groups, whether real or imagined.
A few months later, in March 1989, this conference paper was published in Kluft and Braun's journal, Dissociation. It quickly became a citation success in the SRA literature as evidence in favor of the historical continuity of Satanic cults and their rituals. The message to the public and the mental health professions was clear: elite members of the American psychiatric profession seemed to be sanctioning the SRA moral panic. Satanic cults were probably real, had probably been around for almost 2 millennia, and were abusing children and creating the MPD epidemic.
As for the other members of the DSM-III-R Advisory Committee and the leadership of the ISSMP&D, there was only one response: public silence.

## But shouldn't somebody say something?

That's what I asked myself after I read Hill and Goodwin's article and heard audiotapes of Braun's public lectures. As a 29-year old newly minted clinical psychologist in private practice, with no academic or clinical institutional affiliation, I was in no position to have anyone listen to me if I spoke up. I knew I was not alone in my skepticism and horror. But the resounding silence of the elite psychiatrists could only be interpreted in three ways by those of us "in the trenches" who looked up to them for guidance: these Satanic cults were real (despite the lack of corroborating physical or forensic evidence); the experts did not know if they were real and were afraid of insulting the patients; or there was an abject failure of ethical leadership.
The December 1989 issue of Dissociation brought the first public statements of SRA skepticism to appear in a peer-reviewed psychiatric journal. Psychiatrist George Ganaway wrote a rather convoluted article on "historical truth versus narrative truth," avoiding any direct rejection of SRA claims while doing his best to raise significant doubts. In a "letter to the editor" I contributed a short critique of the historical sources and methods used by Hill and Goodwin, and—with the brashness of youth—declared that most SRA claims were nothing more than "a modern version of (a) paranoid mass delusion—and one in which all too many clinicians and law enforcement officials also share."
Richard Kluft opened the same issue of Dissociation with an impassioned editorial in which he cited the Hill and Goodwin article with approval as a foundational contribution that scientific investigators could use to study clinical material. While careful not to explicitly advocate or reject it himself, Kluft also invoked the specter of a possible "hidden holocaust" perpetuated by Satanic cults. Kluft's editorial, rightly or wrongly, may have been interpreted by many as his public defense of Braun's international conspiracy fantasies. To the many SRA believers who read Kluft's remarks, their biased cognitive filter could reasonably lead them to conclude there were now two members of the DSM-III-R Advisory Committee on Dissociative Disorders deeply involved in granting legitimacy to the Satanic moral panic through the linkage of MPD to SRA claims.

## Another year of silence, then alternatives

Throughout most of 1990 no American psychiatrist, and certainly no other member of the DSM-III-R Advisory Committee for the Dissociative Disorders, made any formal public or published statement explicitly rejecting Braun's Satanic cult conspiracy. No one objected to Kluft's "hidden holocaust" analogy. These were the true plague years as the moral panic continued to rage in day care centers and the courts, destroying reputations and lives.
But by the autumn of 1990, Frank Putnam of NIMH decided to break his skeptical silence. In preparation for the 7th annual ISSMP&D conference to be held in Chicago in November, Putnam arranged to open the event with a special plenary panel of 4 presentations of "alternative" views of the interpretation of SRA claims. The plenary session was held in a large hotel ballroom filled with most of the more than 700 conference attendees. Television crews were on hand to witness the event. So was Gloria Steinem. So was I.
The 4 members of the plenary session panel were Putnam, George Ganaway, anthropologist Sherrill Mulhern, and me. Putnam had read my Dissociation critique and wanted me to present my argument in

person. Putnam and Ganaway presented carefully balanced arguments that did not directly reject the reality of SRA. Instead they expressed concerns about the linkage of MPD to such controversial claims, noting it would hurt future research on child abuse and trauma.

Mulhern and I were strident in our outright rejection of the veracity of SRA claims. She cited anthropological and sociological research while I hammered home the view of historians that ancient accounts of bizarre cult practices had to be read in context. Along with my fellow panelists, I too mentioned the October 1989 preliminary report of an investigation by Supervisory Special Agent Ken Lanning from the FBI Behavioral Science Unit at Quantico which found no corroborating evidence of the existence of Satanic cults engaged in any criminal activity, let alone kidnapping and ritually sacrificing thousands of American babies. Lanning's findings had emboldened Putnam to organize the special plenary session and go public with his private skepticism. The full FBI report appeared 3 years later.

Gloria Steinem approached me after my talk and suggested materials to read which she felt would help me change my opinion of SRA accounts. During the conference I attended one of Bennett Braun's legendary SRA workshops ("See the Satanism!" he screamed as he pointed to a patient's red crayon scratching on a sketch pad. "There it is!"). Several persons—all licensed mental health professionals—approached me and let me know I wasn't fooling them. They knew I was a witch or a member of a Satanic cult who was there to spread disinformation. But apparently the panel presentations had a different effect on others. As one conference attendee, an SRA believer, later wrote, "Mulhern and Noll cut a line through the therapeutic community. A minority joined them in refusing to believe sacrificial murder was going on; the majority still believed their patients' accounts."

## The fade out into forgetfulness

In 1991 Putnam and Ganaway continued to distance themselves from SRA. Braun and others who shared his beliefs continued to exploit the medical literature to bolster the construct validity of SRA. Kluft continued his editorship of Dissociation. In the years that followed, the pages of Dissociation kept possession and exorcism alive as relevant psychiatric issues in diagnosis and treatment.22 Psychiatry could not abandon its jurisdictional claim on the supernatural.

When the new diagnostic manual finally appeared in 1994, MPD had vanished. Renamed and revised as dissociative identity disorder (DID), it also had been dethroned from first place in the sequence of dissociative disorders. "I don't want it to be seen as some sort of circus sideshow," said the chair of the new DSM-IV work group. DSM-IV reinstated the order of DSM-III. The new guards at the APA were doing their best to quarantine the profession from not only the men who had enabled the MPD epidemic but also from any lingering connection to the moral panic.

In May 1994 the ISSMP&D dropped "Multiple Personality" from its name. In December 1997 Dissociation produced its 39th and last issue. The journal's demise reduced the volume of MPD/DID contributions to the medical literature. But by then the "multiple movement," as philosopher Ian Hacking termed it, had already begun to wane.

The False Memory Syndrome Foundation was formed in Philadelphia in March 1992. It became a clearinghouse of legal and scientific information that countered false claims of "recovered memories" of child abuse (Satanic or otherwise). Noted scientists such as Elizabeth Loftus and Carl Sagan became its advocates. Ganaway eventually joined its board of scientific advisors. Its newsletters vilified clinicians such as Bennett Braun and others who had done so much to legitimize the paranoid mass delusion of Satanic cults.

After 1993 the day care ritual abuse panic subsided. By 1994 even the mass media had become critical of SRA. Everyone just wanted to move on.

Are we ready now to reopen a discussion on this moral panic? Will both clinicians and historians of psychiatry be willing to be on record? Shall we continue to silence memory, or allow it to speak?

Dr Noll is Associate Professor of Psychology at DeSales University in Center Valley, Pa. His most recent book, American Madness: The Rise and Fall of Dementia Praecox (Cambridge, Mass: Harvard University

Press; 2011), was the winner of the 2012 Cheiron Book Prize and a 2012 BMA Medical Book Award, Highly Commended in Psychiatry, from the British Medical Association.

**Editorial Note:** In light of the responses we have received regarding this article by Richard Noll, PhD, that was posted on our website on December 6, 2013, the article has been reposted with a modification. Additionally, we are posting responses from certain of the individuals mentioned in the article and from Dr. Noll in order to leave analysis of the article up to our readers.

**RESPONSES 1**

## TWO WRONGS DON'T MAKE A RIGHT

**David Spiegel, MD**
**Willson Professor & Associate Chair of Psychiatry and Behavioral Sciences**
**Stanford University School of Medicine**

Dr. Noll unearths memories of a period during which what was then called Multiple Personality Disorder was linked to reports of satanic ritual abuse. He treats us to accounts of heated meetings involving this. I recall speaking to the International Society of Multiple Personality Disorder and Dissociation and informing them that the name of the disorder would be changed to Dissociative Identity Disorder in DSM-IV. I asked for a show of hands and, to my surprise, given the fact that this would require changing the name of the Society, about two-thirds voted in favor. A group of people sitting in the front rows were wearing T-shirts that read "D.I.D.," which I took to be a good sign. When they turned to leave, I saw that they had printed "D.I.D. NOT" on the back. I appreciated their sense of humor about a serious and often contentious issue. I wish Dr. Noll had the same sense of balance. His piece has a 'good guys' and 'bad guys' tone that does everyone a disservice.

This experience underscored for me the fact that the situation was and is complex, so we need to, indeed, let memory speak. Dr. Noll mentions three psychiatrists as promoters of belief in SRA. One of them, Dr. Bennett Braun, was the founder of the Society, subsequently left it, relocated, and withdrew from the dissociative disorders field. The other two, Drs. Richard Kluft and Frank Putnam, have gone on to have long and distinguished careers studying, writing about, and treating people with dissociative disorders. Dr. Kluft participated actively and constructively in the DSM-IV process. Dr. Noll himself was not then as scornful of reports of extreme abuse of children as he appears to be now. In 1989 he wrote the following in a letter to the editor of Dissociation: "'What, then, are we to make of our patients' recalled childhood experiences of ritualized abuse at the hands of satanists? Some experiences are undoubtedly true. Most, however, fit [British Historian] Cohn's fantasy [beliefs in witches] much too closely to be taken as reports of actual experience." (Dissociation. 1989;II:4:253.)

It is very clear that dissociative disorders are associated with traumatic experience, and child abuse is, sadly, common, not rare. Who would have thought twenty-five years ago that we would learn of widespread abuse of children by clergy, along with institutional cover-ups and failures to report criminal activity to the police and social welfare agencies? There is now a Dissociative Subtype of PTSD in the DSM-5, involving depersonalization/derealization in addition to the other PTSD symptoms. So it is clear that trauma and dissociation are linked. The False Memory Syndrome Foundation, presented in Noll's article as the 'answer,' was highly critical of the diagnosis of DID, those who treated people with the disorder, and vigorously cast doubt upon reports of childhood sexual abuse (not just Satanic Ritual Abuse). Indeed, the FMSF started over credible abuse allegations by the daughter of its founder, well-known psychologist Jennifer Freyd, of abuse by her father. If one can have a false memory that childhood abuse occurred when it did not, one can also have a false memory that abuse did not occur when it did. In addition, one who has been physically, sexually, or emotionally traumatized may provide both true as well as exaggerated

reports. Those who have been abused are terribly damaged, as are those who are falsely accused. Systematic denial of abuse is every bit as wrong as exaggeration of it.

**RESPONSES 2**

## A REPLY TO DR. NOLL

**Richard P. Kluft, MD, PhD**

In discussions of a subject that is relatively unfamiliar, a powerfully articulated stance unchallenged by data and arguments to the contrary may appear to be persuasive and conclusive. When such a stance promotes a polarized perspective that has an a priori resonance with widespread preconceptions and misconceptions, its force is magnified, irrespective of its merit or accuracy. These considerations make it all the more important to subject Dr. Noll's curious and vehement communication to close scrutiny.

Discourse can be conducted with or without dignity. Without the preservation of dignity conflicts become difficult if not impossible to resolve. In my response I will not counter-attack Dr. Noll for his egregious and regrettable ad hominem remarks. Here I will simply state my aversion to attacks against individuals, and my conviction that they distract from rather than enhance one's argument. Dr. Noll seems oblivious to the fact that he is talking about real people. His remarks may cause pain and hurt, and his inaccurate allegations are potentially harmful to the professional reputations of several individuals. I will leave Dr. Noll's readers to contemplate his approaches in the context of the remarks I will make below, and encourage them to draw their own conclusions.

Dr. Noll's "history" brings to mind a wonderful undergraduate seminar on allegory in literature. We learned that as Christianity rose in prominence, early Christian scholars, eager to find the anticipation of Christ as the Messiah in pre-Christian literature and to discover various affirmations of Christian meanings in both current and older works of literature, established several principles of exegesis, rules with which creative works were to be read and interpreted. These guidelines were designed to discover and confirm specific religious interpretations in whatever had been written.

Dr. Noll appears to subscribe to a particular model of exegesis which modern researchers would understand as motivated skepticism toward everyone/everything of which he disapproves, and confirmatory bias toward everyone/everything that pleases him. His "history," albeit riddled with inaccuracies, affirms his faith in his beliefs and justifies the denigration of those who may not share them. All too often his account falls short of objectivity. At times Dr. Noll relies upon opinions, inaccurate statements, innuendos, and mischaracterizations to buttress and confirm his "faith" and presents the total package as an objective understanding.

Dr. Noll makes the remarkable statement that the International Society for the Study of Trauma and Dissociation was founded by a small number of individuals to study the epidemic they did so much to create. Unfortunately for Dr. Noll, this is a dubious line of reasoning. Interest in DID, then called multiple personality, may not have been mainstream, but it was already widespread. George Greaves' 1980 article generated over 5,000 requests for reprints. This suggests that a remarkable interest in DID existed prior to the publications of the individuals whom Dr. Noll accuses of fomenting an epidemic of DID cases, and prior to the establishment of any organization for their study. Please note that Dr. Greaves' article was published in the same year as the publication of Michelle Remembers, often described as the spark that ignited widespread interest in satanic ritual abuse. Any statement that either Michelle Remembers or that authors like Braun, Kluft, and Putnam, who were unpublished in the field in 1980 or before had any connection with the outpouring of interest that greeted Greaves' article cannot be accurate. Patients suspected of or diagnosed with DID were referred by many others to the experts now accused of creating large numbers of DID cases. I am the only person mentioned by Dr. Noll who is somewhat vulnerable to the type of accusations he makes. Many of the cases I identified were discovered in the course of my efforts to develop and test a screening measure for DID. I made active efforts to screen patients I saw in a psychiatric emergency unit and patients assigned to me in rotation at a general hospital psychiatric unit with a

primitive diagnostic instrument. It is important to appreciate that while the underdiagnosis of DID is well-documented in several studies, the over diagnosis of DID remains in the realm of strongly-voiced opinions. After stating the above, I should add that by the mid 1980 my own larger early series included referrals from over 80 colleague clinicians.

Noll weakens his argument by lumping together his concerns about satanic ritual abuse, the iatrogenic creation of DID, and, by example and implication, the recovered memory debate. There is every reason to argue that many reports of satanic ritual abuse were ill founded, and to doubt the extent of what these reports alleged. There is also good reason to avoid going to the extreme of dismissing them completely.

What Dr. Noll experienced in terms of over-energetic confrontations by those trying to force their beliefs upon him is all too familiar to me. There was ample reason to conclude that at times things got out of hand. I would not consider Ms. Steinem's simple offer of information as inappropriate. I am sorry that Dr. Noll was mistreated. I saw and personally experienced similar encounters. I was booed by audiences in many settings for my more agnostic stance and my refusal to be pushed one way of the other on the SRA issue. Sadly, Dr. Noll's current publication is reminiscent of the intemperate confrontations both he and I experienced. I will return to the SRA issue at the close of my remarks.

Before moving on, I feel obliged to the readers of this article to share something Dr. Noll omitted. The symposium in which Noll and others skeptical about SRA made their presentations was put on the program of that meeting by the same Bennett Braun whom Dr. Noll attacks with such vigor. Braun understood that there was considerable conflict about the subject, and was determined to give all perspectives a fair hearing. Dr. Noll seems to have forgotten this.

Having acknowledged an element of veracity in Dr. Noll's account, there is ample reason to dispute many of the other aspects of his argument. Dr. Noll's accusation that there has been wide-spread iatrogenesis of DID in persons initially without a dissociative disorder is worthy of particular notice. Despite the vociferous opinions of many, there is no objective data to support it. That being said, it is clear that iatrogenic pressures may lead to the development of additional self-states in already dissociative individuals.6 Further, evidence has accumulated to demonstrate that while false memories may be induced in a small percentage of vulnerable individuals, the recall of once inaccessible memories that can be documented as accurate is a well-documented phenomenon. Noll's style of argumentation links phenomena commonly attacked together, but he fails to note that even the most complete refutation of every single satanic ritual abuse allegation would leave his skepticism about the possibility of accurate recovered memories and his accusations about the iatrogenesis of DID unproven. In a 19958 article I demonstrated the recovery of initially unavailable accurate memories of trauma, false memories, and the fact that both could coexist in traumatized dissociative patients.

Some of the most intriguing statements Dr. Noll made were news to me. I never realized that I was considered among the nation's elite psychiatrists. Perhaps such inflated attributions, however ironic and tongue in cheek, enhance the target value of those said to be elite. I have never before heard anyone state that the Goodwin and Hill article and my comments upon it were widely understood as validations of rather than simply perspectives on the "satanic panic" and efforts to understand it in a historical context. Nor, since the 1918 influenza epidemic was discussed at length and in depth in at least three courses during my medical education, was I aware that it had been forgotten.

Among the most shockingly inaccurate statements made by Dr. Noll is his assertion that "psychoanalytic clinicians found asylum among the dissociative disorders and their presumed reactive, trauma-induced origins." Nothing could be further from the truth. During the period of time Dr. Noll purports to study, there were only a handful of psychoanalysts in the dissociative disorders field and the mainstream of psychoanalytic thinking minimized the role of actual trauma as defined in the DSM. Trauma was a central concept, but defined in intrapsychic terms. In the years under discussion, mainstream psychoanalysis remained inclined to treat reports of childhood mistreatment as fantasies, and showed aversion rather than interest toward dissociation. A relevant article taking note of these problems was entitled "Incest. See Incest Fantasy." The author, Simon, noted that the denial of attention to severe trauma was so pervasive in the analytic community that the subject of actual incest was not even included in major psychoanalytic

indexes. Hence the title of his article. Of the three discussants of a paper on Holocaust-related trauma, one dismissed the importance of the Holocaust-related trauma, one approached it from a poetic and metaphoric perspective, and only the third considered it important in and of itself. There have always been a few voices in psychoanalysis concerned with trauma as defined in the DSMs, but even today these colleague remain a minority. Dr. Noll's assertions in connection with psychoanalysis are completely inaccurate.

I am deeply troubled by Dr. Noll's misunderstanding or misrepresentation of the DSM process. He stated that the guardians of the profession quarantined those who participated in DSM-III-R from participation in DSM-IV. This is not true. The procedures for developing new editions of the DSM do not remain unchanged from one edition to the next. Also, DSM work groups are different from advisory committees in function, and the ways in which work groups and committees have related have not been the same in all DSM processes. Among those individuals whom Noll states were excluded from the DSM-IV process were several who in fact remained active participants in advisory committee work for the newer editions. Dr. Noll's gratuitous misstatements are detrimental to the professional reputation of those individuals, who actually continued to be involved. As for myself, far from being banished, I was asked to write a first draft for the text of Dissociative Identity Disorder for DSM-IV. Then others provided input and the Chair, David Spiegel, generated a final draft. While the gist of what I wrote was retained, only two sentences emerged unmodified by the process. Dr. Noll simply does not have his facts straight. He has drawn and promulgated provocative and unwarranted conclusions. When Dr. Spiegel, whom Noll does not mention by name, spoke of wanting to avoid a circus, he was not talking about the process of the DSM revision. He was talking about problematic attitudinal issues both within the profession and among the lay public. The condition's name was changed with the hope of defusing the polarized debates that surrounded the condition, not because the condition itself had been invalidated in any way.

I found Dr. Noll's comments about my editorship of Dissociation to be somewhat out of contact with reality, but consistent with his rules of exegesis. He makes disparaging remarks about my publishing certain articles, and then makes significant omissions about my publication of others. Yes, I encouraged serious articles on controversial subjects in which no firm resolution had been reached, hoping to promote further scholarly study and interchange. Of course I accepted a special issue on exorcism and possession! The United States is a religious nation, and modern "exorcism light" or "Christian Deliverance" was ascending in popularity. Dissociative individuals were being encouraged to leave therapy, convert to fundamentalist sects, and be cured by exorcistic procedures. That issue of Dissociation took up the risks associated with exorcism, outlined the unfortunate misuses of exorcistic procedures, and demonstrated that their therapeutic power was minimal and that often such procedures were destructive. It was especially important to publish this information because one of the modern pioneers of DID treatment had indeed advocated exorcism-like interventions in the 1970s. Although their use had already been marginalized and largely abandoned, it was crucial to place appropriate warnings in the literature and discourage any return to such procedures. Yet Dr. Noll describes my publication of that special issue as an ongoing effort to co-opt the supernatural.

Curiously, Dr. Noll neither faults nor compliments me on publishing his contributions or those of George Ganaway. I received a good deal of criticism for publishing them, and strongly defended Drs. Noll and Ganaway. Dr. Noll is probably unaware of this.

An alternative to Dr. Noll's disparaging remarks/innuendos about my editorship is available. Perhaps he should have accused me of being open-minded and encouraging of various perspectives on issues that were as yet unresolved, but there appears to be no place for such an observation within his curious rules of exegesis.

I remember Dr. Noll's contribution well. In it he stated, "What, then, are we to make of our patients' recalled childhood experiences of ritualized abuse at the hands of satanists? Some experiences arc undoubtedly true.". In view of his blatant endorsement of the reality of satanic ritual abuse in this publication, I find his current approach to this subject matter perplexing.

While Dr. Noll accuses me of promoting the colonization of the supernatural, an alternative explanation might be that I have studied the literatures of anthropology and the history of psychiatry to appreciate the wisdom of understanding DID as a secularized expression of possession syndromes. The DSM-5 advisory and work groups made room for pathological (as opposed to culturally-sanctioned) possession syndromes under the rubric of DID, embracing the varied expression of such psychopathological manifestations in different cultures. (For DSM-5 the Roman numerals used for earlier editions have been replaced with Arabic numerals.) The psychiatric profession has moved to endorse the cross-cultural perspective I put forward in 1991, which was based on my reading of the work of Henri Ellenberger, the literature of anthropology, and discussions with several anthropologists about observations they made during their field work. What Dr. Noll excoriates may be understood, alternatively, as a cross-cultural sensitivity increasingly embraced by our profession.

