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Anxiety in children during a new administration

Since the current administration took office, many children continue to grapple with the initial shock of the election results and the uncertainty of what the next 4 years will bring. In the days after the election, several patients sat in my office and spoke of intense feelings of sadness, anger, and worry. Their stress levels were elevated, and they searched desperately for refuge from the unknown. On the other side of the hospital, patients expressing suicidal ideation filed into the emergency room. A similar scene played out nationally when suicide prevention hotlines experienced a sharp increase in calls.

During this emotional time, it is critical to support our children. Some will be more affected than others. Children from immigrant backgrounds might be particularly fearful of what this means for them and their families. In the days after the election, a video surfaced from a middle school in Michigan featuring kids at lunch chanting, "Build the wall!"

Bullying also is a concern. Despite being a third-generation American, an 8-year-old boy woke up the day after the election confused and scared. One mother told me that a student confronted her 11-year-old son at school, yelling that the election outcome was a "good thing" and he should "go back to his country." Like his mother, the 11-year-old was born in the United States.

Kids get their cues from the adults in their lives. Parents and teachers play an important role in modeling behavior and providing comfort. Adults need to support children and to do that properly they need make sure they have processed their own feelings. They do not need to be unrealistic or overly positive, but should offer hope and trust in our democratic system. With discussion, children should have ample opportunity to express how they feel. Psychiatrists can evaluate a child's symptoms and presentation. Are current medications helping enough with the recent changes? Does a child need a medication adjustment or to be seen more often? Does he (she) need to be admitted to the hospital for evaluation of suicidal ideation? As a psychiatrist, do you need to revisit the list of resources in the community and give children a crisis hotline number? Also consider referring a child to a psychotherapist if needed. Some schools offered counseling after the election. It is worthwhile to contact school officials if a student is struggling or could benefit from additional support.

Although many unknowns remain, 1 thing is certain: children will have more questions and we must be ready to answer.

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Two additional adjunctive therapies for mental health

I was excited to read Dr. Nasrallah's editorial about adjunctive therapies for mental health disorders (Are you neuroprotecting your patients? 10 Adjunctive therapies to consider, Current Psychiatry. December 2016, p. 12-14). I am a psychiatric physician assistant and have incorporated the principles of integrative medicine into my practice over the past year. I was thrilled to see the editorial outline many of the holistic treatments I use with clients.

The article missed 2 important vitamins that play a crucial role in positive mental health treatment outcomes: folic acid and vitamin B_{12}. In my practice, I have found up to 50% of my patients with depression have a vitamin B_{12} deficiency. After supplementation, these patients' symptoms improve to the point that we often can reduce or eliminate medication. Folic acid deficiency has been found among individuals with depression and linked to poor response to treatment.[1] Higher serum levels of homocysteine—

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a consequence of low folic acid levels—are linked to increased risk of developing depression later in life, as well as higher risk of cardiovascular disease.[2,3] Folate also can be used for treatment response to antidepressants by increasing production of neurotransmitters.[2]

Another factor to consider is methylenetetrahydrofolate reductase (MTHFR) variants. Approximately 20% of the population cannot methylate B vitamins because of a variation on the MTHFR gene.[4,5] These patients are at increased risk for depression because they are unable to use B vitamins, which are essential in the synthesis of serotonin and dopamine. These patients do not respond to B_{12} and folate supplements. For these individuals, I recommend methylated products, which can be purchased online.

I have found these practices, as well as many of those listed in the editorial, are effective in treating depression and anxiety.

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References

1. Kaner G, Soylu M, Yüksel N, et al. Evaluation of nutritional status of patients with depression. Biomed Res Int. 2015;2015:521481. doi: 10.1155/2015/521481.
2. Seppälä J, Koponen H, Kautiainen H, et al. Association between vitamin B12 and melancholic depressive symptoms: a Finnish population-based study. BMC Psychiatry. 2013;13:145. doi: 10.1186/1471-244X-13-145.
3. Petridou ET, Kousoulis AA, Michelakos T, et al. Folate and B12 serum levels in association with depression in the aged: a systemic review and meta-analysis. Aging Ment Health. 2016;20(9):965-973.
4. Lynch B. MTHFR mutations and the conditions they cause. MTHFR.Net. http://mthfr.net/mthfr-mutations-and-the-conditions-they-cause/2011/09/07. Accessed February 16, 2017.
5. Eszlari N, Kovacs D, Petschner P, et al. Distinct effects of folate pathway genes MTHFR and MTHFD1L on ruminative response style: a potential risk mechanism for depression. Transl Psychiatry. 2016;6(3):e745. doi: 10.1038/tp.2016.19.