The following statements are oversimplified generalizations offered to provide a simple frame for approaching a complex issue. The structure of DID and allied conditions is a cross-culturally distributed pattern of coping with profound psychosocial distress and other overwhelming experiences. The natures of the entities encountered in such conditions are highly influenced by cultural and sub-cultural considerations. Beyond that, once the structure of the condition is established, the creation and nature of particular personalities may be quite sensitive to all manner of external influences, including iatrogenic pressures. In my experience, the particular structure of the personality system and the number of alters created seem more related to the nature and amount of unfortunate experiences and to certain idiosyncratic factors unique to the patient.

By implication, Noll associates the waning of interest in satanic ritual abuse with the demise of the journal Dissociation, and indicates that with its demise, scientific communications about the dissociative disorders effectively had come to an end. In fact, Dissociation came to an end because the International Society for the Study of Trauma and Dissociation wanted more control over its journal. After a rather nasty dispute, it disenfranchised Dissociation and established the Journal of Trauma and Dissociation as its successor. This successor journal continues to publish scientific and clinical contributions in the field of dissociation. Noll's obituary for the literature on the study and treatment of dissociation is outrageously premature.

It would be more accurate to state that as an avalanche of false memory lawsuits began in the 1990s, many therapists adopted a more defensive stance, became more apprehensive that the exploration of traumatic memories of any sort might land them in court, and felt that the cost/benefit ratio of continuing an ongoing exploration of the SRA issue had become prohibitive. Many abandoned working with dissociative and traumatized patients. A more detailed discussion of the era of the "memory wars" is beyond the scope of this response.

I will close with a few remarks about why the SRA issue was very difficult to dismiss once it began to become a topic of discourse. Dr. Noll mentions his youth when he first attended the meetings of the International Society for the Study of Trauma and Dissociation. Indeed, his youth may be an important consideration, and might account for his reduction of the matters that concern him to failures of intellect and moral courage. To follow H.L. Mencken, "For every complex problem there is a simple solution… and it is wrong."

I have a different perspective. In general, the therapists who struggled with how to understand and address SRA were considerably older than Dr. Noll. They were grappling with the challenge of understanding an amazing amount of confusing and unsettling information. I do not fault my colleagues for their courageous efforts to struggle toward understanding complex and confusing matters.

But let me speak for myself, and not presume to speak for others. Contrary to Dr. Noll's assertions, I have never made a secret of my stance. I have shared my perspectives in many professional settings. I grew up under the shadow of the Holocaust, learning more and more about how many nations, including my own, had failed to acknowledge and/or act responsibly in the face of a genocidal disaster. I discovered how those close to the Holocaust were able to rationalize their denials and/or collaborations. Mine is the generation that heard the FBI strenuously deny the existence of organized crime until the very public 1957 Apalachin meeting of Mafia figures came to widespread attention. Then, my generation watched the FBI

do an abrupt and embarrassing about face, reversing its longstanding dismissive position. Mine is the generation that had to deal with Vietnam and the American government's egregious misrepresentation of the reality of the situation there. Further, my generation witnessed its initial denial of the damage done to the young men who served there, and their frequent misdiagnoses as character disordered or psychotic rather than traumatized. My generation watched the estimated frequency of father-daughter incestuous events soar from one case per million in 1975 to one out of twenty biological father-daughter relationships in 1986, and the estimated incidence of therapist-patient sexual exploitation from rare to embarrassingly common. In addition, my generation witnessed the revelation that prestigious mental health professionals had participated in unethical research on human subjects for covert agencies, research that was very destructive to many subjects. Further, as the findings of the Lanning report were becoming known, I was in contact with FBI agents in connection with another matter. I learned that many agents in the field did not believe that the official reports denying many aspects of SRA were honest or accurate.

Faced with these repetitive betrayals of trust and contradictory perspectives from our federal law enforcement agencies, I like many others, could not be comfortable with "authoritative" statements that denied the reality of many aspects of SRA. Strong statements from sources that had undermined their own credibility simply were not convincing — they were just more information to consider. Those who remembered the many dishonesties and betrayals of trust listed above were less likely to accord immediate credibility to a governmental agency's reporting that organized SRA does not exist. For those who had become aware of the numerous instances of mistreatment that had been denied, rationalized, minimized and otherwise kept secret, it was very difficult to believe that something evil and covert was a priori preposterous.

I have often stated that the vast majority of SRA reports I encountered were not credible, and explained how I arrived at that opinion. In brief, I demonstrated that if the atrocities and grotesque rituals allegedly witnessed by a geographical cluster of patients who were convinced that they had victimized in transgenerational satanic abuse had actually occurred, the county in which they resided would have been depopulated in just over a decade. Their claims simply could not be true. Further, I have expressed my concern that the importance of SRA reports as a derivative expression of more mundane abuses that, if acknowledged, would threaten the attachment needs of these patients, has been sorely underestimated. Many patients found it more tolerable to believe that their abusive families simply did to them what they had experienced when they were young and were carrying on a religious tradition than to believe that they had been mistreated because their abusers wanted to abuse them. This stance both rationalizes their abuse experiences and at least partially exonerates their abusers.

However, that being said, it is undeniable that satanic elements are employed at times by those who wish to exploit the power of such materials for the purposes of intimidation and/or to pursue nefarious purposes. They are encountered in the context of organized satanic religion, in idiosyncratic religious or quasi-religious beliefs, and in deviant individuals and/or splinter groups of practices that themselves normally do not endorse such beliefs or practices. They are experienced as symptoms of psychotic/delusional mental disorders. Satanic elements remain problematic realities in many situations.

I remain troubled about the matter of transgenerational satanic cults. Any scientist or thinker has had to grapple with how difficult it is to prove that something does not exist. I am comfortable in saying that if such situations exist, they exist at a level of far less frequency than was once suspected. That being said, in the mid-1970s, years before the surge of interest in SRA during the 1980s, I encountered situations that involved reports by non-participant eyewitnesses who were neither dissociative nor traumatized patients. In fact, they were without psychiatric illness. I would be dishonest if I allowed the pressures of those with strong convictions that such groups either do or do not exist to push me to endorse either stance. Holmes cautioned Watson, "It is a capital mistake to theorize before one has data. Insensibly one begins to twist facts to suit theories, instead of theories to suit facts." As a corollary, it would be a similar error to follow the model of Procrustes, and cut away facts or stretch or otherwise distort them, discarding them or forcing them to fit a particular model or preconception.

I prefer honest uncertainty to false conviction.

**RESPONSES 3**

## BENNETT BRAUN, MD

I am surprised and displeased to have learned about the publication of an article that vilifies and disparages me so extensively only such a short of time before its publication. I would have appreciated having enough advance notice to draft a more suitable and complete response.

Here I will only respond to the things in Dr. Noll's article that relate specifically to me, and leave the task of responding to its other unfortunate inaccuracies and mischaracterizations to others.

I have become accustomed to such slander and misrepresentation, and have been misquoted extensively over the years. Neither the Editors nor the readership of Psychiatric Times would appreciate being treated in this manner.

Remarks taken out of context can be presented in a manner that misrepresents the overall intent of the speaker. I would suggest that the Editors of Psychiatric Times obtain the tapes of the events to which Dr. Noll refers and make their own decisions whether or not I have said what I am alleged to have said, and to place what I have said in the context in which my remarks were made. It is regrettable and shameful that such slanderous remarks will be printed by the world's most read psychiatric publication, and conveyed to colleagues who will not be in a position to question them or judge their accuracy.

Labeling things with a catch-phrase may provide attractive and compelling shortcuts, but they often take on a life of their own that has a questionable connection to reality. Using a term like "Braun's international conspiracy fantasies" is an attractive catch-phrase which can easily evoke strong emotion and take on a life of its own. Once such things are said, they join the ranks of "things that never were true, but always will be." I never referred to any international conspiracy, so how can such a notion be labeled as "Braun's international conspiracy fantasy"? The answer is simple – say it loud enough and long enough and it will be remembered, and what never was true will be regarded as the truth by many.

Dr. Noll's paper is far from scientific as it contains many inaccuracies. For example, the first meeting of what is now the International Society for the Study of Trauma & Dissociation had 125 attendees— not the 300 he stated.

To describe serious educational workshops as a "carnival" demeans the workshops, their faculties, and those who attended them. The proposals for every workshop and paper presented at the meetings of this group were evaluated by 3 reviewers. Only the top 10-20%, depending on category, of the proposals were actually accepted for presentation.

I did at some point say that I had seen a patient in the Netherlands who reported satanic ritual abuse and that I had heard from others in Europe and Canada who reporting similar things. I never said that satanic ritual abuse was an "international conspiracy structured similar to a system of Communist cells." I also said that I had seen evidence of trans-generational aspects to the abuse (as is reported in many forms of child abuse), but I very much doubt that I dated it to 2000 years ago.

Dr. Noll has a flare for the melodramatic. The 1989 workshop he refers to was taped. I never "screamed" anything. I did say the patient who drew the picture stated that it was of a satanic ritual. I passed on what had been communicated to me.

Dr. Noll states that no one on the Dissociative Disorders Committee for DSM IV had been on the DSM III R committee. The implication is that the American Psychiatric Association wanted to get rid of the problematic people who worked on DSM-III-R. Unfortunately for his argument, his statement is historically inaccurate. David Spiegel convened an advisory committee that included some of the people Dr. Noll states were excluded, and even invited the participation of scholars who were very skeptical and wanted to eliminate the disorder from the DSM. I commend Dr. Spiegel's objectivity. I personally have no significant objection to relabeling Multiple Personality Disorder as Dissociative Identity Disorder. The diagnostic criteria and descriptive text basically convey the same meanings as their predecessors.

In my opinion the major reason the Dissociative Disorders suffered, what has proven to be a temporarily reduced presence in the mental health mainstream, was due to the epidemic of false memory lawsuits,

which for several years intimidated therapists and discouraged them from working with this patient population. In response to those lawsuits all too often insurers discouraged fighting these suits and settled them out rather than mount aggressive defenses of their policyholders. Whether this was due to their lack of courage or on the basis of their estimation of the costs of various options is a subject for another time. Unfortunately the results of these tactics often were the ruining of professional reputations and raised insurance rates.

The key lawsuit against me was settled in October 1997. On January 17, 1997, the lead plaintiff testified in her deposition that she had originated all the memories herself. I did not implant any memories, she said. As she said, I only passed on to her what the other patients had reported about her. Unfortunately, the insurance companies settled against my will in October 1997, even though I paid an extra 10% premium to give me the right to refuse settlement.

In the atmosphere that prevailed, so many people in the mental health field, the legal profession, and the insurance industry were intimidated that the path of least resistance seemed preferable to the more expensive option of fighting for justice. Looking back, the articles to which Dr. Noll refers had a powerful impact beyond their lasting merit. Within a few years, those who were not intimidated would be able to mount powerful defenses and demonstrate the shortcomings of the articles that at first many regarded as definitive. But that was not the case during the period of time to which Dr. Noll refers.

In this communication, I have taken up the attacks Dr. Noll made against me. My sympathy goes out to all of the others who were also treated poorly and mischaracterized, and to all of the patients who undoubtedly will be upset and confused, and whose treatments may be undermined or compromised should they come upon Dr. Noll's article without companion publications that refute his many problematic and inaccurate statements and allegations.

**RESPONSES 4**

## RICHARD NOLL, PHD

Psychiatric Times and its editor-in-chief, Dr. James Knoll, are to be lauded for reopening a forum for the open exchange of intellectual discourse on the central issue of my historical article: why has the satanic ritual abuse (SRA) moral panic of the 1980s and 1990s been forgotten? It seems that now the time has finally arrived – uncomfortable as it may be – for a discussion of the part that American psychiatry played in this cultural and medical catastrophe.

I am especially gratified that Drs. Spiegel, Kluft and Braun have graciously contributed commentary to my article. As a young man trying to learn his clinical craft from those older and wiser, I learned a great deal from them all. Let me be clear about my esteem for these three physicians: within the scientific context of the 1970s to mid-1990s, all three men were regarded – and professionally honored -- as having made significant contributions to psychiatry. When future historians of American psychiatry write their accounts of the late 20th century, all three of these distinguished men will be recognized for their influence in the medicine and popular media of that era. They are all modest men, and as such are naturally reluctant to acknowledge their elite status during those decades. Nonetheless, their stories are pivotal in the history of American psychiatry and they belong to the ages.

History, like clinical work, is an imperfect art. We do our best with the evidence at our disposal to reconstruct the past into a narrative for the purpose of teaching those living in the present. Certain facts cannot be disputed, others can disappear into a cloud of conflicting memories, interpretations or – as in the case of the SRA moral panic – feigned forgetfulness. As a historian of psychiatry I am delighted that Drs. Kluft and Braun are open to having their voices added to the historical record. They bring fresh perspectives, insights and new facts to the historians who will certainly be writing about them. At least one book, by journalist Richard Beck, is already in progress. My article was intended as an invitation to open this discussion to professional historians and clinicians. I hope that Drs. Kluft, Braun and others publish memoirs of their careers based on their own personal perspectives. I also hope that they grant young

historians interviews so that the contextual gaps in the history of American psychiatry in the 1980s and 1990s can be corrected.

Readers of the three commentaries on my article may regard them as a bit more emotive than substantive. This quality should not be interpreted by readers as anything more than what it is. We are opening a discussion about sensitive subjects, all of us have feelings, and as humans we sometimes feel hurt.

Dr. Braun makes a valid point about my mischaracterization of his vocalizations as screams in a talk he gave in 1990. I claimed this happened during his animated revelation of the satanic themes in the red crayon scribblings so violently made by his patient on a large sketch pad. Whereas I only saw something in that drawing that could have been . . . a muscle spasm? . . . it was clear to me from the wide eyes and parted lips of many in the audience that they were indeed seeing the satanism. I improperly used the words "he screamed" to characterize Dr. Braun's vocalizations, and I do apologize. As a writer trying to convey the power of a memory from 23 years ago, indeed trying also to capture all of the enthusiasm that Dr. Braun demonstrated during what many of us in the room felt as the emotional climax of his presentation, simply writing "he said" or "he ejaculated" just would not do. Since even now I cannot think of an appropriate alternative term, I hope, as he is an honored expert on human memory, he will forgive my unintentionally melodramatic mnemonic misstatement. It was a memory of an emotional moment long, long ago. And as cognitive science research on memories teaches us, they are highly prone to distortion and must be challenged if contradictory evidence deems them inaccurate – or blatantly false. This is where historians and clinicians share the same ethical responsibility. Remaining silent is morally unacceptable.

As for the number of persons attending the first proto-ISSMP&D meeting, the source for what I regarded as a minor point in my narrative may have been wrong, and I concede there may have been less than 300 enthusiasts at that prelapsarian conclave. I am sure historians will be hotly debating the true number for decades.

Humans are endlessly surprising creatures. They get mixed up in all sorts of things. As anyone who is old enough to remember Charlie Manson and his Family will agree, the diabolic potential of small group dynamics in isolated environments knows no bounds. My comment in my 1989 letter about the probability of some SRA reports being true was an expression of this reasonable surmise, and nothing more. Ken Lanning of the FBI said in print in 1992 and on camera in the recent New York Times video story on the McMartin day care scandal that he also started off with this same reasonable assumption when he first heard of SRA claims. Philosopher Ian Hacking also expressed such a view in the 1995 book that I cite in my article. But organized Devil-worshipping cults kidnapping, abusing and ritually sacrificing children? Nope. Never. Never for a moment did I believe these stories were true, and just to correct a remark in the comments above, Dr. Frank Putnam never did either.

Following standard academic practice, to back up claims in my article I cited sources from what the community of scholars has regarded as reliable historical scholarship about SRA claims and about the role of American psychiatrists in the moral panic. These sources go back almost 25 years, and among the best and most highly regarded are the works of sociologist Mary de Young. Her 1994 article and two scholarly books on the moral panic, all cited above, have been regarded as the most scrupulously accurate compilations of the basic facts. Sherril Mulhern, Jeffrey Victor, Robert Hicks, Debbie Nathan and many others produced a body of scholarship based on primary sources (their own participant observations, transcripts of lectures, audio- and videotapes, etc.) some two decades ago when these events were fresh. Others who were there, such as Johns Hopkins psychiatrist Paul McHugh in his 2008 book referenced above, have recently contributed new historical evidence about American psychiatry's role in the SRA moral panic.

If any one of the facts in this large scholarly literature of the past quarter century has truly been maliciously misinterpreted or is incorrect, as is alleged in the commentaries above, I think it is therefore ethically imperative for Drs. Braun and Kluft to offer published historical documentation to contradict such a false claim robotically repeated by decades of scholars. But they need to make a case to the public based on historical and scientific evidence, not on polemics. Let's all hope they do this. I know they have much to teach us.

None of us are getting any younger. For all those who were witnesses or participants, skeptical or otherwise, during the SRA moral panic of the 1980s and 1990s, now is the time to think about how one's career and reputation is to be reconstructed by future historians. Now is the time for everyone to share their memories.

With the reposting of a modified version of my article, the vigorous commentaries, and my final response, perhaps the veil is lifted on the past and memory may now be allowed to speak. Let us open more doors within our cultural memory palace and let us learn from our mistakes.

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http://www.psychiatrictimes.com/blogs/history-psychiatry/speak-memory

## DOCTORS TO RECEIVE ARMS LICENCES, TRAINING FOR SELF-PROTECTION

**Our correspondent**

All doctors of the province will be provided arms licences and proper weapon handling training by the Sindh Rangers, who will also be setting up an anti-extortion cell at the PMA House.

These decisions were taken in a high-level meeting between senior officials of the Pakistan Medical Association and DG Rangers Major General Rizwan Akhtar at the Rangers Headquarters.

After discussions over the increasing threats and harassment being faced by the medical community, it was agreed that immediate steps must be taken to improve both personal and state protection of doctors.

These measures include complete facilitation of all doctors applying for arms licences. They will also be given proper handling training and be allowed to carry their weapons without any legal or administrative hindrances.

Another important decision was one taken with regards to the establishment of a special Rangers cell at the PMA's main office. Dedicated specifically for extortion calls or threats to doctors, the cell will function round-the-clock and also be networked with the police.

Similarly, other small networks will be established in various areas of the city and be directly connected with the PMA cell.

Law enforcement officials also advised the delegation to install CCTV cameras at clinics and hospitals..

The PMA delegation comprised Dr S Tipu Sultan, Dr M Idrees Adhi, Dr Aziz Khan Tank, Dr SM Qaisar Sajjad, Dr Qazi M Wasiq and Dr Mirza Ali Azhar, while Brigadier Basit Shuja and CID DIG Sultan Khawaja were also in attendance.

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http://www.thenews.com.pk/Todays-News-4-239223-Doctors-to-receive-arms-licences-training-for-self-protection

# WHAT A GOOD EHR COULD DO

**By Fred N. Pelzman, MD**

Under the new patient-centered medical home paradigm we, obviously, want to put the patient back at the center of the healthcare experience. New tools and techniques incorporated into an electronic health record (EHR) can build a system that helps patients achieve optimal care under a variety of different circumstances.

My dream is to create an EHR that works with our patients and our providers, to more effortlessly and effectively allow them to improve their health.

Right now, as many of us using these EHRs will affirm, there's a lot of clicking for not a lot of benefit. Working with them clearly creates an (overwhelmingly) detailed and full recording of some semblance of what went on at the office visit, but it is probably not really providing the added value that we need it to.

We want the EHR to become a living, breathing, active partner in the healthcare process. Wouldn't it be nice if the healthcare record recognized that something was overdue and alerted patients and us through the patient portal, rather than waiting for all of us to get around to recognizing it?

The system could be trained to realize the patient had not come in for refills, or has not come in for a visit in over a year, or needed reminding about previously ordered testing, consultations, healthcare maintenance items, or taking medications.

Many new systems are being created that collect data from our patients, send reminders to their phones or to their emails, that track their calories consumed, or how much sleep they got.

Many more alerts can be created to remind patients to take medicines, or that they're overdue for some home monitoring such as blood pressure or checking fingerstick glucose readings.

I'm not saying that we need to create a more authoritarian or paternalistic system, but one in which we can engage our patients and get them to team up with us, to help figure out how to get them through all of these things using the EHR to their benefit.

Harassment is not what this is about, badgering patients is not what this is about, making them feel guilty is not what this is about. We hope that this creates an environment where patients feel more engaged, once again at the center of their care, so that they feel more in charge and empowered by the healthcare process.

Right now, through our patient portal, I can send the patient a widget, which allows them to enter their blood pressure from a home unit, and send me their values, to help track at home how their blood pressure is doing on a medicine or on a nonpharmacological intervention. I can also send them one that allows them to enter their weight, or their blood glucose readings, along with several other home monitoring modalities.

These types of interventions return the patient to the center of the care, putting them in control, and helping me get more information to help bring them through to the other side.

This sort of thing speaks to the core of the patient-centered medical home. Their care continues beyond the office visit, and the patient begins to feel that their healthcare system, their health itself, is continuing well past the confines of the office visit.

Every time they take their blood pressure, every time they record their exercise, every time they get encouraged to come back in for a follow-up appointment, they're more engaged in this process of bringing them to a better health state.

We as practitioners cannot allow this to come about simply as a result of bureaucratic pressures from the forces that are creating "meaningful use"; it is much better if this comes about as a result of an organic process whereby we as practitioners, along with our patients, figure out new patient-centered ways for technology to help them reach their health goals.

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http://www.medpagetoday.com/PatientCenteredMedicalHome/PatientCenteredMedicalHome/44407

# NONSURGICAL PEYRONIE'S OPTION GETS FDA OK

**By Charles Bankhead, Staff Writer, MedPage**

The first effective nonsurgical treatment for Peyronie's disease received FDA approval Friday

The agency's decision expanded the indications for collagenase clostridium histolyticum (CCH, Xiaflex) to include treatment of penile plaque accumulation that results in abnormal curvature of the penis, causing pain, interfering with sexual function, and severely affecting a man's quality of life.

CCH is an enzyme that dissolves the plaque and, combined with physical therapy, can alleviate the curvature and associated symptoms.

"Today's approval expands the available treatment options for men who experience Peyronie's disease and enables them, in consultation with their doctor, to choose the most appropriate option," Audrey Gassman, MD, deputy director of the FDA division of bone, reproductive, and urologic products, said in a statement.

The new indication covers men who have penile curvature of at least 30°. CCH received initial approval in 2010 for treatment of Dupuytren's contracture, a progressive condition affecting connective tissues in the hand and fingers, making normal use difficult or impossible.

According to the FDA, CCH will be available only through a Risk Evaluation and Mitigation Strategy (REMS), a stipulation the FDA places on approved therapies when a risk of potentially serious adverse effects exists, in this case, penile fracture and other serious injuries to the penis. The REMS for CCH requires healthcare professionals to complete a training program for administration of CCH to patients with Peyronie's disease.

Clinical data to back up the application for a new indication came from a placebo-controlled trial involving 832 men enrolled at 54 centers in the U.S. and 10 in Australia. Eligibility criteria included penile curvature of 30-90°. Men received as many as eight injections of CCH during four treatment sessions, and follow-up continued for a year. The results showed that CCH led to significant reductions in penile curvature as compared with placebo.

The etiology of Peyronie's disease remains imprecise, but injury or trauma to the penis, possibly during sexual activity, is suspected in most cases. The accumulation of fibrous scar tissue (plaque) and subsequent curvature of the penis arise from chronic inflammation of the tunica albuginea, a normally spongy, pliable tissue in the shaft of the penis.

The epidemiology of Peyronie's disease also remains unclear, because many men are embarrassed to consult a physician about the problem. The estimated prevalence is 5% of men older than 50.

Burbank, Calif., urologist Martin Gelbard, MD, who has evaluated CCH for more than 30 years, said data from insurers suggest that about 120,000 men seek treatment for Peyronie's disease each year. Of those, 1,500 opt for surgery, which has been the only treatment to provide durable results.

"[CCH] is the first nonsurgical treatment for Peyronie's disease to show effects above and beyond what has been observed with minimally invasive therapies in the past, which essentially have been ineffective," Gelbard, who has a clinical appointment at the University of California Los Angeles, told MedPage Today. "The scientific data are an order of magnitude in quality beyond anything that has been done before."

The phase III trial that led to the new indication for CCH employed a validated quality-of-life survey developed specifically for Peyronie's disease. Results suggested that the Peyronie's Disease Questionnaire "actually shows what it is like to have Peyronie's disease," said Gelbard.

The therapeutic effects of CCH in Peyronie's disease appear durable. Gelbard has followed some of his own patients since he began working with CCH in the 1980s, and results have been maintained over the long term in most cases.

During the first follow-up after the initial injection session, patients receive instruction in stretching the penis as an adjunct to CCH. For the most part, men have practiced the manual manipulation, and the occasional patient who has not remained adherent has had less improvement in the condition as compared with men who practiced the stretching exercises.

"Adherence really hasn't been a problem; these men are highly motivated," said Gelbard.

Despite the REMS requirement attached to the approval, serious adverse events have been uncommon, he added. The most frequent adverse reaction has been bruising and swelling at the injection site, effects that usually resolve within a few days.

Approval of the new indication had been anticipated in September. The product's manufacturer, Auxilium Pharmaceuticals, submitted revisions to the REMS and proposed labeling, which the FDA interpreted as a major amendment filed during the final 3 months of review. As a result, the agency extended to Dec. 6, the Prescription Drug User Fee Act goal date for the company's supplemental biologics license application.

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http://www.medpagetoday.com/urology/urology/43283

## WATER BABIES: IS MATERNAL IMMERSION DURING LABOR AND DELIVERY SAFE?

Diane J. Angelini, EdD, CNM, FACNM, FAAN, NEA-BC reviewing Obstet Gynecol

Immersion during the second stage of labor is not recommended outside the setting of a clinical trial.

Water immersion during labor and delivery is controversial. Now, authors of a joint Committee Opinion from the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics review evidence, proposed benefits, and reported complications associated with this birthing mode. As noted in a 2009 Cochrane review of 12 randomized, controlled trials involving 3243 women, many studies were small, retrospective, observational, and did not clearly define immersion or indicate when during labor this intervention was used.

Some individual studies support benefits of immersion, although findings are inconsistent. Combined results indicate that immersion during the first stage of labor is associated with decreased use of epidural, spinal, or paracervical anesthesia (6 trials; risk ratio, 0.90; 95% confidence interval, 0.82–0.99) and no difference in risk for perineal trauma or tears; however, it is unclear whether other interventions (e.g., frequency of examinations) affected these outcomes. Reported complications associated with immersion during labor's second stage include maternal or neonatal infections (especially in the setting of ruptured membranes), compromised neonatal thermoregulation, umbilical cord avulsion or rupture if the infant is lifted incorrectly from the tub, and respiratory distress secondary to water aspiration.

**COMMENT**

I agree with the committee's conclusions that water immersion during the first stage of labor, while possibly diminishing maternal pain, does not seem to improve any other perinatal outcomes; and that immersion during second-stage labor should be limited to clinical trials because of its potential to cause neonatal complications. More large, randomized trials must be conducted. In the meantime, rigorous standards should be followed regarding maternal eligibility for first-stage immersion, infection control procedures, close monitoring of women during immersion, and protocols for emergency transfer.

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http://www.jwatch.org/na34061/2014/03/20/water-babies-maternal-immersion-during-labor-and-delivery#sthash.A6yyBMbt.dpuf

# EFFECT OF ANXIOLYTIC AND HYPNOTIC DRUG PRESCRIPTIONS ON MORTALITY HAZARDS: RETROSPECTIVE COHORT STUDY

BMJ 2014


## Abstract

Objective To test the hypothesis that people taking anxiolytic and hypnotic drugs are at increased risk of premature mortality, using primary care prescription records and after adjusting for a wide range of potential confounders.

## Design Retrospective cohort study.

Setting 273 UK primary care practices contributing data to the General Practice Research Database.
Participants 34 727 patients aged 16 years and older first prescribed anxiolytic or hypnotic drugs, or both, between 1998 and 2001, and 69 418 patients with no prescriptions for such drugs (controls) matched by age, sex, and practice. Patients were followed-up for a mean of 7.6 years (range 0.1-13.4 years).

**Main outcome** All cause mortality ascertained from practice records.

**Results** Physical and psychiatric comorbidities and prescribing of non-study drugs were significantly more prevalent among those prescribed study drugs than among controls. The age adjusted hazard ratio for mortality during the whole follow-up period for use of any study drug in the first year after recruitment was 3.46 (95% confidence interval 3.34 to 3.59) and 3.32 (3.19 to 3.45) after adjusting for other potential confounders. Dose-response associations were found for all three classes of study drugs (benzodiazepines, Z drugs (zaleplon, zolpidem, and zopiclone), and other drugs). After excluding deaths in the first year, there were approximately four excess deaths linked to drug use per 100 people followed for an average of 7.6 years after their first prescription.

**Conclusions** In this large cohort of patients attending UK primary care, anxiolytic and hypnotic drugs were associated with significantly increased risk of mortality over a seven year period, after adjusting for a range of potential confounders. As with all observational findings, however, these results are prone to bias arising from unmeasured and residual confounding.


## INTRODUCTION

Prescribing of hypnotic and anxiolytic drugs is common and increasing in places. In 2011-12 more than 16 million prescriptions for these drugs were written in general practice in England at a cost of over £60m ($100m; €73m) per annum. Benzodiazepines currently account for 62% and Z drugs (zaleplon, zolpidem, and zopiclone) 32% of total prescriptions for hypnotics and anxiolytics in primary care in England.

Evidence of adverse effects5 including increased risk of dementia and other psychomotor impairments (daytime fatigue, ataxia, falls, and road traffic incidents), cancer, pneumonia, and other infections has increased concerns of an association with premature mortality. Until recently evidence for this was based on a small number of studies, which varied in setting, sample (especially age distribution), length of follow-up, source of drug usage data, type of drug, and the extent of control for confounding (especially from physical and psychiatric comorbidity, co-prescribing, socioeconomic status, smoking, and drug and alcohol misuse). Although two studies in older populations did not report a statistically significant association between benzodiazepine use and mortality after adjusting for confounders, four others (in younger samples) found evidence of significantly increased mortality. A study in people with schizophrenia reported associations with suicide and with all cause mortality. Adjusted hazard ratios have varied substantially,

ranging from 1.1421 to 4.56.16 A recent study found that the mortality risk extended to those with low levels of use, was greater in younger people, and that heavy use of hypnotics increased the risk of developing cancer. Questions remain about effect size, interactions with age, and confounding (particularly by anxiety and other psychiatric disorders).

We tested the hypothesis that people taking anxiolytic or hypnotic drugs, or both, are at significantly increased risk of death compared with non-users and to estimate the size of this association after adjusting for a wide range of potential confounders using prescribing data from UK primary care.

## Methods

We undertook a retrospective, matched cohort study using the General Practice Research Database (GPRD). GPRD (incorporated into the Clinical Practice Research Datalink in 2012) was created in 1987 and is the largest anonymised, longitudinal primary care database in the world, with around 70 million patient years of high quality validated data from 630 practices. In 2011 over 11 million patient records were in the GPRD (five million active), equivalent to 8.3% of the UK population. The database contains records from clinical consultations with general practitioners, prescriptions, secondary care referrals, and hospital admissions.

This project was awarded a licence as part of a scheme operated by the UK Medical Research Council and Medicines and Healthcare products Regulatory Agency to provide data access on up to 100 000 patients. Data were based on records from 273 primary care practices in England, Scotland, Wales, and Northern Ireland.

## Participants

Eligible participants were patients aged 16 years and older, permanently registered with a practice contributing data to the GPRD, and with at least 12 months of up to standard records (as per GPRD data quality standards). We identified patients who had received study drugs by incident (first ever) prescription of an anxiolytic or hypnotic drug (see chapters 4.1.1 and 4.1.2 of the British National Formulary), excluding barbiturates, during the recruitment window from January 1998 to December 2001. We only included patients who received at least two prescriptions for a given study drug during the recruitment period. This was done to minimise misclassification of use among people who received but did not fill the prescription or take the drug. We reasoned that a second (that is, repeat) prescription indicated that the first had been filled and taken. Examination of a subsample of GPRD records (not reported here) found that 40.3% of people in receipt of a lifetime prescription for an anxiolytic or hypnotic drug only ever received a single prescription for that drug. No prescriptions for any study drugs were recorded for participants (whether users or non-users) for the duration of their practice record before recruitment into the study. Mean duration of registration with study practices before recruitment was 15.6 years.

To improve efficiency and reduce the number of required patients who were prescribed the study drugs, we matched each patient prescribed any study drugs to two controls from among those with no prescription for any study drugs, on age (three years either way), sex, and practice. The 2:1 recruitment strategy was also determined by the 100 000 limit on the total sample size under the terms of our data license. Matching occurred (and follow-up started) at the time of the first prescription for a study drug. The period during which the study outcome (death) was ascertained therefore began at exactly the same time for both patients prescribed the study drugs and (matched) controls. Both groups of patients were followed until the earliest of death, censorship (no longer registered with practice), or truncation (end of the observation period on 31 October 2011). Study outcome was all cause mortality as recorded in the practice record. The observation period for the ascertainment of covariates was the entire interval for which data are available for a patient between the time their record starts (before recruitment) and either death, censorship, or truncation. To reduce the likelihood of bias arising from the prescription of study

drugs to those who were terminally ill and nearing the end of life, we restricted the study sample further in our final model to patients who survived for longer than 12 months after recruitment.

## Ascertainment of study drug use

We ascertained the receipt of hypnotic and anxiolytic drugs from electronic prescribing records. Use was initially quantified in terms of defined daily doses from study entry point to the end of each patient's observation period. The defined daily dose is the assumed average maintenance dose per day for a drug used for its main indication in adults (considered to be someone of 70 kg body weight). The defined daily dose, a measure of equivalence that permits pooling of usage data across different drugs used for the same indications and values, are available from the WHO Collaborating Centre for Drug Statistics Methodology (www.whocc.no/atc_ddd_index). The defined daily doses in the exposed group were recoded as a categorical variable: 1-30, 31-60, 61-90, and ≥91, corresponding to prescriptions of one, two, three, or more than three months' duration. We classified study drugs as benzodiazepines, Z drugs (zaleplon, zolpidem, and zopiclone), and other. Patients who were prescribed study drugs were further dichotomised according to whether or not the study drug continued to be prescribed after the first 12 months of observation.

## Covariates and potential confounders

Statistical adjustment was undertaken for potential confounders. Controlling for confounding by indication (that is, possible reasons for being prescribed a study drug) is especially important. Potential confounders included sex, age at study entry, sleep disorders, anxiety disorders, other psychiatric disorders, medical morbidity, and prescriptions for non-study drugs. Smoking and alcohol use were recorded within the dataset as current, former, or never. As a means of controlling partially for differences in socioeconomic status, we matched patients who were or were not prescribed study drugs by practice.

Medical morbidity was ascertained using Read codes for arthritis and musculoskeletal problems, asthma, cancer, chronic obstructive pulmonary disease, diabetes, gastrointestinal disorders, epilepsy, hypertension, ischaemic heart disease, stroke, and sleep disorders. We subdivided psychiatric codes into anxiety disorders (the main indication for anxiolytic prescribing) and all other psychiatric disorders.

## Data analysis

Using Cox proportional hazards models, we estimated the hazard ratios for death after recruitment into the study cohort (defined as the first prescription of a study drug). Exploratory analyses showed that the hazard function (for the association between study drugs and mortality) varied with age (results available from authors); we therefore stratified regression analyses by this variable.

In the first model we included prescriptions for all study drugs during the observation period (following recruitment) and included all deaths, regardless of timing. In the second model (to minimise confounding of use by survival) we restricted the exposed patient sample to those who were prescribed study drugs only in the first year after recruitment. All deaths were included, regardless of timing. In the third and final model, we further restricted both patient groups to those who survived for more than 12 months (and therefore after study drug prescription had ceased in the group using the study drugs).

We assessed the extent of co-prescribing of study drugs. Since 75.9% (n=26 347) of patients who used study drugs had received at least one prescription for a benzodiazepine and 31.5% (n=10 877) had received more than one class of study drug, we opted to pool estimates of association with mortality across groups in our primary analyses. We undertook subgroup analyses in which the group prescribed the study drugs was restricted to those who received benzodiazepines only, Z drugs only, or other study drugs only, in the first year after recruitment. MF and HP undertook all analyses by using SPSS version 19.0.

## Results

Data were obtained on 34 804 patients who were prescribed the study drugs and 69 585 patients (matched) who were not (controls). Seventy seven patients who were prescribed the study drugs were excluded (with 154 matched controls) owing to insufficient data to allow defined daily doses to be calculated. We also excluded 13 "unexposed" patients who had been prescribed melatonin during the observation period. The final sample for study models comprised 104 145 patients, of whom 34 727 were prescribed the study drugs and 69 418 were controls. Censorship (excluding death) was observed for 26.7% (n=9314) of the patients who were prescribed the study drugs and 31.2% (n=21 644) of controls.

Benzodiazepines (63.7% (n=22 116) of patients prescribed the study drugs) were more common as the index drug class than Z drugs (23.0%) (n=7971) or other study drugs (13.4%) (n=4640). Co-prescribing was common. In total, 76.3% (n=26 436) of patients using study drugs received a prescription for a benzodiazepine, 38.8% (n=13 444) a prescription for a Z drug, and 33.5% (n=7444) a prescription for one or more of the other study drugs. The most commonly prescribed study drugs were diazepam (47.9% of those prescribed the study drugs, n=16 638), temazepam (35.1%, n=12 208), and zopiclone (34.1%, n=11 764). Among the group prescribed the study drugs, 24.2% (n=8404) were only prescribed diazepam, 14.8% (n=5140) only temazepam, and 12.2% (n=4237) only zopiclone.

shows the characteristics of the study sample. Patients who were prescribed study drugs were more likely than controls to be current smokers and to have higher rates of all forms of physical morbidity, most notably cancer and respiratory disorders. The group prescribed study drugs also had higher rates of sleep (28.1% (n=9741) v 5.8% (n=4009)), anxiety (44.1% (n=15 299) v 11.3% (n=7849), and other psychiatric disorders (56.9% (n=19 770) v 21.7% (n=15 026)) than controls, and received more prescriptions for non-study drugs.

We found statistically significant associations with mortality at all levels of study drug use. Our initial model classified use irrespective of when this occurred, and included all deaths regardless of when these occurred during the observation period. The hazard ratio for mortality in the group with the highest use of study drugs was lower than that in all three groups with fewer defined daily doses, suggesting that use was confounded by survival. We also noted reverse confounding on adjusting for study covariates.

In the second model, the exposed group was restricted to those who received no prescriptions for the study drugs after their first year of observation. The age adjusted hazard ratio for mortality for any use of study drug was 3.46 (95% confidence interval 3.34 to 3.59), decreasing slightly to 3.32 (3.19 to 3.45) after adjusting for potential confounders. A clear dose-response association was found, with an adjusted hazard ratio for mortality of 4.51 (4.22 to 4.82) among those who received more than 90 defined daily doses of any study drug in the first year of follow-up. Associations with mortality, and dose-response effects, were found for each of the three separate classes of study drug. Hazard ratios were largest for benzodiazepines and smallest for other study drugs.

We further excluded patients in both groups with less than one year of follow-up. Those who survived the first year but did not receive prescriptions for the study drugs beyond the first year of observation are the subgroup analysed in. They had lower rates of physical and mental health problems on all 14 indicators of comorbidity than those who were prescribed study drugs beyond the first year, including cancer (22.9% (n=5050) v 18.6% (n=1599)), chronic obstructive pulmonary disease (15.7% (n=3449) v 13.5% (n=1158)), and ischaemic heart disease (22.5% (n=4955) v 19.6% (n=1683)). Those only prescribed study drugs in year 1 also differed slightly from those who took study drugs beyond the first year on mean age at study entry (52.6 years (SD 18.9) v 54.3 years (SD 18.6), P<0.001) and age at death (77.2 years (SD 13.8) v 76.8 years (SD 14.3), P=0.38). Patients who were only prescribed study drugs in year 1 were less likely to die than

those who continued to take drugs (18.8% (n=1610) v 22.0% (n=4852)) but more likely to be censored for other reasons (33.5% (n=3028) v 22.3% (n=4906)).

Patterns of association remained in this third model, although effect sizes were reduced (adjusted hazard ratio for >90 defined daily doses was reduced to 2.63 (95% confidence interval 2.34 to 2.95). The same patterns of association were found across all three classes of study drugs, with hazard ratios for benzodiazepines being the largest. The adjusted hazard ratio for use of any drug in model 2, which included early deaths during drug use, was 3.32 (95% confidence interval 3.19 to 3.45), compared with an adjusted hazard ratio for any drug use in model 3, limited to deaths after prescriptions for the study drugs had finished, of 1.75.

## Discussion

We found evidence of an association between prescription of anxiolytic and hypnotic drugs and mortality over an average follow-up period of 7.6 years among more than 100 000 age and general practice matched adults. In patients who were prescribed these drugs, there was an estimated overall statistically significant doubling of the hazard of death (hazard ratio 2.08), after adjusting for a wide range of potential confounders, including physical and psychiatric comorbidities, sleep disorders, and other drugs. This association remained significant and followed a dose-response pattern after restricting analyses to those with at least 12 months of follow-up and to those who were only prescribed the study drugs in the first year after recruitment (hazard ratio 1.75). Crude cumulative mortality in those given drugs was 26.46 per 100 people over the full follow-up period compared with 16.82 per 100 controls. After excluding deaths in the first year, there were approximately four excess deaths linked to drug use per 100 people followed for an average of 7.6 years after their first prescription.

While overall effect sizes were broadly in keeping with most previous findings, our estimates of association were lower than that reported by one study,23 which reported an adjusted hazard ratio of 4.56 over 2.5 years. This may reflect differences in the length of follow-up, as both studies reported declining associations with mortality over time.

## Strengths and limitations of this study

Use of data from the UK General Practice Research Database was an obvious strength, given the size and representativeness of the sample, and the quality, completeness, and duration of the follow-up data. Data on drug use were based on documented prescriptions rather than self reported receipt or use of drugs. We had detailed information on a wide range of potential confounders, going back several years. In particular, we were able to control for a large number of physical and psychiatric morbidities as well as prescriptions of other drugs. This is especially important given the possibility of confounding by indication (that is, study drugs may be given more often to those who are seriously ill and who may not be able to sleep because of pain or other consequences of long term or life threatening illnesses). In contrast with a recent report,23 we were able to adjust for anxiety disorders as well as all other psychiatric disorders. We were also able to identify and control for recorded instances of sleep problems (including those secondary to physical and psychiatric disorders).