An honest perspective on *Cannabis* in therapy

I enjoyed Dr. Nasrallah's editorial "Maddening therapies: How hallucinogens morphed into novel treatments" (From the Editor, Current Psychiatry. January 2017, p. 19-21). In this world, physicians still regard "street" drugs as issues of morality and criminality rather than a health issue, so it is refreshing when respected physicians take fearless, evidence-based approaches to potential therapeutic use of such drugs. Dr. Nasrallah did not glorify or condemn their effects; he simply described them.

As a psychiatrist specializing in bipolar and psychotic disorders—as well as the founder and Board President of Doctors for Cannabis Regulation—I appreciate his reservations about the potential of *Cannabis* to trigger psychosis in vulnerable individuals. My reading of the literature is there is good evidence for marijuana as a trigger—not as a cause—of the disease. However, what is the evidence for hallucinogens?

Cannabis can have adverse effects on brain development, but it is not clear whether those effects are worse than those caused by alcohol. In the absence of any head-to-head studies, how can we proceed?

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Dr. Nasrallah responds

LSD can cause psychosis, paranoid delusions, and altered thinking in addition to vivid visual hallucinations in some individuals but not all, because vulnerability occurs on a spectrum. I postulate that the recently discovered inverse agonist of the serotonin 5-HT2A receptor, pimavanserin (FDA-approved for visual hallucinations and delusions of Parkinson's disease psychosis), might be effective for LSD psychosis because this hallucinogen has a strong binding affinity to the serotonin 5-HT2A receptors.

Studies show that marijuana can induce apoptosis, which would adversely affect brain development. Patients with schizophrenia who abuse marijuana have a lower gray matter volume than those who do not abuse the drug, and both groups have lower gray matter volume than matched healthy controls. I strongly advise a pregnant woman against smoking marijuana because it could impair the fetus's brain development.

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Self-administering LSD: Solution or abuse

Dr. Nasrallah's editorial (From the Editor, Current Psychiatry. January 2017, p. 19-21) gave an interesting update about the potential therapeutic uses of LSD. However, he did not mention the growing self-prescribed usage of microdoses of LSD, which is said to reduce anxiety and depression with less risk than usual dosages.

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Dr. Nasrallah responds

I am not aware of any systematic data about self-prescribed use of microdoses of LSD to reduce anxiety and depression. Among

persons with anxiety and depression who have not had access to psychiatric care, self-medicating with agents such as alcohol, stimulants, ketamine, or LSD is regarded as substance abuse. It also is questionable whether people can determine which microdose of LSD to use. Finally, most drugs of abuse are not "pure," and many are laced with potentially harmful contaminants.

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Why medical psychiatry is vital for my patients

Dr. Paul Summergrad's guest editorial "Medical psychiatry: The skill of integrating medical and psychiatric care" (Current Psychiatry. February 2017, p. 11-13) was enormously helpful and validating for those of us who treat the full array of biomedical causes of psychiatric symptoms. My specialty is treating persons with intellectual and developmental disabilities who do not communicate through speech, display serious symptoms such as severe aggression toward themselves or others, or have life-threatening failure to thrive. For my patients, the key is to accurately diagnose and treat the vast array of co-occurring biomedical conditions. This requires me to perform physical examinations that my colleagues have skipped in the 5-minute primary care visits they are allowed, make a lot of home visits, and order more blood tests and imaging studies than my fellow psychiatrists in other specialties do. Only in these ways, I am able to offer effective treatment options that improve the quality of life of these suffering individuals. I suspect there are many more psychiatrists who work the same way.

For me, the most inspiring sentence in Dr. Summergrad's editorial was, "It is incumbent on us to pursue the medical differential of patients when we think it is needed, even if other physicians disagree." I believe this describes our job as physicians who specialize in psychiatry. To see a clinician of Dr. Summergrad's stature write this was inspiring because it goes to the core of what more of us should do.

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