Our recruitment strategy and ascertainment of drug use were further strengths. We minimised misclassification by excluding people who had received only one prescription, since some people never fill prescriptions or take the drugs. Using defined daily doses to quantify cumulative use of study drugs allowed us to combine the effects of different drugs in a way that is not possible by counting prescriptions or pills.23 In further contrast with previous research,23 we chose to classify study drugs by class rather than by indication for the purposes of recruitment; for example, we included all benzodiazepines, not just those recorded as having been prescribed for insomnia. We would argue that this resulted in a more accurate estimation of use of these drugs, as well as ensuring that our results are generalisable to all of

those who receive anxiolytic and hypnotic drugs in primary care. Our models were adjusted for all main indications for these drugs. Although pooling of study drugs may have overlooked variation in associations with mortality across classes, subgroup analyses indicated statistically significant associations (and dose-response effects) between mortality and all three classes of study drug. The largest hazard ratios were found for benzodiazepines.

Despite using prescribing records, we may have underestimated use of study drugs. Patients with more serious psychiatric disorders may be cared for by secondary care services rather than solely in primary care. Although in most cases responsibility for longer term (repeat) prescribing is usually delegated to general practice, it is possible that prescribing for these patients may be under-recorded in the General Practice Research Database. Likewise, we had no information on the use of study drugs that were obtained illicitly, although this was likely to have been modest compared with use of prescribed drugs. It is highly unlikely that study drugs were used before recruitment among the patients eventually prescribed the drugs or controls, given that the patients were registered with the study practices for 15 years on average. This was not so in a previous study,23 in which around one fifth of the exposed group had received a prescription for a study drug before recruitment.

The length of follow-up was also a strength, particularly for the generalisability of the findings. However, higher effect estimates obtained when we restricted our sample of exposed patients to those with no further prescriptions for the study drugs after the first 12 months suggests that results from our initial model, which included patients who continued to receive prescriptions for the study drugs throughout the observation period, may have been biased towards the null by the confounding of use and survival. Results of models in which use was restricted to the first year after recruitment and deaths restricted to those occurring after that first year suggest that much of the excess mortality risk arises early in the period of drug use but remains statistically significant even after discontinuing study drugs. We were not, however, able to explore temporal risk trajectories in detail. It was possible that patients who discontinued drugs within the first year did so because they were particularly unwell (and more morbid than those who continued to take these drugs). However, our findings show that the opposite was true, which strengthens the validity of our estimates of excess mortality in this group compared with the control group. Although those for whom prescriptions for study drugs stopped after the first year were more likely to be censored for reasons other than death, there is no reason to believe that this inflated the association between study drugs and mortality.

Non-randomised outcome studies are especially prone to confounding, including confounding by indication. One option for dealing with confounding by indication is using a comparator group more closely aligned with the exposed group—for example, patients who were starting other types of drugs. However, in the absence of previous evidence that comparator drugs were free of other indication effects, this would again have not ruled out this bias, even though it may have accounted for bias related to the comparison with non-users. Instead, we chose to deal with this in four ways: by taking account of a large number of potential confounders, by comparing effects across different groups of study drugs, by conducting subgroup analyses that limited exposure to year 1 and excluded all deaths during that first year in patients who both used and did not use the study drugs (on the grounds that confounding by indication will have the largest effect in year 1), and by adjusting our estimates of association for comorbidities occurring across the entire follow-up period. Nevertheless, although we controlled for many potential factors that were associated with study drug use and mortality and eliminated confounding of use and survival, it is impossible to exclude confounding arising from unmeasured factors or measurement error.33 34 35 While effects on estimates of association can be substantial,33 such bias is greatest for unmeasured confounders and those that are uncorrelated with other confounders but correlated with the study exposure.34 Bias tends to be greatest in studies that control for relatively few measured confounders.34

Although bias due to confounding was likely to have occurred, the impact was offset by the large number of covariates included in our analyses. One important unmeasured confounder is socioeconomic status, since records in the General Practice Research Database do not include detailed information on occupation, education, housing tenure, income, or employment. However, this variable was partially controlled for by matching by practice. Residual confounding, arising from a mixture of misclassification and indication, was also likely to have occurred in the recording of clinical diagnoses, and through our inability to quantify the severity of illness. Again, this is likely to have been offset to an extent by controlling for a wide range of comorbidities. Adjustment for a large number of measured confounders failed to negate our finding of an association between drug use and mortality but has resulted in appropriately more conservative estimates of the size of this association.23

Cohort studies are also prone to immortal time bias, which arises if the period participants are considered at risk differs between comparator groups.36 Although mortality was counted from the time of the first prescription for all patients, the time until second prescription would be “immortal” for patients who used the study drugs and who had to survive to get a second prescription to be in the study. This would not have applied to controls. However, excluding deaths among those who did not survive to receive a second prescription would have underestimated mortality in patients who used the study drugs. Any bias in the mortality comparison would therefore have been towards the null. Furthermore, this would not have biased the subgroup analysis that excluded early deaths, since deaths were ascertained only after the first year of follow-up for patients who both did and did not use the study drugs.

We considered the possibility of collider bias, a form of selection bias that may occur when two variables are not associated but share a common antecedent or outcome. Adjusting for such a factor can result in a spurious association.37 It is possible, for example, that study drug use and mortality are both associated with (for example) physical illness but themselves are not related. Since adjusting for comorbidities reduced estimates of association between study drugs and mortality, we suggest that these variables were likely to have been acting as classic confounders rather than sources of selection bias.

We did not have access to data on cause of death and therefore were unable to explore associations between prescription of study drugs and specific forms of morbidity such as pneumonia. Neither did we explore interactions between individual forms of morbidity and vulnerability to specific drug classes. In the light of consistent evidence of associations with mortality, such investigations are needed and will be the subject of future studies.

## Conclusions

These findings are consistent with previous evidence of a statistically and clinically significant association between anxiolytic and hypnotic drugs and mortality. Using prescribing data from a large primary care database and after adjusting for a wide range of potential confounders, prescriptions for these drugs were associated with significantly increased risks of mortality over an average follow-up period of 7.6 years. This association followed a dose-response pattern for all three classes of study drug and extended beyond the time of use. However, as with all observational studies, these findings remain prone to many forms of bias. While we have largely excluded immortal time bias and selection bias, we are unable to exclude the possibility that the results were due to confounding by indication or to residual confounding by unmeasured or incompletely measured factors, such as socioeconomic status. This applies especially to deaths in the first year of observation. These results add to evidence of an association with mortality, but must be treated with caution.

## Footnotes

This study is based on data from the Full Feature General Practice Research Database obtained under licence from the UK Medicines and Healthcare Products Regulatory Agency (MHRA). However, the

interpretation and conclusions contained in this study are those of the authors alone. Access to the General Practice Research Database was funded through the Medical Research Council's licence agreement with MHRA. We thank Tarita Murray-Thomas at the MHRA for producing the dataset, and all contributing general practitioners and their patients. PC is a senior investigator for the National Institute for Health Research.

Contributors: SW, MF, SS, and IC had the original idea for this study. SW and MF were responsible for study hypotheses, design, data specification, analysis, and drafting of the manuscript. MF and HP undertook the analyses, and results were interpreted by all authors. PC advised on data analysis and interpretation of the study findings. MF had full access to all the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis. All authors contributed to the drafting of the manuscript. SW is the guarantor.

Funding: This study received no specific funding. This project was awarded a licence as part of a scheme operated by the UK Medical Research Council and Medicines and Healthcare products Regulatory Agency to provide data access on up to 100 000 patients. Data were based on records from 273 primary care practices in England, Scotland, Wales, and Northern Ireland. The providers of this license did not have any involvement in the conduct of the research and were not consulted in the drafting of the manuscript.

Competing interests: All authors have completed the ICMJE uniform disclosure form at www.icmje.org/coi_disclosure.pdf and declare: no support from any organisation for the submitted work; no financial relationships with any organisations that might have an interest in the submitted work in the previous three years; no other relationships or activities that could appear to have influenced the submitted work.

Ethical approval: This project was approved by the Warwick Medical School Biomedical Research Ethics Committee (reference 192-03-2012).

Data sharing: No additional data available. The study data remain the property of the Clinical Practice Research Datalink (formerly General Practice Research Database) and was provided to the authors under license.

Transparency: SW (the manuscript's guarantor) affirms that the manuscript is an honest, accurate, and transparent account of the study being reported; that no important aspects of the study have been omitted; and that any discrepancies from the study as planned (and, if relevant, registered) have been explained.

# OMEGA-3 FATTY ACIDS: STUDIES DON'T SUPPORT HEART BENEFIT

By Elizabeth DeVita Raeburn, Contributing Writer, MedPage Today

Dietary guidelines that encourage high intake of polyunsaturated fatty acids and low consumption of saturated fats are not clearly supported by research, according to a recent meta-analysis.

When data from 27 randomized controlled trials of fatty acid supplementation was analyzed, the relative risks for coronary disease were 0.97 (95% CI 0.69 to 1.36) with beta-linolenic acid, 0.94 (95% CI 0.86 to 1.03) for long-chain omega-3 polyunsaturated acid, and 0.89 (95% CI 0.71 to 1.12) for omega-6 polyunsaturated fatty acid, Rajiv Chowdhury, MD, PhD, of the University of Cambridge, and his co-authors wrote March 17 in the *Annals of Internal Medicine*.

Analysis of 32 observational studies found that the relative risks for coronary disease, comparing top and the bottom third of baseline dietary fatty acid intake, were 1.01 (95% CI 0.97 to 1.07) for saturated, 0.99 (95% CI 0.89 to 1.09) for monounsaturated, 0.93 (95% CI 0.84 to 1.02) for long-chain omega-3 polyunsaturated, 1.01 (95% CI 0.96 to 1.07) for omega-6 polyunsaturated, and 1.16 (95% CI 1.06 to 1.27) for trans fatty acids.

Looking at data from 17 studies of circulating fatty acids measured via biomarkers, the relative risks for coronary disease were:

- 1.06 (95% CI 0.86 to 1.30) for saturated fats
- 1.06 (95% CI 0.97 to 1.17) for monounsaturated fats
- 0.84 (95% CI 0.63 to 1.11) for long-chain omega-3 polyunsaturated fats
- 0.94 (95% CI 0.84 to 1.06) for omega-6 polyunsaturated
- 1.05 (95% CI 0.76 to 1.44) for trans fatty acids

"The pattern of this analysis did not yield clearly supportive evidence for current cardiovascular guidelines that encourage high consumption of polyunsaturated fatty acids and low consumption of saturated fats," concluded Chowdhury and his co-authors. What's more, they said, "Nutritional guidelines on fatty acids and cardiovascular guidelines may require reappraisal to reflect the current evidence."

The meta-analysis included more than 600,000 participants from 18 countries. All of the studies were published before July 1, 2013. The majority were culled from electronic searches of Medline, Science Citation Index, and the Cochrane Central Register of Controlled Trials. The researchers also looked for relevant studies in the reference lists of identified articles, and for author correspondence related to the studies.

The review "provides a comprehensive systematic synthesis of available evidence," the authors said.

Nutritional guidelines have encouraged low intake of saturated fats, high consumption of omega-3 polyunsaturated fatty acids from fish and plant sources, and avoidance of trans fats, especially partially hydrogenated fat, as a way to improve cardiovascular health, the authors wrote.

But there has been considerable variation, they said, in the international guidelines about the amount and types of fatty acids. "This variation reflects, in part, uncertainties in the available evidence," they authors said.

Interpretation of prospective observational studies has been complicated by potential misclassification in the self-report questionnaires, they said. Early analyses also did not assess the consistency between dietary self-report and biomarker measures of fatty acids in coronary disease, they noted.

Additionally, interpretation of randomized trials of fatty acid supplements has been complicated by the difference in dietary habits of trial populations, the absence, presence, and type of vascular disease in study populations at the beginning of trials, trial duration, composition of supplement regimens, and differences in the efficacy of coronary prevention, the authors said.

Earlier this year, James DiNicolantonio, PharmD, a cardiovascular research scientist at Saint Luke's Mid America Heart Institute in Kansas City, Mo., wrote an editorial in *BMJ's Open Heart* journal questioning the evidence for guidelines, calling the benefits of a low-fat diet -- especially a diet that replaces saturated fats with carbohydrates or omega-6 polyunsaturated fatty acids -- "severely challenged."

Previous meta-analyses "inappropriately combined trials that were mixed omega-3 and omega-6 and stated that they were omega-6 trials," he said, in an email to *MedPage Today*. "When looking at the trials that solely replaced saturated fat with omega-6, there was an increase in CHD [coronary heart disease] and CV [cardiovascular] death."

Past meta-analyses also inappropriately excluded the Sydney Diet Heart Study and another study investigating the consumption of corn oil patients with a history of heart disease, both of which showed harm when omega-6 replaced saturated fat, said DiNicolantonio, who believes the high-carb, low-fat diet many followed as a result of the current guidelines has contributed to the obesity epidemic and the rise in diabetes and metabolic syndrome.

Studies like this one should lead to the public eating "real" food, "even if these foods containhigh amounts of saturated fat, instead of ingesting industrialized seed oils, particularly corn and safflower oil," says DiNicolantonio.

The authors of this meta-analysis acknowledged limitations to their study. These included a "moderate" amount of available data on some circulating fatty acids and "possible overestimation of associations because of preferential publications of extreme findings or selective reporting of results for particular fatty acids with striking associations," the authors said.

Selective reporting appeared minimal in the randomized trials, they said. But they noted that few observational studies reported on all measured circulating fatty acids. "Therefore it is possible that selective under-reporting may have contributed at least in part to the observational findings in this meta-analysis."

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http://www.medpagetoday.com/Cardiology/Prevention/44803

## THE RISE IN EMERGENCY PSYCHIATRY

**By Scott L. Zeller, MD**

**BRIEF COMMUNICATION**

Not long ago, in many parts of the country, mental health care only took place in 2 locations: outpatient offices or inpatient wards. But you would be far less likely to hear that now. Emergency psychiatry services, which can be delivered virtually anywhere—via mobile teams, in crisis stabilization units, or over the Internet via telemedicine—have spread rapidly across the nation.

Emergency psychiatry is where acute mental health care, the legal system, emergency medicine, police work, and the sequelae of substance abuse intersect in a sometimes dizzying, always fascinating, “open-24-hours-a-day” discipline. The various hats worn by emergency psychiatry clinicians include triage, medical screening, targeted pharmacology, crisis intervention, consultation for other disciplines, referral and linkage, crisis stabilization, supportive psychotherapy, family therapy, and short-term case coordination—all tied together with a goal of collaborative, compassionate, noncoercive care, and all occurring over minutes, rather than days.

Still a relatively nascent subspecialty, emergency psychiatry continues to grow in stature. Fellowship programs are now offered at a number of major medical centers. Several original comprehensive emergency psychiatry textbooks have been published in the past few years, and the 4th edition of the exhaustive, 3000-page textbook *Psychiatry,* by Tasman and colleagues,[1] which will be released this year, will for the first time contain an extensive, multi-chapter section dedicated solely to emergency psychiatry topics. [for the 3rd edition, please click here]

A leading factor that drives the growth in this specialty has been the recourse it provides to the dwindling number of inpatient psychiatric beds in the US (a dilemma recently the subject of major media scrutiny, even featured on the *60 Minutes* television program). For many locations, the long-used default plan for most patients in a mental health crisis, be it acute agitation, suicidal ideation, or disturbing command hallucinations, has been to get individuals to safety in a medical emergency department (ED), and then refer out for psychiatric hospitalization. When there was a greater supply and lesser demand for psychiatric beds, this system was barely adequate. Nowadays, however, this process can lead to long hours of patients waiting, often untreated, in those medical EDs, sometimes even in physical restraints, while elusive bed space is sought.

Given these lengthy delays, this model now seems to be rather misdirected and outdated. It is comparable to having a patient with an asthma attack sit in an ED and wait for an inpatient bed, finally get hospitalized, and only then be given inhaler treatment.

In contrast, emergency psychiatry reverses this design, and instead begins treatment at the initial contact, often even bringing the care to the patient's location rather than trying to send him or her to a defined facility. And when such interventions can commence more quickly, the chances are better that hospitalization will not be necessary. As discussed *Psychiatric Times*, if an appropriate treatment is started promptly, the majority of psychiatric emergencies can be resolved within 24 hours, with no hospitalization needed.

Yet while different regions of the country have recognized this potential, and endeavored to develop effective emergency psychiatry programs, they have often been hindered by a limited general knowledge base, since there have not been many well-known forums for best practices, communication, and sharing of ideas. Not surprisingly, then, urgent mental health programs have tended to be as idiosyncratic as the wide-ranging areas they reside in. But that, too, is changing, with 2 major organizations leading the way.

For individual psychiatrists and providers, the American Association for Emergency Psychiatry, known as "the Voice of Emergency Mental Health Professionals," provides multiple educational opportunities at conferences around the country and publishes its own journal. Its members-only discussion board regularly has lively debates about best practices and ethical issues. More information is available at the organization's website.

In December 2013, the National Council for Behavioral Health started a listserv for institutions, administrators, and individual providers of mental health and addictions crisis services. Within 1 month, there were more than 1000 subscribers from all over the country. The listserv encourages subscribers to share information and to learn from one another about all types of crisis services. Topics on the listserv have included financing, crisis respite, mobile crisis teams, partnering with law enforcement, and training for crisis intervention teams. The listserv is open to both members and nonmembers of the National

Council who provide some form of crisis intervention. For more information or to subscribe, contact Jenny Crawford at Jennyc@thenationalcouncil.org.
Here are a few examples of the diverse programs around the country that are now communicating on the National Council listserv:

- Centegra Health System in McHenry County in Illinois. Centegra is working on creating what may be the first-ever psychiatric ED in the state. And although their initial research showed that such programs elsewhere are commonly funded by state and federal grants, and often do not have the ability to be self-sustaining, Centegra's leaders have made ambitious efforts to show private insurers the benefits of crisis care. They now project that their negotiated contracts with private providers, as well as with Medicaid, will enable them to run the program without any fiscal loss.

- The Crisis Response Center, in Tucson, Arizona. CRC provides 24-hour services for anyone in surrounding Pima County experiencing a mental health or substance use crisis, regardless of insurance coverage. In addition, the CRC serves over 12,000 adults and children annually, the onsite Community-Wide Crisis Line answers more than 15,000 calls every month, and first responders make 12 to 15 drop-offs daily.

- The "Pre-Committal Program." This unique operation, located in Council Bluffs, Iowa, was developed to help individuals who are filing psychiatric committal paperwork on their loved ones in court to have an alternative option. Instead, an individual can use their crisis response team to have a therapist come out immediately and assess that person to see if a formal court committal is really needed. If not, staff will connect that individual to immediate services, sometimes a same-day integrated evaluation. Positive collaboration with law enforcement, judges, hospitals, and the community all have been important to make this program successful.
- Salt Lake City, Utah has created a comprehensive crisis response system over the last 2 years and was the only such community system invited to the President's Mental Health Conference last spring to discuss their model. Their outcomes have been quite promising so far, with both decreased ED visits and inpatient days, plus clearly improved services to community members.
- South Carolina has instituted a statewide program of emergency telepsychiatry consults in all its medical EDs, lowering its average length of stay in the ED for a patient in crisis from 2 to 3 days to less than 6 hours.

The continued development of new emergency psychiatry programs is just part of the optimism in this subspecialty. New, rapid-acting, non-coercive approaches for agitation are becoming available, which might help reduce the reliance on physical restraints and forcible medications still too common in acute care locations. Meanwhile, more and more programs are employing former patient "peers" to assist patients in crisis—giving individuals an experienced ally during their treatment process, which can help to reduce anxiety and may improve outcomes. And a growing number of states are seeing the value of expanding urgent mental health care, and are creating grant programs to encourage the development of novel crisis programs throughout their cities and towns.
Just as many surgeries which once required hospital stays are now done on an ambulatory basis, so too is emergency psychiatry helping to redefine acute mental health treatment—facilitating timely access, in less restrictive, outpatient levels of care, for patients in crisis.

# THE LINK BETWEEN SUBSTANCE ABUSE, VIOLENCE, AND SUICIDE

By Mark Ilgen, PhD and Felicia Kleinberg, MSW

Emerging research suggests that some individuals with particular types of substance use and abuse may be more likely to engage in suicidal behaviors. For example, those who use opiates, cocaine, or sedatives may have a noticeably higher risk of suicide than those who use other drugs.

Suicide is the 11th leading cause of death in the United States; it accounts for more than 34,000 deaths per year. And an even greater number of people attempt suicide. Based on data from community surveys, approximately 5% of adults have made a serious suicide attempt.

Mental health problems are some of the best-known and well-studied risk factors linked to suicidal ideation, suicide attempts, and suicide mortality. Approximately 90% of all individuals who completed suicide met criteria for 1 or more diagnosable psychiatric conditions. Mental health conditions most strongly associated with fatal and nonfatal suicide attempts include depression, bipolar disorder, schizophrenia, posttraumatic stress disorder, and alcohol and/or drug use disorders. Because mental health treatment providers are in regular contact with patients at risk for suicide, they are an important resource for early detection and prevention of suicidal behavior.

**Substance use and suicide risk**

Although it is difficult to compare the relative impact among different mental health problems with the risk of suicide, alcohol and drug use disorders have been found to be strongly related to suicide risk. Individuals with a substance use disorder (ie, either a diagnosis of abuse or dependence on alcohol or drugs) are almost 6 times more likely to report a lifetime suicide attempt than those without a substance use disorder. Numerous studies of individuals in drug and alcohol treatment show that past suicide attempts and current suicidal thoughts are common. Recent evidence from veterans indicates that men with a substance use disorder are approximately 2.3 times more likely to die by suicide than those who are not substance abusers. Among women, a substance use disorder increases the risk of suicide 6.5-fold.

**Identifying substance abusers at greatest risk for suicide**

Although a consistent association exists between substance use disorders and suicidal behaviors, the vast majority of those with substance-related problems will never die by suicide. Therefore, it is important to identify those individuals with substance use disorders who might be at particularly high risk for suicide.

Many risk factors for suicide in the general population also apply to those with substance use disorders. Older men with substance use disorders are at greater risk for nonfatal attempts and for death by suicide than are younger persons. Past suicide attempts are a strong risk factor for subsequent suicidal behaviors in those with substance use disorders. Depressed mood is a risk factor for suicidal behaviors in the general population and also predicts a greater likelihood of suicide in those with alcohol or drug use disorders.3,6,10 The link between depression and suicidal behaviors in those with substance use disorders may be particularly strong given the high comorbidity between mood and substance use disorders. Although it has not been examined thoroughly, independent mood disorders and substance-induced mood disorders are likely to confer risk for suicide.

Emerging research suggests that some individuals with particular types of substance use and abuse may be more likely to engage in suicidal behaviors. For example, individuals who use opiates, cocaine, and sedatives may have a noticeably higher risk of suicide than those who use other drugs. Among those with an alcohol use disorder, a greater severity of recent drinking is associated with the greater likelihood of suicide attempt and suicide mortality. Co-occurring alcohol and drug use disorders may be particularly strong indicators of increased risk of suicide. Thus, the severity of substance use disorders (ie, a greater number of substances or misuse of more than 1 substance) may predict a greater likelihood of suicide.

**Violent behavior toward others**

The tendency to engage in violent behavior is a potentially important risk factor for suicide in substance abusers. Up to 75% of those who begin addiction treatment report having engaged in violent behavior (eg, physical assault, mugging, attacking others with a weapon). Emerging research also indicates that violence may partially account for the connection between substance abuse and suicide risk. For example, in those seeking treatment for substance use disorders, the perception that they have difficulty in controlling their own violent behavior was associated with a greater likelihood of a prior suicide attempt. Tiet and colleagues hypothesized that individuals who have difficulty in controlling their anger may be more likely to act impulsively, thus turning the violence on themselves rather than on others.

Individuals with alcohol use disorders and prior aggressive behavior are more likely to report suicidal thoughts or past suicide attempts. In one recent study of more than 6000 adults who began addictions treatment, those who had committed serious violent acts (eg, rape, murder, assault resulting in serious injury) were more than twice as likely to report multiple suicide attempts. This finding held true even after statistically controlling for demographic characteristics, depression, and past victimization.

Another study compared accident victims with individuals who completed suicide. Violent behavior in an individual's last year of life was linked to a higher likelihood of suicide, even when controlling for alcohol use disorders and other potential suicide risk factors.

**Partner violence**

Violence toward a romantic partner may be a particularly important predictor of suicidal thoughts and behaviors in individuals with substance use disorders. In a study that examined data from a sample of 488 individuals who began substance and alcohol treatment, physical aggression toward a partner was associated with higher levels of suicidal ideation than was aggression toward a nonpartner. In addition, a history of domestic violence is common in men with alcohol use disorders who complete suicide. Individuals who perpetrated domestic violence were more likely to be separated from their partners; they therefore lacked social support (a key protective factor of suicide risk).

**Understanding the link between violence and suicide risk**

Several factors can explain why engaging in interpersonal violence is associated with increased risk of suicidal behaviors in those with substance use disorders. Violence correlates with greater severity of substance abuse; thus, violent behavior may be a proxy indicator for the relationship between severity of substance abuse and suicide risk.

Moreover, violence may be an indicator of increased impulsivity, which has been found to increase the risk of suicide.28 The relationship between impulsivity as an independent entity (distinct from aggression) and suicide risk has been rarely studied. One study that examined impulsive aggression (ie, reactive aggression) found that it did not increase the likelihood of suicide attempt in comparison with premeditated aggression (ie, proactive aggression).

Self-report measures of impulsivity appear less closely associated with suicidal behaviors than laboratory measures of impulsivity. The literature does not provide a clear indicator of whether impulsivity fully or partially explains the link between violence and suicidal behaviors.

Another possible explanation for the link between violence and suicide is that violence, particularly partner violence, can create significant social isolation, which increases the risk of suicide. Also, Joiner proposed that individuals who harm themselves have acquired the capacity to engage in self-injury through repeated exposure to violence and painful stimuli. Inflicting an injury on someone else may be a form of behavioral rehearsal for suicidal behaviors.

**Clinical implications**

Causal mechanisms that explain the links between substance misuse, violence, and suicidal behaviors are not fully understood. Nevertheless, the literature provides several important clinical implications for mental health treatment providers. In all settings, it is important to incorporate questions about violent

behavior and substance abuse into broader assessments of suicide risk. Clearly, patients who report a combination of past suicide attempts and/or serious plans of suicide, depression, significant substance misuse, and episodes of interpersonal violence are at significantly elevated risk for future suicidal behaviors. For such patients, treatment that focuses on only 1 of these domains (eg, depression) may not be optimally effective.

- Treatment providers should develop a strategy that directly addresses each of these problems and contains specific steps for managing an acute suicidal crisis.
- Treatment providers should consider prescribing medications that directly address the addictive disorder and/or make referrals to specialty addiction treatment facilities.
- Treatment providers should consider referring violent patients to anger management therapy or to couple's behavioral therapy designed to address aggressive behaviors and improve interpersonal problem solving and communication.

Research is needed to determine whether such integrated treatment effectively reduces suicidal behaviors in high-risk individuals with substance use disorders and/or violent behavior.

Cognitive-behavioral therapy (CBT) focuses directly on suicidal thoughts and behaviors. A large, randomized, controlled trial found that CBT significantly decreased the likelihood of suicidal behaviors over 18 months of follow-up. Recently, we have developed a modified version of CBT that focuses specifically on suicidal behaviors in those with substance use disorders. Although the evaluation of this intervention is ongoing, patients appear to appreciate the opportunity to discuss the links between their substance abuse, prior impulsive behaviors, and suicide attempts.

Even without a specific CBT approach, the therapeutic relationship can benefit from a direct discussion of the patient's perception of the connections between his or her substance abuse, tendency to become violent with others, and prior suicide attempts.

**CASE VIGNETTE**

Frank is 45 years old, unemployed, and undergoing court-ordered residential treatment for cocaine dependence following his arrest for drug possession. He reports that he began drinking heavily and using cocaine and marijuana on a regular basis during his late teens. He also reports experiencing frequent "up and down" moods that coincide with his drug use. He has been in numerous romantic relationships, many of which involved physical and verbal altercations.

Frank has received inpatient treatment for his addictions in the past. On one occasion, he left treatment early; he completed treatment twice, only to relapse within a week. Frank has made 2 suicide attempts. In previous treatment, he mentioned his suicide attempts, but the response was either focused on his safety (eg, assigning him a "buddy" to accompany him to the restroom) or an antidepressant or mood stabilizer was prescribed.

We added 8 sessions of CBT (2 sessions a week for 4 weeks) for suicidal thoughts and behaviors to standard residential drug treatment. We took a detailed history of Frank's earlier suicide attempts and identified his perception of the link between his substance abuse, his feelings of frustration or anger, and his suicidal thoughts and behaviors. Much of this work was focused on helping him conceptualize suicidal thoughts as something that he could manage and that does not require him to take action.

With our help, Frank was able to develop a detailed list of steps that he could take to keep himself safe when he is feeling suicidal. Frank and the therapist also discussed reasons to be hopeful and ways that he could remember these reasons posttreatment. The final CBT sessions involved an imaginary exposure exercise during which Frank was asked to recall his most recent suicide attempt and then envision himself seeking help before making the attempt.

Overall, Frank seemed to appreciate the intervention, and he described the focus on his suicidal behavior as unique and helpful. The relative safety and stability of a residential addictions treatment facility allowed us to focus directly on content related to Frank's suicidal thoughts, plans, and suicide attempts. Frank stayed for the full 60 days and plans to stay with his brother after discharge. He is part of an ongoing pilot CBT trial and will be followed up 3 months after leaving treatment.

**Summary**
Research indicates that substance misuse is consistently associated with suicidal thoughts, suicide attempts, and suicide mortality. The risk of suicide is likely to be greater in persons with more severe levels of substance abuse as well as in those with depression. In addition, a propensity to engage in interpersonal violence is an important suicide-related risk factor. These findings reinforce the need for increased suicide assessment and intervention efforts to address co-occurring problems in individuals with substance use disorders and/or interpersonal violence.

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http://www.psychiatrictimes.com/substance-use-disorder/

## PRESCRIBING PSYCHOTROPICS FOR WOMEN OF CHILDBEARING POTENTIAL

**By Marlene P. Freeman, MD**

Mood disorders frequently have a chronic or recurrent course, and women with mood disorders typically experience the onset of these disorders before or during their reproductive years.1 Therefore, women commonly experience mood episodes during the perinatal period (during pregnancy and postpartum). Many women plan for a pregnancy with a preexisting mood disorder and while receiving maintenance treatment with psychotropic medication. Ideally, women plan ahead to conceive and make any necessary treatment changes to maximize wellness and minimize fetal medication exposure—especially to medications that are known teratogens or have unknown reproductive safety profiles.

However, about 50% of pregnancies in the US are unplanned. This fact underscores the need to routinely counsel women of reproductive potential about their medications, regardless of their plans to conceive. It is also of major importance to select medications for women of reproductive potential that would be of least risk should they experience an unplanned pregnancy.

**Plan for the unplanned**

The psychopharmacologist should actively inquire about a woman's plans for conceiving. If a woman is not planning to become pregnant, contraception should be discussed routinely. If a woman is using hormonal contraception, such as an oral contraceptive, there are important potential drug actions to factor into medication dosing.

Many women who report that they are not trying to conceive are not using an effective contraceptive. One recent national study demonstrated that among young women, one-third were using the "withdrawal method" as their primary form of birth control. Among them, 21.4% experienced an unintended pregnancy.

Our role is 2-fold: we need to actively integrate patients' desires for pregnancy into our treatment plans, but also extend the use of selective prescribing for women of reproductive potential regardless of stated plans.

**Pregnancy has inherent risks**

The rate of congenital malformations in the general population of the US is approximately 3% of all pregnancies. Maternal age is a known risk factor for pregnancy complications and birth defects, as are smoking, alcohol use, uncontrolled diabetes, and obesity. In most cases, causes of birth defects are unknown. Decision making around treatments for psychiatric disorders in pregnancy requires consideration of what is known about the medications in pregnancy, the disorder being treated, and exposures to the baby of both untreated maternal illness and medication. For women of reproductive age planning pregnancy, the CDC recommends the following:

- Take folic acid (higher doses are recommended when a woman is taking an anticonvulsant before trying to conceive6)
- Maintain healthy diet and weight
- Continue regular physical activity
- Quit/abstain from tobacco use, alcohol, and drugs
- Communicate with health care professionals about screening for and management of chronic diseases

The CDC also recommends that sexually active women who wish to delay or avoid pregnancy should use effective contraception correctly.

**Treatment considerations when planning for pregnancy**

It is a major treatment dilemma when a woman decides to try to conceive or becomes pregnant while being treated with a particularly risky medication. A switch during pregnancy means that a woman will have more than one medication exposure during her pregnancy, and a trial of a med-ication that is new to her is complicated by the fact that the risk to benefit ratio for her is unknown. Therefore, the initial selection of psychotropics for women with psychiatric disorders should include consideration of reproductive potential and data regarding use in human pregnancy.

Unfortunately, it is challenging to remain apprised of data pertaining to medication use in pregnancy, since the literature is constantly evolving. For some medications, such as SSRIs, lamotrigine, and benzodiazepines, there are a great number of published studies—some with conflicting results.7 For other medications that are known teratogens, such as lithium and valproic acid, the association with birth defects is clear, but the absolute risk of teratogenicity must be understood to make informed decisions. With lithium, which has a known association with a specific cardiovascular malformation—Ebstein anomaly—the absolute risk is low. Approximately 0.1% to 0.2% of pregnancies are affected when there is exposure in the first trimester. In contrast, valproate has a known and common association with neural tube defect, estimated to occur in 1% to 5% of exposed pregnancies.

Unfortunately, the FDA pregnancy categories (A, B, C, D, X) are of limited use and can be misleading regarding what constitutes a relative risk of one medication compared with another when used in pregnancy.8 The risks of the untreated disorder also are not reflected in this system. Most psychotropic medications are labeled as C or D. The process of category labeling is as follows for a new drug: When a new drug comes to market, a letter is assigned and usually there is a paucity of human data at that point. Pharmaceutical companies are required to have a modest amount of animal data on hand. In general, however, there is no incentive for a company to have human pregnancy data at the time of approval. In fact, women who are pregnant or who are using inadequate methods of contraception are generally barred from participation in clinical trials.

This means that only postmarketing surveillance data are derived from pregnant women. Pregnant women are disqualified from randomized trials of psychotropic medications. Naturalistic studies are used, which must be interpreted with care to account for variables (including the underlying disorder, factors associated with the illness, and medication use) because groups of women receiving a particular medication may not be adequately matched with controls.

The effect of the FDA pregnancy categories is that some newer medications without human pregnancy data receive a relatively favorable category, such as “B,” while older medications that are well studied and

may have a well characterized small risk or inconsistently reported risk may be labeled as “D.” However, it is possible—and common—that a drug in the “D” category would be preferable to one labeled “B,” especially when the older drug has received a great deal of study and has a very small absolute risk, and the newer drug labeled “B” is unknown in human pregnancy. The bottom line is that the FDA categories are seductive—they lead us to believe that the medications fall into clear and distinct categories, when in fact they rarely inform us about how to select medications for women.

In advance of a pregnancy, the following are guidelines to keep in mind:

- Aim for remission before a pregnancy; encourage a period of wellness before conception
- Provide psychotherapy before a pregnancy
- Select the drugs that are most reasonable on the basis of the patient’s personal history of illness and treatment response (valproate is the most commonly used psychotropic agent with the highest risk of teratogenicity)
- Minimize the number of drugs and doses while maintaining euthymia
- Arrange for careful monitoring of mood throughout pregnancy and the postpartum period

**Clinical caveats**

Pregnancy is inherently risky. Our goals are to decrease risks to and promote wellness for the mother and baby as much as possible. We are not able to state that any medication is absolutely “safe.” When initiating treatment with medications, keep in mind that unplanned pregnancies are common. The FDA pregnancy categories are extremely limited in clinical value. The risks of untreated disorders must be taken into account in terms of fetal and infant exposure. In this area with so many unknowns, collaborative decision making with the patient is essential.

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## WHAT DEPRESSION DOES TO OUR MINDS WHEN IT ATTACKS

**By Elizabeth J. Griffin, MD**

"Depression is overwhelming and overpowering, and it crushes its prey." Here: a pediatrician tells of her 40-year battle with severe depression, and offers insights about how to talk with someone who is depressed.

After two of my acquaintance died on the same day in the same way—by shooting themselves—I heard various comments:

“But he was such a strong Christian! How could he do this?”

“I guess he took the easy (or, ‘the coward’s’) way out.”

“He wasn’t thinking about his family at all, that’s for sure!”

“Well, I always thought only losers had depression, like people living on the street, or alcoholics and drug addicts – nobody but losers!”

None of the people who said these things understood depression at all or what it can do to anybody.

I’ve been a journalist, a college teacher in Hong Kong, and—for 22 years—a pediatrician. I was chief of staff and a trustee at a 700-plus bed medical center with 2 campuses and 400 doctors. I am a dedicated Christian, a Presbyterian elder, and a veteran of medical mission trips to the Amazon. I speak fluent Spanish, some Portuguese, a little German, and a bit of Cantonese. When I am thinking rationally, I can see that I am intelligent, witty, well-liked and respected.

I also have battled depression for more than 40 years, and when I am depressed, I do think I am a complete loser.

I have been so depressed that I have considered killing myself many times. I decided 30 years ago that I could never safely own a firearm because I knew what I would do with it someday. Even so, I have come

close to buying a gun. A few years ago, I had extremely severe, treatment-resistant depression—an epoch more than an episode—that lasted several years and steadily worsened despite multiple medicines and weekly visits to my psychiatrist. Eventually, I did go shopping for a pistol. With great difficulty, I chose not to buy it and committed myself to the hospital instead.

I had extreme depression— much more severe than that endured by the great majority of people who become depressed. Most need only counseling and perhaps medicine to become happy once more. They don't lose their jobs or have to be admitted to hospitals, and they do not come close to killing themselves. Unfortunately, most who are depressed do not seek any help—often because they fear what others will think. This is a mistake, because effective help is available.

I too was afraid of the stigma and of being labeled a loser. Until I entered the hospital for intense treatment, I hid my depression as long as possible. I was afraid others would think me weak instead of strong, think there was something "wrong" with me, that I was broken and could not be "fixed." I feared they would believe I could not be an effective physician if they knew I had depression.

I also have a stubborn independent streak. I believed that I could "handle it"—a trait common among physicians. We see a problem and we fix it. Before I ended up in the hospital, I (eventually) let only my partners, my pastor, and a few close friends know that I was seeing a psychiatrist and taking medicine. No one in my own family knew. I was too ashamed to tell anyone I had a mental illness.

That severe bout of depression had begun 4 years earlier, while I watched my husband battle renal failure and then cancer. I cared for him until he died, and then I nearly died, too. During the last year of my husband's life, I never missed a scheduled day of work until 2 days before his death. A week after he died, I went back to work. I never missed another day until I went shopping for that gun 2 years later.

I was determined not to let my illness stop me from doing my job. I decided that no one would say I was weak instead of strong and tough. I continued to work during a depression that was totally debilitating. I couldn't pay my bills on time. I couldn't clean my house. I lost 60 pounds in a year without trying because I couldn't eat. I quit opening my mail and answering my phone. I completely isolated myself, and I often sat at home weeping. (Again, this was an extreme in the spectrum of depression.)

Even so, I made sure to put on a good face whenever I was with other people. I still smiled at my patients, partners, and friends. I went to church every week, and I cracked jokes that made everyone laugh. I was still respected. I hid my problems at all cost.

The time finally came, though, when my illness did affect my performance. I arrived late for office hours. I could not complete my charts. I could not concentrate. I hid in my office crying at times. Sometimes I wrapped my stethoscope tightly around my neck, finding that sadly comforting. Some of my partners even began to wonder whether I was using drugs. Finally, they told me, "You're going to take two weeks off now and go do whatever you need to do to fix whatever is wrong with you; if you don't fix it, your job will be in jeopardy."

I had struggled valiantly just to stay alive, yet I was about to be fired for being depressed. I was devastated. I knew I could not possibly "fix" in 2 weeks the life-threatening illness my doctor and I had been unable to halt during a 4-year battle. I couldn't take the thought of not being a pediatrician, and I feared I would never work again. Nor could I handle the horror of the public humiliation I was sure would accompany losing my job. At that point I simply could no longer fight the psychic and emotional pain of my severe depression.

So I went shopping for a gun.

And almost 6 years later, I still can feel the its cool smoothness and weight and balance as I stood there at the store counter holding it. It was extremely comforting: I could finally end my suffering.

But I decided to put down the weapon and walk out to my car. I sat there 10 minutes, debating whether or not to buy the gun. I told myself, "OK, Betty, this is it. If you buy it, you die tonight. If you don't buy it, you go into the hospital."

I feared the stigma of admission to a psych ward as much as that of being fired. Yet I could no longer bear living as I had been. I longed to die. I even begged God to take me to Heaven to be with him. But I said

instead, “I’ll try one more time.” I drove away weeping. I cried not in relief but in the agony of complete despair because I had just denied myself the only way I saw to stop my pain.
I am alive now only because 2 months earlier my father had stood in front of my car and refused to let me leave his home until I promised not to kill myself. Somehow, on that day in the gun store parking lot, I managed to try one more time to keep that promise.

**An overpowering foe**

Depression is overwhelming and overpowering, and it crushes its prey. Next time, I may not be able to overcome it. I have sunk into despair and hopelessness more times than I can count. So far, I’ve not committed suicide, but I have teetered on the edge many times. I do think that depression might kill me someday.
For people like me who have considered suicide seriously and have even longed for it, suicide is not some horrifying, appalling idea. When we are depressed, it is like an old friend we simply have not yet embraced, and for many of us it seems a bridge home to God. That’s how dangerous and seductive depression can be.
When we are depressed, it is our irrational (or non-rational and untrue) yet inescapable thoughts that can kill us. They completely mutilate our normal thought processes and destroy our well-being. When our depression is truly severe, they hurtle us toward suicide.
When severely depressed, I fiercely bombarded myself with untrue accusations. I continually told myself that I was stupid, worthless, incompetent, unloved and unlovable. My self-hatred grew more and more powerful. I believed my depression would go on forever, without end and with no rescue possible at any time or in any way. I felt completely alone. I became certain that no one wanted me around and that I had ruined not only my own life but also, simply by virtue of my presence, the lives of all who cared about me. I felt overwhelming guilt because I firmly believed that my continuing to live deprived some other, more worthy person of a job, money, and shelter.
Severely depressed persons grow convinced beyond any doubt whatsoever that our families would be better off if we were dead. We believe that only by suicide can we help them salvage whatever remnants of their lives we have not already destroyed, even if we actually have done nothing that would hurt them or anyone else.
I believed that everyone felt and thought this way to some extent. I once explained some of this to one friend, a compassionate and extremely intelligent physician. He looked at me in amazement and said, "You do know, don’t you, how completely foreign everything you just said is to me?"
In fact, learning just that was a real eye-opener for me, "a light-bulb moment."
Those who aren’t depressed don't realize that a vast difference exists between their feeling blue and my being depressed. My brother told me, "I get depressed, too; you just need to do what I do – just put one foot in front of the other one and keep going." And my sister said to me, “Your life is fine! There’s no earthly reason for you to be depressed, so you just need to snap out of it and move on!”

**People don’t know how to talk about depression**

My partners had seen me struggle years earlier with depression when my husband spent 3 months in an out-of-town hospital while I was working up to 60 hours a week 160 miles away. Fortunately, I recovered from that episode and was healthy until my husband died 8 years later.
Three months before I was hospitalized with severe depression, I finally told my partners that I was having trouble once more. Nobody said a word. Everybody looked anywhere except at me. Then somebody changed the subject. Nobody said one single word to me after I confessed what I believed was a shameful secret. I felt completely rejected.
My partners were decent, caring people and compassionate physicians. But non-depressed people do not know how to tell us that their truth is drastically different from ours . . . that our depression will improve . . . and that they want and need us in their lives. Even depressed physicians and their colleagues often don’t know what to say to each other.

**How to talk about depression**

- People with depression need someone to speak up when we cannot, especially to explain our illness to our loved ones. Most of us are too frightened and ashamed to talk about it. Unless we learn how to be open about depression, the stigma will remain, and people who need treatment will continue to avoid seeking it.
- If you have depression, tell someone you can trust and seek professional help. It is available—and it can help. Depression does not have to last forever; you really can get better with time and treatment.

- If someone you care about is depressed, tell him you do care, that you love him, and that you want to understand and help. Tell her how important she is to you and what you admire about her. Tell him you want him and need him in your life, and that things will get better. Ask her to hang on until they do. Beg him to promise that he won't do anything to hurt himself, that he will not commit suicide.

You may save the life of someone you love.

**DISCLOSURES:**

Dr Griffin earned a B.A. in Spanish and journalism at Baylor University and then studied history there. She was a newspaper reporter in Waco, TX, and she taught history and English in Hong Kong. After completing her M.D. degree and her pediatric residency at the University of Mississippi, she practiced in Wilmington, NC, for 18 years. She now works at the Duplin County Health Department in rural North Carolina.

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http://www.psychiatrictimes.com/major-depressive-disorder

## DOES MOVING POOR FAMILIES TO LOW-POVERTY AREAS HELP THEIR CHILDREN?

**Barbara Geller, MD reviewing Kessler RC et al. JAMA**

Counterintuitively, in a long-term follow-up of families who moved to low-poverty areas, boys sustained higher rates of depression, PTSD, and conduct disorder.

Between 1994 and 1998, the U.S. government sponsored a program to test whether moving to a higher socioeconomic region would help poor families. The study randomized families from impoverished areas to receive vouchers to move to a low-poverty neighborhood (n=1819), traditional vouchers to relocate anywhere (n=1346), or no vouchers (n=1439). At baseline, only 23% percent of eligible families applied for study entry, and only 48% of low-poverty vouchers and 63% of traditional vouchers were actually used.

At follow-up 10 to 15 years later, 2872 adolescents (age range, 13–19 years) completed a structured interview for psychiatric disorders in the previous year (a baseline interview did not occur). Compared with no-voucher boys, those from families with low-poverty vouchers had greater rates of depression (odds ratio, 2.2), post-traumatic stress disorder (PTSD; OR, 3.4), and conduct disorder (OR, 3.1). Traditional-voucher girls had lower rates of depression and conduct disorder than no-voucher girls (ORs, 0.6 and 0.1, respectively).

**COMMENT**

Because school data were not available, it is difficult to compare these results with other studies' findings that school mobility increases psychotic-like symptoms (J Am Acad Child Adolesc Psychiatry 2014 Feb 14) and other psychopathology (Pediatrics 1994; 93:303). The present findings are also limited by lack of data on family income changes, which is germane because increases in income have been associated with lower rates of mental health disorders (NEJM JW Psychiatry Dec 10 2003 and NEJM JW Pediatr Adolesc Med Jun 9 2010). During recruitment for the current study (1994–1998), unemployment was low, but follow-up (2008–2010) coincided with a recession. Overall, clinicians need to be mindful that both housing and school mobility may negatively affect child behavior.

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http://www.jwatch.org

## YOUNG WOMEN WITH MYOCARDIAL INFARCTION ARE VULNERABLE TO MENTAL STRESS

**Joel Yager, MD reviewing Vaccarino V et al. Psychosom Med**

Post-MI, women aged 50 and younger were twice as likely as men to develop myocardial ischemia after an emotionally stressful task, but not after physical stress.

Each year, 10,000 American women under age 45 suffer a myocardial infarction (MI) and have roughly twice the risk for hospital mortality as similarly aged men. To study the various stressors on myocardial function in post-MI patients, investigators recruited 49 women within 6 months of MI and age matched them to 49 men with MI. The groups had similar numbers of participants aged 50 or younger and with non-ST elevation MIs.

Patients underwent single-proton emission computed tomography (SPECT) scans of myocardial perfusion at rest and during mental-stress and physical-stress tests. For the mental-stress task, participants had 5 minutes to prepare and present a videotaped talk to a “white-coat” audience concerning an imagined mistreated sick relative.

Analyses were stratified by age (≤50 vs. >50). In the younger group, mental stress provoked myocardial ischemia in twice as many women as men. Differences remained significant in analyses accounting for demographics, lifestyle factors, disease severity, depressive symptoms, and time since MI. Sex differences were not seen in the older group or with physical stress.

**COMMENT**

These results need to be confirmed in larger studies and those examining other stressors. Still, the findings suggest sex differences in stress vulnerability affecting myocardial function in younger patients. The underlying mechanisms for the different stress responses remain unclear, although other studies suggest that women have greater coronary artery reactivity and microvascular dysfunction with stress, factors that may foster ischemic heart disease. Clinicians working with young women after myocardial infarction should be particularly attentive to sources of mental distress and should intervene to help these patients increase stress tolerance and coping capacities.

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http://www.jwatch.org/na33977/2014/03/17

## FAMILY-FOCUSED TREATMENT FOR ADOLESCENTS WITH BIPOLAR DISORDER: WHEN IS IT WORTH THE EFFORT?

**Joel Yager, MD reviewing Miklowitz DJ et al. Am J Psychiatry**

Twenty-one sessions of adjunctive family-based treatment offered few benefits over three weekly psychoeducation sessions.

Several types of psychosocial interventions, including interpersonal and social rhythm therapy, have been shown to add benefit to medication management for adults with bipolar disorder. In a well-designed, well-conducted, 2-year, multisite study, 145 community-recruited adolescents diagnosed with bipolar I or II disorder (mean age, 15.6) were stratified by diagnostic group and polarity of initial episode and then randomized to protocol-driven medication management plus either 21 weekly sessions of family-focused therapy (FFT) over 9 months or three weekly psychoeducation sessions in the first month designed to mimic "enhanced" treatment as usual. FFT involved three modules on psychoeducation, communications-enhancement training, and problem-solving skills. Booster sessions were available to all participants. Adherence to medication protocols was assessed as full in 57% to 70% at the three sites and as partial in 17% to 27%.

Contrary to expectations, FFT yielded no additional benefits compared with enhanced care on several primary outcomes, including time to recovery, mood symptom severity, or number of weeks ill. However, in secondary analyses, patients receiving FFT showed fewer manic symptoms during year 2 of the study. Patients with comorbid anxiety disorders or not living with two biological parents had earlier mood recurrences.

**COMMENT**

Not surprising, family distress, comorbidities, and more severe symptoms predict more difficult courses in patients with bipolar disorder. This research group had positive results from a similar previous study; the more standardized medication protocol in the current one may have yielded fewer between-group differences. Additional family therapy may be of value for patients particularly at risk for manic recurrence or when family stress is high. However, adding excellent psychoeducation to good medical management might often produce results as good as those seen with more elaborate family treatment.

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www.jwatch.org/na34075/2014/03/27/

## THE DEFAULT MODE NETWORK IN PSYCHOPATHY AND DEPRESSION

**Steven Dubovsky, MD reviewing Contreras-Rodríguez O et al. Biol Psychiatry**

The two disorders are associated with distinctive profiles of functional connectivity.

The default mode network (DMN), a network of regions including the medial prefrontal cortex, cingulate cortex, parietal cortex, and precuneus, mediates self-referential activity and moral judgment. Two new studies look at its role in psychopathy and depression.

Psychopathy is characterized by criminal behavior, lack of empathy, and reduced ability to learn from experience; this lower ability might be characterized by deficient processing of emotional information. Contreras-Rodríguez and colleagues used combined functional and anatomical neuroimaging to measure global gray-matter connectivity so that they could assess processing of emotional information in 22 men with serious criminal histories and 22 controls with neither criminal histories nor psychopathy. Compared

with controls, psychopathic subjects had lower functional connectivity of prefrontal areas with limbic and paralimbic structures (insula, amygdala, hypothalamus, and posterior cingulate cortex) and greater connectivity within the dorsolateral prefrontal cortex. These differences were proportionate to the severity of psychopathy.

In an industry-supported study, Korgaonkar et al. used diffusion tensor imaging to measure white-matter connectivity in 95 outpatients with major depression and 102 matched controls. In the patients, connectivity was reduced in two networks — the DMN and a frontal-subcortical network involving frontal regions and the right medial orbital prefrontal cortex, thalamus, and caudate.

**COMMENT**

Decreased connections between frontal and limbic centers within the default mode network make it possible for psychopathic individuals to notice emotional information, but not process it for effective learning. Increased functional connections in the prefrontal cortex may be a substrate of inflexible, goal-driven behavior that does not respond to new information. In depression, inability to down-regulate the DMN seems related to perceptions and behavior being driven by internal affective states that can be equally unresponsive to environmental cues. As more is understood about the complex interactions between neuronal networks, it may become possible to direct treatments toward faulty connections in diverse conditions, as occurs when deep-brain stimulation is directed at a hyperactive component of the DMN.

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www.jwatch.org/na34086/2014/03/31

## BYSTANDER INTERVENTION IN DRUG OVERDOSES ASSOCIATED WITH LOWER MORTALITY

**By Joe Elia**

A program to help people recognize and treat signs of opioid overdose and provide nasal naloxone dispensers to opioid users and their associates was associated with lower mortality rates, according to a BMJ study.

Researchers studied 19 Massachusetts communities with five or more overdose deaths annually. The program, called OEND, consisted of less than an hour's training within syringe-access programs, at drop-in centers and other venues. Participants also received naloxone rescue kits. Those eligible for training included users and potential bystanders, including family, social service agency staff, and friends.

After OEND implementation, the rates of overdose mortality related to opioids were significantly lower, both in communities with 100 or fewer enrollees per 100,000 population (rate ratio, 0.73) and in those enrolling more than 100 (RR, 0.54).

The locations of overdose prevention programs in the U.S. and information on prescribing naloxone rescue kits are provided below.

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www.jwatch.org/fw201302010000003/2013/02/01

# META-ANALYSIS FINDS ACE INHIBITORS SUPERIOR IN PATIENTS WITH DIABETES

**By Amy Orciari Herman**

Angiotensin-converting-enzyme (ACE) inhibitors are the antihypertensive treatment of choice in adults with diabetes, according to a BMJ meta-analysis.

Researchers examined nearly 70 randomized trials evaluating 11 antihypertensive regimens in roughly 37,000 adults with diabetes. Outcomes included all-cause mortality, end-stage renal disease, and doubling of serum creatinine.

**Among the findings:**

Combination therapy with ACE inhibitors plus calcium-channel blockers appeared most likely to reduce all-cause mortality; beta-blockers showed a significant increase in mortality.

Only ACE inhibitors significantly prevented the doubling of serum creatinine, compared with placebo.

Outcomes did not differ significantly between ACE inhibitors and angiotensin-receptor blockers, but ACE inhibitors "consistently showed higher probabilities of being at the superior ranking positions among all outcomes," the authors write.

The authors conclude that ACE inhibitors should be first-line antihypertensive therapy in adults with diabetes, noting that calcium-channel blockers might be added when blood pressure cannot be controlled with ACE inhibitors alone.

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www.jwatch.org/fw108074/2013/10/28/

# CORRELATES OF INCONTINENCE GO BEYOND BLADDER CONTROL

**Anne A. Moore, DNP, APRN, FAANP reviewing Hung KJ et al. Obstet Gynecol**

Disability at work and depression are linked to incontinence.

As many as one third of U.S. women older than 60 suffer from urinary incontinence (UI). The impact on quality of life is tremendous, yet little is known about the economic consequences of this condition. In an analysis of data from 4511 women (mean age, 59; 86% white) who participated in the survey-based Health and Retirement Study, researchers examined the relations between incontinence ("During the last 12 months, have you lost any amount of urine beyond your control?"), depression (score of ≥3 on the Center for Epidemiologic Studies Depression Scale), and effects on the workforce ("Do you have any impairment or health problem that limits the kind or amount of paid work you can do?").

A total of 727 women (17%) reported UI at baseline; of those, 212 (29%) reported losing urine on more than 15 days during the past month. In all, 1052 women (22%) had probable depression and 1276 (27%) had some degree of work disability. The presence of UI was associated with increased risk for probable depression (adjusted hazard ratio, 1.4) and for work disability (adjusted HR, 1.2). However, no association was found between UI and workforce exit.

**COMMENT**

Overactive bladder and urinary incontinence have become major foci in women's health and require innovative strategies for management. This study highlights the need to address depression and the potential for social isolation in women who have or are at risk for UI.

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www.jwatch.org/na34139/2014/04/03

## WITH SLEEP, TIMING IS EVERYTHING

**Jonathan Silver, MD reviewing Archer SN et al. Proc Natl Acad Sci U S A**

Disruptions of circadian rhythm can alter gene expression via RNA transcription and translation.
Disruptions in circadian rhythm adversely affect physical and mental health (e.g., NEJM JW Psychiatry Jan 9 2012; and Feb 14 2011), and circadian rhythms are seen in both the modifiers of chromatin structure and the process of RNA transcription and translation. To examine how forced dyssynchrony affects the human blood transcriptome (i.e., the universe of RNA molecules), researchers subjected 22 healthy volunteers to three 28-hour days (i.e., sleep was progressively delayed 4 hours on each day); during scheduled waking episodes, low light was provided.
This protocol allowed for normal melatonin rhythms and only slightly fewer hours of sleep (decreased from 450 minutes to 446, 401, and 388 minutes on each night); thus, study effects were not due to sleep deprivation. Mistimed sleep decreased rhythmic transcripts in the blood transcriptome from 6.4% to 1.0%. In a parallel analysis, the time course of expression changed in 34% of transcripts, including those involved in circadian clock genes, chromatin modification, CREB binding protein, and regulators of transcription and translation processes.

**COMMENT**

Mistimed sleep as in jet lag and shift work (rather than sleep restriction) has a major suppressive effect on translation and transcription and, probably, downstream effects on the expression of thousands of other genes. This finding makes apparent why disrupted sleep cycles are detrimental to health and why treatment of sleep problems may have antidepressant effects (Physician's First Watch Nov 11 2013). Other questions arise: Does disrupted circadian rhythm impair the efficacy of antidepressants, which may improve mood by increasing synaptogenesis? Would taking melatonin at the “wrong” time disrupt the link between biologic and circadian rhythms? We need to continue to emphasize to patients that a regular and appropriate sleep-wake cycle is important for health.

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www.jwatch.org/na33736/2014/03/05

## MORNING CORTISOL LEVELS ARE PREDICTIVE OF DEPRESSION IN ADOLESCENT MALES

**Barbara Geller, MD reviewing Owens M et al. Proc Natl Acad Sci U S A**

Although depression occurred more frequently in teenaged girls, high cortisol levels were associated only with depression in boys.
To study the potential usefulness of morning cortisol levels as a biomarker for vulnerability to depression, researchers examined depression and cortisol levels in two cohorts totaling 1858 teenagers in the U.K. between 1999 and 2009 (mean age, 14; 52% female).
Latent class analysis of baseline self-reported depressive symptoms and morning cortisol levels produced four baseline groups:

- Class 1 (31%), low depression scores and low cortisol
- Class 2 (27%), low depression scores and high cortisol
- Class 3 (25%), high depression scores and low cortisol
- Class 4 (17%), high depression scores and high cortisol

The model was sex-differentiated, with class 1 being 33% female and class 4 being 72% female.

At follow-up, which occurred 1 or 3 years later and involved in-person diagnostic interviews of 93% of participants, 12% had major depression. In males, diagnoses occurred more frequently in class 4 than other classes, whereas females were more likely to be depressed in classes 3 and 4 than in the other two (i.e., regardless of cortisol levels). Adversity histories and overgeneralized autobiographical memories (thought to occur more frequently in depression) did not differ by sex.

**COMMENT**

That more girls than boys were in the highest class of depressive symptoms is consistent with other studies. However, the lack of a sex difference in adversity histories differs from the speculated relationship between the higher prevalence of depression in teenaged girls and environmental factors (Psychol Bull 1994; 115:424). Without data on family depression histories, researchers could not examine the known associations between cortisol metabolism and familial depression (Lancet 1979; 1:739). Family history is an important diagnostic aid; however, elevated cortisol is not yet a specific, sensitive clinical tool.

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www.jwatch.org/na33808/2014/03/10

## CBT FOR INSOMNIA IN PATIENTS WITH PTSD

**Deborah Cowley, MD reviewing Talbot LS et al. Sleep**

Focused cognitive-behavioral therapy improves sleep, but its effects on nightmares are inconclusive.

Sleep disturbance is a common symptom of post-traumatic stress disorder (PTSD) and is associated with significant functional impairment. In a randomized, controlled trial, researchers compared the effects of 8 weeks of cognitive-behavioral therapy for insomnia (CBT-I) or a waiting list in 45 patients with PTSD and chronic insomnia (31 women; mean age, 37; mean duration of PTSD, 18 years). Participants could be on medications or in therapy so long as doses were stable and type of therapy was unchanged during the study.

Both after treatment and at 6-month follow-up, CBT-I was superior to the waitlist condition in sleep diary ratings of sleep onset latency, wake after sleep onset, sleep efficiency, total sleep time, and energy level. None of the waitlist patients but 41% of CBT-I recipients reported remission of insomnia at posttreatment. CBT-I also yielded significantly greater polysomnography-measured total sleep time and was associated with self-reported improvements in work and interpersonal functioning. Both groups showed decreases in PTSD symptoms and nightmares.

**COMMENT**

This study suggests that CBT for insomnia, which includes stimulus control and sleep restriction therapies, is effective for chronic insomnia and improves functioning in individuals with PTSD, with gains maintained for at least 6 months. It remains unclear how effective CBT-I is for PTSD-related nightmares. Clinicians treating patients with PTSD and persistent insomnia should consider a referral to a behavioral sleep specialist, adding CBT-I to the treatment regimen, or both.

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www.jwatch.org/na33879/2014/03/10

## PSYCHODYNAMIC THERAPY FOR SOCIAL ANXIETY DISORDER

**Deborah Cowley, MD reviewing Bögels SM et al. Depress Anxiety**

It's as effective as cognitive-behavioral therapy, even among patients with comorbid personality disorders.
Psychodynamic therapy (PDT) has been shown to be effective for social anxiety disorder but inferior to cognitive-behavioral therapy (CBT), a well-established treatment for this disorder (NEJM JW Psychiatry Jun 3 2013). The current researchers compared the two therapies and examined the effects of comorbid personality disorders.
Participants with generalized social anxiety disorder (N=49; 22 women; mean age, 30) were first placed on a waiting list and then randomized to up to 36 sessions of CBT or PDT. Exclusion criteria were substance use disorders, psychotic disorders, suicidal behavior, or cluster A or B personality disorders, except for paranoid and narcissistic personality disorders. All participants were required to display sufficient self-reflection, assessed in a discussion of an emotionally meaningful situation. PDT was short-term, nonmanualized, and used Malan's triangles: (1) a triangle of conflict (forbidden thoughts, feelings, and wishes; symptom/anxiety; defenses) and (2) a triangle of relationships (past/early caregivers; current; therapist). Session number was flexible, based on treatment plan and clinical course (mean sessions: CBT, 19.8; PDT, 31.4).
Waitlist patients who had to wait at least 3 months showed no improvement in social anxiety prerandomization (N=27; mean, 17.3 weeks). Both treatment groups improved markedly post-treatment and at 3-month and 1-year follow-ups, with no group differences in self and independent-rater reports of social anxiety symptoms, goal attainment, behavior and anxiety in feared social situations (assessed with the Behavior Approach Test), or defense mechanisms. Remission rates were over 50% and similar with both treatments. Outcomes did not differ between participants with and without personality disorders.

**COMMENT**

This study adds evidence for the efficacy of psychodynamic therapy for generalized social anxiety disorder. PDT requires both more sessions and patients' self-reflection, raising questions of generalizability and cost-effectiveness. However, if patients with SAD prefer and seem well-suited to PDT, clinicians can feel confident that this therapy will work.

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www.jwatch.org/na33884/2014/03/12

## ASSOCIATION OF NUT CONSUMPTION WITH TOTAL AND CAUSE-SPECIFIC MORTALITY

**Ying Bao, M.D., Sc.D. & colleagues**

Increased nut consumption has been associated with a reduced risk of major chronic diseases, including cardiovascular disease and type 2 diabetes mellitus. However, the association between nut consumption and mortality remains unclear.
We examined the association between nut consumption and subsequent total and cause-specific mortality among 76,464 women in the Nurses' Health Study (1980–2010) and 42,498 men in the Health Professionals Follow-up Study (1986–2010). Participants with a history of cancer, heart disease, or stroke were excluded. Nut consumption was assessed at baseline and updated every 2 to 4 years.
During 3,038,853 person-years of follow-up, 16,200 women and 11,229 men died. Nut consumption was inversely associated with total mortality among both women and men, after adjustment for other known or suspected risk factors. The pooled multivariate hazard ratios for death among participants who ate nuts, as compared with those who did not, were 0.93 (95% confidence interval [CI], 0.90 to 0.96) for the

consumption of nuts less than once per week, 0.89 (95% CI, 0.86 to 0.93) for once per week, 0.87 (95% CI, 0.83 to 0.90) for two to four times per week, 0.85 (95% CI, 0.79 to 0.91) for five or six times per week, and 0.80 (95% CI, 0.73 to 0.86) for seven or more times per week (P<0.001 for trend). Significant inverse associations were also observed between nut consumption and deaths due to cancer, heart disease, and respiratory disease.

In two large, independent cohorts of nurses and other health professionals, the frequency of nut consumption was inversely associated with total and cause-specific mortality, independently of other predictors of death. (Funded by the National Institutes of Health and the International Tree Nut Council Nutrition Research and Education Foundation.)

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http://www.nejm.org/doi/full/10.1056/NEJMoa1307352#t=abstract

## TOFFEE TV - UNWRAP AND SAVOUR URDU POEMS AND STORIES

**(From an article by Fatima Zakir in the news international magazine)**

It was on the second day of Children Literature Festival recently held in Karachi that I had the pleasure of attending the storytelling session by Toffee TV. The session was great and it made me smile from ear to ear. It was actually the response the session got from the kids that made me walk up to them … I simply had to get time for a detailed meeting so I could learn about their work in detail. What I got to know when I met them up was extremely inspiring. Toffee TV is not telling stories or singing poems at different events. Toffee TV is actually our digital library for Urdu poems and stories for the kids. In this age and time when kids are born with a tablet or cell phone in their hands, digital education is 'the' thing. I have seen kids in my family who have learnt colours, shapes, numbers, alphabets and even nursery rhymes before going to school, all with the help of YouTube or other such sites. What we didn't have - and didn't really pay attention to - was the fact that all of this content is not in Urdu. No wonder our kids are not really fond of Urdu poems and stories. In order to make our kids familiar with our very own language in a fun way, Toffee TV took up the responsibility of churning out content in our national language with the help of funky animations and catchy tunes. Now, what is Toffee TV? Well, it is basically two girls with an aim to promote Urdu language amongst our kids using technology. Rabia Garib, Chief Wrapper, and Talea Zafar, Chief Illustrator, started their website toffeetv.com on 4th July, 2011. It's like Talea creates the toffee and Rabia wraps it in such a fascinating way that children would want to unwrap and savour every bit of it. Let's talk to them and find out more about this venture…

**Us: What, exactly, is Toffee TV?**

**Talea Zafar:** offee TV is actually a website that has songs, stories, events and updates. We get the Urdu versions of our nursery rhymes, sing them, come out with animations and upload them on our website. The poems in our text books are quite monotonous; we use the same tune for three to four poems which gets boring for the kids. So, we wanted to produce them in an engaging manner. Basic idea is to promote Urdu amongst our children.

**Rabia Garib:** Not that our website is solely in Urdu … we do have English songs and stories, too, but we try to have more of Urdu content. We translate the English poems that don't have an Urdu version, and add them to our library. In fact, we have a couple of songs in Punjabi, too, which have a huge following. Like we have The Hokey Pokey Song in Punjabi also and kids from Lahore and Islamabad love it. We have Heads, Shoulders, Knees and Toes in Arabic. We are even venturing into Memoni and will soon come out with a song in it.

**Us: Tell Us something about the Toffee TV team?**

**Talea:** Well, Rabia and I are the core members, Rabia being the IT expert. Besides, she has a '100s of voices' within her. She can also sing and play the guitar. I handle the artistic side of things like animations and illustrations. In addition, we have our storytellers, whom we call Toffee Tellers. We have our Toffee TV Chef for the kids, and our volunteers who often help us with the songs and stories.

**Us: You plan to revive Urdu poems for children, but did it occur to you that this might not work out keeping in mind the obsession with English these days?**

**Rabia:** Urdu and technology is a great combination. It's ironic that we haven't really made good use of it till now. We knew if we can merge the two and come out with something really interesting the kids will love it. After all, they watch the English educational songs with so much interest! We are doing exactly the same thing with a slightly different agenda: we are promoting our culture. Everything is not replicable. As long as the content is exciting and visually relevant, people will watch it.

**Talea:** You can better understand it with a simple example; in our first year we had one million followers and in our second years we reached a two million mark within eight months.

**Us: What do you have in mind while designing content?**

**Talea:** When we started thinking about the animation aspect of our songs, we were sure that we wanted to keep it very Pakistani. For example, when we did the Urdu version of 'Wheels on the Bus', we had a minibus we daily see on our roads, women in burqa, the conductor in a waistcoat etc, just to keep the Pakistani flavor alive.

**Rabia:** Once we were in USA and a kid kept on requesting for 'Bus Kay Payyay'. Later on his mother informed us that the video was so relatable that she shared with her kids all the memories of Pakistan, the bus rides and the people. It felt so good. This is why we keep our animations very local so that our kids can stick to our roots.

**Us: How frequently do you publish content and what are your most watched videos?**

**Talea:** We upload three videos per week, which means we have to come out with three different songs or stories with complete audio and visuals in a week. This is challenging for both of us but we plan to expand and introduce more people into our Toffee factory so that more content can be churned out more frequently. Till now we have 300 posts on our website, which is good keeping in mind we are just 2.5 years old.

**Rabia:** As for our most liked ones, it has to be Itsy Bitsy Spider, Makri ka Jaala, the Unm Yumm Yumm song etc. Our New Year Song is quite a hit as well since it's a very optimistic song that can be used year after year.

**Us: You have volunteers at Toffee TV too. How does that operate?**

**Rabia:** We have volunteers working with us on and off, especially in summers. Parents want their children to be a part of Toffee TV in any way. We have a teenage guy who has come out with his own science show. He would wear different costumes, perform easy-to-learn experiments, shoot his own show and then go to school and tell everyone to watch his show on Toffee TV. We want them to come up with creative stuff and not just spend time at the factory, not doing anything.

**Talea:** We have shows produced by the children for the children. Our volunteers contribute to the production of our content from writing poems to singing them and from telling stories to decorating cupcakes. With so many children we get a variety of voices for our songs. Sometimes, even we are amazed by the things our youngsters can do. Some of the stories, the poems and the way they deliver them is mind blowing.

**Rabia:** Then you have excited parents who are enthralled to see their children's work on the internet. We often have parents who want to learn the art of storytelling so that they can practice it at home. They take our storytelling workshops and then have small gatherings at their place showcasing their skill. Plus, we even encourage our interested children and parents to perform in our events like a group of our volunteers performed at NAPA theatre festival last year. This acts as a motivational force for a lot of other parents and children too.

**Us: Your main focus is your website but don't you think the events have given you more mileage?**

**Talea:** Definitely! Since we mostly rely on word of mouth, events have played a very important role in taking our name across to the people. For this, we are greatly thankful to our Toffee Tellers who take out their precious time to perform with us.

**Us: When did you start doing events?**

**Rabia:** In October 2011. When we got an opportunity to have a storytelling session we were not sure of the response. It was sheer good luck that we ran into Sania Saeed, the actress, and asked her if she would be interested in doing a storytelling session for the kids. Gladly, she agreed and we had our first session with Sania Saeed. A lot of people showed up for it, making it an immediate success. That's when we realised we should do more events as it brings us face to face with our audience and we can see the immediate response to our stories and songs. Besides, events are an important medium for spreading our word across to the masses, making our work more prominent.

**Us: Would you like to see the schools adapting this culture too?**

**Talea:** Oh, we would love that! Ideally, we would want them to establish a system with us where they can use our content initially and then help us build new content, too. This fun way of education will help young minds in a better way.

**Us: With so much production going on and plans of expansion, did you guys face any economic constraints?**

**Rabia:** Well, we have Toffee TV apps for different phones like for Nokia, Apple and now even Android and we have monetised them, which has been really positive for us. Besides, we are still very young and have a long way to go. We didn't start it as a side business: this is our passion and we take it as our full time commitment. So we can't bring in finances and make it an excuse for not delivering; that's simply not an option for us.

**Us: Where do you see Toffee TV in five years?**

**Talea:** On a number of different platforms like radio and TV, a bigger library, expanded organisation, even a film … you never know!

**Rabia:** You can even talk about next year. With the arrival of 3G, accessibility challenges will be reduced by many folds. Our library would explode as more people would want to produce content for kids. The learning for kids is going to be revolutionized, and Urdu is going to enjoy its much deserved share on a number of avenues.

**Toffee Tellers on Toffee TV.**

**Hira Ilyas:** I am an architect by profession and have studied architecture at NCA. I have been involved in theatre for the past seven years so when I got to know about Toffee TV, I thought of giving it a shot. It's been nearly two years that I have been working with them and I must say it has been a joyous ride throughout. Performing for kids is amazing; you get instant reaction, the audience is very responsive and you get to explore yourself too, since you have to improvise by the response you get. This was something new for me; haven't really seen a lot of stuff happening for children and it is very interesting. I love my

sessions with the kids and would like to continue doing it for as long as I can.

**Fawad Khan:** I have been associated with Toffee TV for the past two years now and it has been a great working experience. I am a NAPA alumnus and have a strong association with theater, both in terms of acting and direction so I can understand what the audience wants. I love telling stories to the kids because the response I get is immediate and exciting. As for Toffee TV, the best thing about them is their emphasis on Urdu. Not only can the kids associate themselves with the stories easily but it also keeps them glued to their roots. We all know that our kids are usually hungry for entertainment since there is not much happening for them. Recently, NAPA organised a play for them – Ali Baba Chalis Chor – that was a huge success because children as well as their parents want educational entertainment. Despite my commitments to NAPA or TV, I make it a point to take out time for Toffee TV because this is one platform that will benefit our generations to come. And, of course, I love interacting with the children too.


## Whatchya cooking, kid!?

**Chef Juhi:** I'd never done anything of this kind before so when Toffee TV asked me to do some food decorations for young kids, I thought I'd try and find out if children were even interested in such activities or not. I was surprised to see the kind of response I got. What we basically do is 'create' food without knives and burners since we are dealing with very young kids. We usually decorate cookies, cupcakes and other desserts. We even use our day to day food items like rice and use them in a number of ways to teach the kids how to utilise their leftovers creatively and in a delicious manner. I have been associated with Toffee TV for two years and it has been a wonderful experience for me. The children who come to learn from me take so much interest that the positive energy is transmitted to me and I get more motivated to teach them new things. In fact, it's not just the children; even their parents get so excited when they see their children baking cupcakes or making chocolate. Their appreciation is such a booster for me and the kids.

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# A SMARTPHONE APPLICATION TO SUPPORT RECOVERY FROM ALCOHOLISM A RANDOMIZED CLINICAL TRIAL

**By David H. Gustafson, PhD and colleague**

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**ABSTRACT**

**Importance** Patients leaving residential treatment for alcohol use disorders are not typically offered evidence-based continuing care, although research suggests that continuing care is associated with better outcomes. A smartphone-based application could provide effective continuing care.

**Objective** To determine whether patients leaving residential treatment for alcohol use disorders with a smartphone application to support recovery have fewer risky drinking days than control patients.

**Design, Setting, and Participants** An unmasked randomized clinical trial involving 3 residential programs operated by 1 nonprofit treatment organization in the Midwestern United States and 2 residential programs operated by 1 nonprofit organization in the Northeastern United States. In total, 349 patients

who met the criteria for DSM-IV alcohol dependence when they entered residential treatment were randomized to treatment as usual (n = 179) or treatment as usual plus a smartphone (n = 170) with the Addiction–Comprehensive Health Enhancement Support System (A-CHESS), an application designed to improve continuing care for alcohol use disorders.

**Interventions** Treatment as usual varied across programs; none offered patients coordinated continuing care after discharge. A-CHESS provides monitoring, information, communication, and support services to patients, including ways for patients and counselors to stay in contact. The intervention and follow-up period lasted 8 and 4 months, respectively.

**Main Outcomes and Measures** Risky drinking days—the number of days during which a patient's drinking in a 2-hour period exceeded 4 standard drinks for men and 3 standard drinks for women, with standard drink defined as one that contains roughly 14 g of pure alcohol (12 oz of regular beer, 5 oz of wine, or 1.5 oz of distilled spirits). Patients were asked to report their risky drinking days in the previous 30 days on surveys taken 4, 8, and 12 months after discharge from residential treatment.

**Results** For the 8 months of the intervention and 4 months of follow-up, patients in the A-CHESS group reported significantly fewer risky drinking days than did patients in the control group, with a mean of 1.39 vs 2.75 days (mean difference, 1.37; 95% CI, 0.46-2.27; P = .003).

**Conclusions and Relevance** The findings suggest that a multifeatured smartphone application may have significant benefit to patients in continuing care for alcohol use disorders.

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http://archpsyc.jamanetwork.com/article.aspx?articleid=1847578

## SHOULD IT REALLY TAKE 14 YEARS TO BECOME A DOCTOR?

**By Brain Palmer**

**It's time to experiment with medical school**

We need more doctors. On a global scale, the shortage is staggering: The World Health Organization says we need 15 percent more doctors. In the United States, the American Association of Medical Colleges estimates the current deficit at almost 60,000 and forecasts a worrisome 130,600-doctor shortfall by 2025. There's one simple solution: We have to consider ways to manufacture doctors faster and cheaper.

An American physician spends an average of 14 years training for the job: four years of college, four years of medical school, and residencies and fellowships that last between three and eight years. This medical education system wasn't handed down to us by God or Galen—it was the result of a reform movement that began in the late 19th century and was largely finished more than 100 years ago. That was the last time we seriously considered the structure of medical education in the United States.

The circumstances were vastly different at that time. Until the Civil War, private, for-profit medical schools with virtually no admissions requirements subjected farm boys to two four-month sessions of lectures and sent them off to treat the sick. (The second session was an exact duplicate of the first.) The system produced too many doctors with not enough training. Abraham Flexner, the education reformer who wrote an influential report on medical education in 1910, put a fine point on the problem: "There has been an enormous over-production of uneducated and ill trained medical practitioners," he wrote. (Emphasis added.) "Taking the United States as a whole, physicians are four or five times as numerous in proportion to population as in older countries like Germany."

In other words, our current medical education system was originally designed to reduce the total number of people entering the profession. The academic medical schools that sprang up around the country—such as the Johns Hopkins Hospital in 1889—made college education a prerequisite. Medical school expanded from eight months to three years and solidified at four years in the 1890s. Postgraduate training programs were implemented, beginning with a one-year internship. These were brilliant reforms at the time.

Over the past century, there have been additions to, but few subtractions from, the training process. Residency and fellowship programs became longer and longer ... and longer. The path to some specialties is now almost comically arduous. Many hand surgeons, for example, complete five years in general surgery, followed by three years in plastic surgery, followed by another year of specialized hand surgery training. To be a competitive candidate for a hand surgery fellowship, it's also strongly recommended to spend two additional years on research at some point during the process.

Yay, only 10 more years to go!

The current system has costs beyond making doctors expensive and rare. The long process doesn't just weed out the incompetent and the lazy from the potential pool of physicians—it deters students who can't pay for so many years of education or who need to make money quickly to support their families. That introduces a significant class bias into the physician population, depriving a large proportion of the population of doctors who understand their background, values, and challenges.

One solution is to simply lop off a few years from the process. Writing in the Journal of the American Medical Association in 2012, bioethicist Ezekiel Emanuel (one of those Emanuels) and economist Victor Fuchs recommended shortening each stage by about 30 percent. Four years of premedical training shouldn't be a requirement for those who don't want it or can't afford it, they argued. The fourth year of medical school is largely a breeze, and a few progressive medical schools are now offering three-year programs to reflect that reality.

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**Editor's Note :**

A pour country likes Pakistan should especially think about this topic. UP to the fifties there used to be "Medical Schools" with a cough of four years after matric and the degree awarded was L.S.M.F.

These doctors evidently worked very well. They were also encouraged to take two years of additional education and training in order to get can MBBS degree. One advantage was that these doctors were not acceptable in foreign countries so there was no brain drain. It time me considered starting L.S.M.F., again in order to provide medical aid to the population specially the small areas where MBBS doctor art loth to go.

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http://www.slate.com/articles/health_and_science/medical_examiner/2014/03/physician

# APPS TO HELP TRAVELLERS BEAT LANGUAGE BARRIERS

**(From an article by Sarah Mishkin in The News)**

A few activities are more difficult and time-consuming than learning a language. But after working and travelling in Asia, the Middle East and Europe, I know how annoying it can feel to be lost and unable to ask for directions, or hungry but unable to read the menu. Luckily, a new generation of apps can help.

Little beats living and working abroad or chatting regularly with native speakers, but the best apps provide a decent substitute - and even the priciest is cheaper than an air ticket.

That pricey choice would be one of the apps from Rosetta Stone that act as companions or as standalone versions of the language-learning companyâ€™s software (iOS and Android, 12-month subscription for $299/ Â£299 in the UK).

The methodology is unusual and immersive: words are repeated aloud or as text while more complex grammar is gradually added to give learners a chance to recognise and internalise patterns. Explicit explanations are few, making the Rosetta experience good for those who have the time to follow along but frustrating if you want to speed up a bit.

A cheaper option is Babbel, which comprises an app and online community (iOS, Android, $12.95 a month/$83.40 annual) and offers lessons in languages from Danish to Turkish. The app provides brief lessons including audio of pronunciation, and tests you by asking you to fill in sentences or match written words with their translation.

But it is hard to justify paying for either Rosetta or Babbel when there are good alternatives for free.

Duolingo (iOS, Android) offers similar brief lessons in the basics, while testing learners with games as they move through the levels. It offers five European languages so far and the top levels are still fairly basic but for new learners it is a cost-effective choice.

Duolingo also links up with Facebook to show your friends progress, so you can feel superior or inadequate, depending on your studiousness.

I have been using it on my commutes to brush up on my French grammar. Whether Iâ€™m making meaningful progress straightening out feminine nouns from the masculine ones is debatable. But I am at least beating my friends who also use the app and possibly impressing the strangers looking over my shoulder on the San Francisco subway.

A good companion for any of the apps is Anki (free for Android and web, $24.99 for iOS), which is funded by donations. Type in the vocabulary you want to learn and Anki uses an algorithm to make sure you go through each of a series of flashcards often enough to really learn it.

Other free resources online include those of national broadcasters. The BBC offers lessons in languages from German to Urdu. A handful of French broadcasting channels and Qatarâ€™s Al Jazeera, among others, offer lessons and interactive exercises.

But who really has time for all that? Not many of us. And so we turn to translation apps such as Jibbigo (iOS, Android, free to download with some in-app purchases),Vocre(iOS $4.99, Android 99 cents) and Google Translate (iOS, Android, web, free).

As with any computer translation, they seem a bit robotic but they are serviceable - and clearer than the strategy of gesturing wildly and speaking loudly that some people adopt when abroad.

Google Translates app offers a frightening number of languages (Afrikaans or Hmong, anyone?). For some text, including Chinese and Japanese characters, it is possible to take a picture of the words and receive a translation.

Jibbigo has more limited functionality but slightly better speaking capabilities: it can translate text from English to a foreign language and then play you a spoken version.

Vocre is far more fun. It is designed to translate conversations, with one person sitting either side of the smartphone, much as you would when playing chess. The keyboard flips to the side of the screen near the person whose turn it is to speak, and the resulting translation is both written and spoken. It requires patience and an internet connection, but it is easy to see situations in which Vocre would be handy.

# AMERICAN GENERAL PLEADS GUILTY TO HAVING SEX WITH JUNIOR FEMALE OFFICERS

**(AFP)**

A US general accused of sexual assault pleaded guilty on Thursday to three lesser charges, a remarkable admission sure to end the military career of a man once regarded as a rising star among the Army's small cadre of trusted battle commanders.

The case against Brig. Gen. Jeffrey A. Sinclair, believed to be the most senior member of the U.S. military ever to face trial on sexual assault charges, comes as the Pentagon grapples with revelations of rampant rape and sexual misconduct within the ranks.

The US Senate blocked a bill that would have stripped senior military commanders of their authority to prosecute rapes and other serious offenses in the ranks. The bill was firmly opposed by the Pentagon.

In his immaculate blue dress uniform, Sinclair stood ramrod straight before a judge and pleaded guilty to three charges that could send him to prison for up to 15 years.

Sinclair, 51, still faces five other charges stemming from the claims of a female captain who said he twice forced her to perform oral sex. But by pleading guilty to the lesser charges, Sinclair's lawyers believe they will strengthen his case at trail by potentially limiting some of the salacious evidence prosecutors can present. The former deputy commander of the 82nd Airborne could be sentenced to life in prison if convicted of the sexual assaults. Pohl accepted Sinclair's plea after nearly three hours of often intimate questions about the married general's flirtations and dalliances with four women — three military officers and one civilian.

Asked by judge Col. James Pohl whether he clearly understood the consequences of his admissions, the decorated veteran of five combat deployments answered in a clear voice, with no emotion: "Yes sir."

The general pleaded guilty to having improper relationships with two female Army officers and to committing adultery with a third, the captain who was his longtime mistress. Adultery is a crime in the military.

He also admitted to violating orders by possessing pornography and to conduct unbecoming of an officer and a gentleman. After he knew he was under investigation, Sinclair also admitted deleting nude photos from a personal email account sent by a civilian woman with whom he was childhood friends.

Sinclair's lawyer Richard Scheff said before the plea that his client was taking responsibility for his actions, but also strengthening his legal position. By admitting guilt on the three charges for which there is the strongest evidence, the married father of two hoped to narrow the focus of the trial to charges that rely heavily on the testimony and credibility of his former mistress.

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**Editor's Notes:** If even female officers in the army of the so called "most advanced" country of the world can't save themselves from sexual acts of their seniors (and sometimes colleagues) then is it not time to consider The Islamic injunction about the role of women in society.

# MQM LEADER JAILED FOR FRAUD NOT MORTGAGE

**(From an article by Murtaza Ali Shah in The News)**

Imbisat Malick, a Muttahida Qaumi Movement's London-based Central Co-ordination Committee member, was jailed because of his involvement with the MQM and the fraud for which he was prosecuted came to light during a police investigation into the finances of the MQM, court papers obtained by The News confirm.

Some MQM leaders have gone on record to state that Imbisat Mallick has been jailed for 21 months over a mortgage fraud that was his personal matter, but the court papers available with this correspondent unambiguously state that "the fraud came to light during a police investigation into the finances of the MQM, a Pakistani political party based in the UK, the investigations has shown that members of the organisation have access to large cash balances and have an extensive property portfolios."

In cases where mortgage frauds are involved, police rarely get involved as banks pursue such civil cases, but Mallick's conviction is unique in the sense that around 15 members of the Counter Terrorism Command Unit officials – the same unit that's responsible for the murder investigation of Dr Imran Farooq and the associated money-laundering cases—raided the house of Imbisat Mallick under the Police and Criminal Evidence Act (PACE), after executing such warrants. The court papers clearly show that Mallick's mortgage was 100 percent up-to-date. The court papers confirm that Mr Mallick, who was sentenced at Isleworth Crown Court here on 13th of January this year, didn't cause loss to the lender—the Santander Bank—and used the house to live with his family and was not speculating the sale of the house. Mallick's lawyers presented in the court the letter from the Santander Bank of 3rd January 2014, advising change to monthly mortgage and giving the details of the future payment. They demonstrated that the bank didn't raise any concerns, was happy to carry on doing business with Mr Mallick and didn't object to the mortgage arrangement with Mr Mallick.

The court papers show that the Scotland Yard detectives raided the property of Mr Mallick on 17th of July 2013 – roughly a month after the detectives raided the residential properties of the MQM chief Altaf Hussain and his cousin Iftikhar Hussain Qurasihi. On 24th of June, the police arrested Quraishi, 52, at the Heathrow Airport when he was returning to London after attending a wedding in Canada. The Counter Terror unit executed a dawn raid at Mr Mallick's Northwood home on 17th July. The police took away mobile phones, navigation system, computers, multi media laptops, data storage devices and almost all documents found in the house. The News has confirmation that the detectives, after arresting Mr Mallick, searched the property for a day.

According to sources, Mr Mallick was going to plead not guilty because it was a broker who had originally arranged all the paper work to obtain mortgage for Mr Mallick and for this, he was paid in the tune of about 6 thousand GBP. But the solicitor advised Mr Mallick that on prima facie the charges of mortgage fraud in a court before the jury could lead to wider exposure of the matters relating to the MQM where further witnesses could have been called to explain the property portfolios and the large cash balances. The prosecution paper clearly state that Mr Mallick is a central MQM leader and also son-in-law of Muhammad Anwar, one of the most senior MQM leaders and a key adviser to the party on international affairs.

The court papers say that Imbisat Mallick's father-in-law is MQM's senior leader and that he would be able to "purchase the house for cash if he was inclined to do so".

The court papers show that the prosecution made a witness statement in support of an application for a restraint order under Section 41 Proceeds of Crime Act 2002. This application in the case of Mr Mallick means that his sentencing is linked with the wider money-laundering probe because no cash was found during raid on Mallick's hosue.

The News is aware that Mr Mallick was advised by his solicitors that a trial could open a Pandora's Box that could lead to several MQM figures also standing in the court for witness statements and other forms of questioning. The source confirmed that Mr Mallick pleaded guilty to avoid that situation and therefore, he has become the first martyr for the party in the multiple active probes.

As mentioned above, several leaders of the MQM are distancing themselves from Mr Mallick that his conviction is a personal matter, but his case is a test for the MQM and throws up a dilemma for the party as in whether the party acknowledges his huge sacrifice or tries to distance itself from one of their closest associates who now finds himself behind the bars for his very involvement in the party affairs.

The court papers show that Regina Vs Waya mortgage fraud precedent was used in the Isleworth Crown Court to sentence Mr Mallick but Mr Waya, in a similar mortgage fraud case, was sentenced to 80 hours of community service reflecting the judge's view of the relatively low level for his culpability. The judge in the case of Mr Waya went on to say that "he was not guilty of a serious mortgage fraud, involving dishonest overvaluation of property. There was no loss to the mortgage lender."

The papers seen by The News show that the case involving Mallick relates to a property in London's Northwood area, which is subject to a mortgage in the sum of £399,734 and the approximate value of the property is £637,000.

The papers show that "the benefit will be the amount of equity in the property that can be attributed to the amount gained from the fraud.

The present value of the house is approximately £637,000 so the equity is around £127,000. The mortgage of £434,945 represents 85 percent of the purchase price. The benefit gained by the fraud is therefore 85 percent of £127,000 which is £107,950."

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۱۱۔ غیر مسلم باشندگانِ مملکت سے حدودِ شریعہ کے اندر جو معاہدات کیے گئے ہوں، ان کی پابندی لازمی ہوگی اور جن حقوق شہری کا ذکر دفعہ نمبر ۷ میں کیا گیا ہے ان میں غیر مسلم باشندگانِ ملک اور مسلم باشندگانِ ملک، سب برابر کے شریک ہوں گے۔

۱۲۔ رئیس مملکت کا مسلمان مرد ہونا ضروری ہے، جس کے تدین، صلاحیت اور اصابتِ رائے پر جمہور کے منتخب نمائندوں کو اعتماد ہو۔

۱۳۔ رئیس مملکت ہی نظمِ مملکت کا اصل ذمہ دار ہوگا۔ البتہ وہ اپنے خیالات کا کوئی جزو کسی فرد یا جماعت کو تفویض کر سکتا ہے۔

۱۴۔ رئیس مملکت کی حکومت مستبدانہ نہیں بلکہ شورائی ہوگی۔ یعنی وہ ارکانِ حکومت اور منتخب نمائندگانِ جمہور سے مشورہ لے کر اپنے فرائض انجام دے گا۔

۱۵۔ رئیس مملکت کو یہ حق حاصل نہ ہوگا کہ وہ دستور کو کلاً یا جزواً معطل کر کے شوریٰ کے بغیر حکومت کرنے لگے۔

۱۶۔ جو جماعت رئیس مملکت کے انتخاب کی مجاز ہوگی وہی کثرتِ آرا سے اسے معزول کرنے کی بھی مجاز ہوگی۔

۱۷۔ رئیس مملکت شہری حقوق میں عام المسلمین کے برابر ہوگا اور قانونی مواخذہ سے بالاتر نہ ہوگا۔

۱۸۔ ارکان و عمالِ حکومت اور عام شہریوں کے لیے ایک ہی قانون و ضابطہ ہوگا اور دونوں پر عام عدالتیں ہی اس کو نافذ کریں گی۔

۱۹۔ محکمۂ عدلیہ، محکمہ انتظامیہ سے علیحدہ اور آزاد ہوگا، تاکہ عدلیہ اپنے فرائض کی انجام دہی میں ہیئت انتظامیہ سے اثر پذیر نہ ہو۔

۲۰۔ ایسے افکار و نظریات کی تبلیغ و اشاعت ممنوع ہوگی جو مملکتِ اسلامیہ کے اساسی اصول و مبادی کے انہدام کا باعث ہوں۔

۲۱۔ ملک کے مختلف ولایات و اقطاع مملکت واحدہ کے اجزا انتظامی متصور ہوں گے۔ ان کی حیثیت نسلی، لسانی، یا قبائلی واحدہ جات کی نہیں محض انتظامی علاقوں کی ہوگی، جنہیں انتظامی سہولتوں کے پیش نظر مرکز کی سیادت کے تابع انتظامی اختیارات سپرد کرنا جائز ہوگا، مگر انہیں مرکز سے علیحدگی کا حق حاصل نہ ہوگا۔

۲۲۔ دستور کی کوئی ایسی تعبیر معتبر نہ ہوگی جو کتاب و سنت کے خلاف ہو۔

## اسمائے گرامی حضراتِ شرکائے مجلس

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# پاکستان میں اسلامی دستور کے لیے علماء کرام کے متفقہ ۲۲ نکات

## اسلامی حکومت کے بنیادی اصولوں کے حوالے سے میں سارے مکاتبِ فکر کے علما کی طرف سے متفقہ طور پر منظور کردہ علما کرام کے ۲۲ نکات

## (معارف فیچر)

ایک مدتِ دراز سے اسلامی دستورِ مملکت کے بارے میں طرح طرح کی غلط فہمیاں لوگوں میں پھیلی ہوئی ہیں۔ اسلام کا کوئی دستورِ مملکت ہے بھی یا نہیں؟ اگر ہے تو اس کے اصول کیا ہیں اور اس کی عملی شکل کیا ہو سکتی ہے؟ اور کیا اصول اور عملی تفصیلات میں کوئی چیز بھی ایسی ہے جس پر مختلف اسلامی فرقوں کے علما متفق ہو سکیں؟ یہ ایسے سوالات ہیں جن کے متعلق عام طور پر ایک ذہنی پریشانی پائی جاتی ہے اور اس ذہنی پریشانی میں ان مختلف دستوری تجویزوں نے اور بھی اضافہ کر دیا ہے جو مختلف حلقوں کی طرف سے اسلام کے نام پر وقتاً فوقتاً پیش کی گئیں۔ اس کیفیت کو دیکھ کر یہ ضرورت محسوس کی گئی کہ تمام اسلامی فرقوں کے چیدہ اور معتمد علما کی ایک مجلس منعقد کی جائے اور وہ بالاتفاق صرف اسلامی دستور کے بنیادی اصول ہی بیان کرنے پر اکتفانہ کرے بلکہ ان اصولوں کے مطابق ایک ایسا دستوری خاکہ بھی مرتب کر دے جو تمام اسلامی فرقوں کے لیے قابل قبول ہو۔

اس غرض کے لیے ایک اجتماع بتاریخ ۱۳، ۱۲، ۱۴ اور ۱۵ ربیع الثانی ۱۳۷۰ھ مطابق ۲۱، ۲۳، ۲۲ اور ۲۴ جنوری ۱۹۵۱ء بصدارت مولانا سید سلیمان ندوی، کراچی میں منعقد ہوا۔ اس اجتماع میں اسلامی دستور کے جو بنیادی اصول بالاتفاق طے ہوئے، انہیں فائدہ عام کے لیے شائع کیا جا رہا ہے۔

### اسلامی مملکت کے بنیادی اصول

اسلامی مملکت کے دستور میں حسبِ ذیل اصول کی تصریح لازمی ہے:

۱۔ اصل حاکم تشریعی و تکوینی حیثیت سے اللہ رب العالمین ہے۔

۲۔ ملک کا قانون کتاب و سنت پر مبنی ہو گا اور کوئی ایسا قانون نہ بنایا جا سکے گا، نہ کوئی ایسا انتظامی حکم دیا جا سکے گا، جو کتاب و سنت کے خلاف ہو۔

(تشریحی نوٹ) اگر ملک میں پہلے سے کچھ ایسے قوانین جاری ہوں، جو کتاب و سنت کے خلاف ہوں تو اس کی تصریح بھی ضروری ہے کہ وہ بتدریج ایک معینہ مدت کے اندر منسوخ یا شریعت کے مطابق تبدیل کر دیے جائیں گے۔

۳۔ مملکت کسی جغرافیائی، نسلی، لسانی یا کسی اور تصور پر نہیں بلکہ ان اصولوں و مقاصد پر مبنی ہو گی جن کی اساس اسلام کا پیش کیا ہوا ضابطہ حیات ہے۔

۴۔ اسلامی مملکت کا یہ فرض ہو گا کہ قرآن و سنت کے بتائے ہوئے معروفات کو قائم کرے، منکرات کو مٹائے اور شعائر اسلامی کے احیاو اعلا اور مسلمہ اسلامی فرقوں کے لیے ان کے اپنے مذہب کے مطابق ضروری اسلامی تعلیم کا انتظام کرے۔

۵۔ اسلامی مملکت کا یہ فرض ہو گا کہ وہ مسلمانانِ عالم کے رشتہ و اتحاد و اخوت کو قوی سے قوی تر کرنے اور ریاست کے مسلم باشندوں کے درمیان عصبیت جاہلیہ کی بنیادوں پر نسلی، لسانی، علاقائی یا دیگر مادی امتیازات کے ابھرنے کی راہیں مسدود کر کے ملتِ اسلامیہ کی وحدت کے تحفظ و استحکام کا انتظام کرے۔

۶۔ مملکت بلا امتیاز مذہب و نسل وغیرہ تمام ایسے لوگوں کی لابدی انسانی ضروریات یعنی غذا، لباس، مسکن، معالجہ اور تعلیم کی کفیل ہو گی جو اکتساب رزق کے قابل نہ ہوں، یا نہ رہے ہوں یا عارضی طور پر بے روزگاری، بیماری یا دوسری وجوہ سے فی الحال سعی اکتساب پر قادر نہ ہوں۔

۷۔ باشندگانِ ملک کو وہ تمام حقوق حاصل ہوں گے جو شریعت اسلامیہ نے ان کو عطا کیے ہیں۔ یعنی حدودِ قانون کے اندر تحفظ جان و مال و آبرو، آزادی مذہب و مسلک، آزادی عبادت، آزادی اظہارِ رائے، آزادی نقل و حرکت، آزادی اکتسابِ رزق، ترقی کے مواقع میں یکسانی اور رفاہی ادارات سے استفادہ کا حق۔

۸۔ مذکورہ بالا حقوق میں سے کسی شہری کا کوئی حق اسلامی قانون کی سندِ جواز کے بغیر کسی وقت سلب نہ کیا جائے گا اور کسی جرم کے الزام میں کسی کو بغیر فراہمی موقعہ صفائی و فیصلہ عدالت کوئی سزا نہ دی جائے گی۔

۹۔ مسلمہ اسلامی فرقوں کو حدودِ قانون کے اندر پوری مذہبی آزادی حاصل ہو گی۔ انہیں اپنے پیروؤں کو اپنے مذہب کی تعلیم دینے کا حق حاصل ہو گا۔ وہ اپنے خیالات کی آزادی کے ساتھ اشاعت کر سکیں گے۔ ان کے شخصی معاملات کے فیصلے ان کے اپنے فقہی مذہب کے مطابق ہوں گے اور ایسا انتظام کرنا مناسب ہو گا کہ انہی کے قاضی یہ فیصلہ کریں۔

۱۰۔ غیر مسلم باشندگانِ مملکت کو حدودِ قانون کے اندر مذہب و عبادت، تہذیب و ثقافت اور مذہبی تعلیم کی پوری آزادی حاصل ہو گی اور انہیں اپنے شخصی معاملات کا فیصلہ اپنے مذہبی قانون یا رسم و رواج کے مطابق کرانے کا حق حاصل ہو گا۔

گلے لگا لیا۔ کارپٹڈ استقبال ہوئے۔ نوبل انعام کے لیے نامزدگی کی گئی۔ بلاشبہ مغربی دنیا نے ملالہ کو اس مقام پر پہنچادیا کہ جہاں خواب وخیال ہی نہیں جاسکتا تھا۔ لیکن اسکی آڑ میں حقائق کو موڑ کر جس مخصوص ایجنڈے کو آگے بڑھایا ہے اور اسلام و مسلمانوں کی تضحیک کا جو گھناؤنا کھیل شروع کیا ہے وہ ''آئی ایم ملالہ'' سے بخوبی عیاں ہے۔ جہاں ان کے والد گرامی بازوؤں پر سیاں پٹیاں باندھ کر جشن آزادی منائے ہیں۔ جس میں پاک فوج اور آئی ایس آئی کو طالبان ہمدرد دو مددگار فوج ثابت کیا گیا اور اظہار افسوس کیا گیا اس بات پر کہ ضیاء الحق نے عورت کو نیکر پہن کر کھیلوں میں حصہ لینے کی اجازت نہ دی۔ پاکستان کو ایسی ریاست قرار دیا کہ جہاں عورت نہ سانس لے سکتی ہے نہ گھر سے نکل کر تعلیم و ملازمت کا حصول ممکن بنا سکتی ہے۔

''میں مستقبل میں وزیر اعظم بننا چاہتی ہوں'' اقوام متحدہ کی جنرل اسمبلی سے کیے گئے خطاب میں ملالہ کے یہ الفاظ بہت سوں کے لیے تشویش کا باعث بنے تھے۔ بیشتر دانشوران نے صفحات کے صفحات کالے کردیے اس ضمن میں مشورے دیے گئے کہ ملالہ وزیر اعظم بننے کے ارادوں کو چھوڑ دے اور اپنے عظیم مقصد یعنی تعلیم کے فروغ کے لیے جدوجہد جاری رکھے۔ لیکن جس طریقے سے اس کی ''ذہن سازی'' کی جارہی ہے اس کی خیالات وافکار کو جس طرح سے ''بانکپن'' عطا کیا جارہا ہے۔ اور نظریات جس ''سانچے'' میں ڈھال کر ''پروان'' چڑھائے جارہے ہیں واضح طور پر سمجھا جاسکتا ہے کہ آنے والے وقتوں میں ہمارے لیے کیے گئے منصوبے فیصلے اور لائحہ عمل تشکیل کے مراحل میں ہیں۔ اور ہمارے منصوبہ سازوں و پالیسی سازوں نے اس حوالے سے کتنی مکمل تیاری کر رکھی ہے۔ تبھی جہاں ''گل مکئی'' کے پیچھے بی بی سی کے رپوٹر کا نام تھا اب ''آئی ایم ملالہ'' کی پہنچ برطانوی صحافی کرسٹینا لیمب تک دراز ہوگئی۔

یوں گل مکئی سے لے کر ملالہ پر قاتلانہ حملے اور ''آئی ایم ملالہ'' تک تمام بنے گئے تانے بانے واضح طور پر نمایاں ہوچکے ہیں کہ یہ پیش بند واقعات ایک مخصوص ایجنڈے کی تقویت کا سامان بخوبی فراہم کرتے چلے آرہے ہیں۔

# ''آئی ایم (ناٹ) ملالہ''

صفیہ نسیم

اسّی کی دہائی کے اختتام پر ملعون سلمان رشدی کی اہانت آمیز کتاب "The Satanic Verses" منظر عام پر آئی تو پوری دنیا کے مسلمان سراپا احتجاج بن گئے۔ نہ صرف پاکستان وایران بلکہ عرب دنیا وبنگلہ دیش سمیت بھارت، برطانیہ، جرمنی، امریکا اور سیکنڈے نیویا کے مسلمانوں نے شدید ردعمل کا اظہار کیا۔ آیت اللہ خمینیؒ کے فتوے کی تمام دنیا کے مسلم اسکالرز نے بھرپور حمایت کی۔ بلکہ بعض معتدل مزاج مغربی مصنفین تک نے اس کتاب کے مندرجات کو ناقابل اعتبار و نامناسب قرار دیا۔ واضح رہے پاکستان میں اس کے خلاف احتجاجی مظاہروں کی قیادت نوابزادہ نصر اللہ خان نے کی جو بابائے جمہوریت اور حکمران جماعت پی پی کے حلیف تھے (کوئی ملا نہیں تھے) اور سلسلہ مضامین مولانا کوثر نیازی نے شروع کیا جو ذوالفقار علی بھٹو کے دست راست اور بے نظیر دور میں اسلامی نظریاتی کونسل کے چیئرمین تھے (یعنی روشن خیال ملا) اس حقیقت آمیز پس منظر کو سامنے رکھتے ہوئے پچیس چھبیس برس بعد ایک پاکستانی مصنفہ جو محض سولہ سال کی بچی ہے یعنی جس نے ملعون رشدی کی کتاب کی اشاعت کے کوئی دس برس بعد اس دنیائے فانی میں قدم رنجہ فرمایا ہوگا۔ اس کتاب کو اظہار رائے کی آزادی کی دلیل کے ساتھ قبول کرنے اور اس کی مخالفت کرنے والوں کو سخت گیر و ملا قرار دے کر مسلم معاشرے کے بنیادی عقیدے و ایمان کو چیلنج کرنے کی جسارت کرے، کیا کتاب کا قاری یہ تسلیم کرسکتا ہے کہ یہ خیالات والفاظ سولہ سال کی بچی کا قلم اگل رہا ہے؟ یہی نہیں غیر مسلم اقلیت کا مقدمہ لڑنا (حالانکہ اقلیتیں اگر دنیا کے کسی خطے میں بلاخوف وخطر رہ رہی ہیں تو وہ پاکستان ہی ہے) اور احمدیوں کو غیر مسلم قرار دینے کو ریاست کے ظلم سے تعبیر کرنا اور سب سے بڑھ کر توہین رسالتؐ کے قانون پر وار کرنا۔ ایسے متنازع امور ''آئی ایم ملالہ'' نامی کتاب کا حصہ کیوں بنے؟ عورتوں کی گواہی کا معاملہ، جنرل ضیاء الحق کی اسلامائزیشن کا مذاق پرویز مشرف کی مدح سرائی عاشقان رسولؐ کی مداہنت وغیرہ جیسے ان گنت منتشر خیالات ونظریات کا ملالہ کی اسٹوری، ہسٹری، خدمات و کارکردگی سے کیا تعلق؟ آئی ایم ملالہ'' کو تو ان ہی دائروں میں مقید ہونا چاہئے تھا جو خود اسکی اپنی ذات، اس پر بیتنے والے حالات، اور مستقبل کے عزائم سے متعلق تھے۔ لیکن ظاہر ہے ایسی کتاب کو وہ عالمگیر پذیرائی کہاں ملتی ''جو آئی ایم ملالہ'' کو ملی کہ ملکہ برطانیہ سے لے کر بارک اوباما تک سب نے