

AJP Audio – Ross, Barone, Eisenlohr-Moul – January 2023

Aaron van Dorn:

Welcome to AJP Audio for January 2024. I'm Aaron van Dorn. In this episode of the podcast, I spoke with three authors from a paper in this month's issue of the American Journal of Psychiatry looking at the impact of the menstrual cycle on rates of suicidal ideation and planning among female psychiatric patients who menstruate. I'll let them introduce themselves in a moment. Following that interview, we'll once again hear from AJP editor-in-chief Dr. Ned Kalin about the rest of the January issue. I hope you'll enjoy it. But first up, let's introduce our featured authors.

Dr. Jaclyn M. Ross:

I'm Jackie Ross, a clinical research scientist at University of Illinois at Chicago.

Ms. Jordan C. Barone:

I'm Jordan Barone. I am a MD PhD candidate at the University of Illinois at Chicago.

Dr. Tory A. Eisenlohr-Moul:

And I'm Tory Eisenlohr-Moul. I am an associate professor of psychiatry at the University of Illinois at Chicago Department of Psychiatry.

Aaron van Dorn:

Dr. Ross, suicide is a leading cause of death in the US and assigned at birth females are three times more likely to report suicidal ideation, planning and suicide attempt than assigned at birth males. Your study looked at the day-to-day impact of menstrual cycle on changes in suicide related symptoms. What can you tell us about what you found?

Dr. Jaclyn M. Ross:

So first, we looked at the relationship between daily changes in specific psychiatric symptoms, that symptoms like feelings of depressed mood, anxiety, hopelessness, anger, and similar symptoms of the like, along with daily changes in suicide related symptoms. So a current challenge in the field of suicide prevention is that we do not have a strong understanding of which factors predict acute suicide risk. So while prior work has made strides in understanding which lifetime or trait level characterological risk factors may make individuals more vulnerable to suicidal ideation, much less is known about what day-to-day symptoms lead to escalation in acute risk for suicide. And by that, I mean we don't have a strong understanding of which factors lead to increases in the intensity of suicidal ideation on a given day, nor do we understand which factors lead to the conversion from suicidal ideation to more specific suicidal planning.

So our first goal was just to explore these questions in a large trans diagnostic sample of female outpatients who are already prone to suicidal ideation. And what we found is that most of our psychiatric symptoms did co-vary with suicidal ideation on the daily level. So increases in any of these symptoms on a given day, co-varied with increases in suicidal ideation on that same day. And for suicidal planning, so that's that more concrete specific form of suicidal ideation, thinking about when and how you might kill yourself, there, we found that a number of depressive symptoms co-varied with suicidal planning at the daily level. So that was depression, hopelessness, rejection sensitivity, being sensitive to rejection or hurt feelings. And perceived burdensomeness, feeling like a burden to the people around you. This gave us information about how suicidal ideation and suicidal planning change day-to-day. And

the big takeaway here was just that these experiences, they're not constant, they're not uniform day-to-day.

They do fluctuate within a given person. And they fluctuate in concurrence with these increases in other affective psychiatric symptoms. So that was the first just descriptive piece of the study. Next, we wanted to characterize how all of these symptoms change across the menstrual cycle, in service of answering this really critical clinical question of when and why suicide risk fluctuates with inpatients who are already broadly at risk for suicide. And the menstrual cycle is this predictable, recurrent and measurable factor that we can actually leverage in service of better predicting acute suicide risk. And a huge strength of our work here is that we used a urine hormone test to confirm ovulation, which means we're actually quite confident in the specific hormonal profiles that we're comparing between participants. So what we found here is that most symptoms did show a perimenstrual exacerbation pattern. So they tended to be lowest during the early luteal phase and really peaked during the perimenstrual phase.

We also found really large random effects throughout, which means we saw just really significant individual differences in these effects. So yes, on average, people experience this perimenstrual peak of symptoms, but it's so different from person to person. The strength of that effect is different, even the direction of that effect. There's so much individual variability here. But overall we found that suicidal ideation and suicidal planning were most severe in the perimenstrual phase with these notable random effects. And then finally, and probably the most unique part of our study, is that we were able to test mediation or which symptoms actually account for these perimenstrual changes in suicidal ideation and planning. And here, we found that it was the depressive symptoms. So depression, perceived burdensomeness, hopelessness, anhedonia or loss of interest. These were the symptoms that mediated that perimenstrual worsening of suicidal ideation. And meanwhile, we found that it was really just depression that mediated that perimenstrual worsening of suicidal planning. So in other words, we can say that it was really these changes in depressive symptoms that specifically play a role in the cyclical worsening of suicidality.

Aaron van Dorn:

Your study looked at previously established between person and within person associations between psychiatric systems and suicidality. Can you explain the distinction between these two categories?

Ms. Jordan C. Barone:

Yeah, I'm happy to answer that. So I think Jackie did a great job touching on that as she was describing our findings, but I can just pull out a little bit more of what that means. So a lot of the research in this realm so far has been between person, meaning identifying for example, what trait level risk factors someone has that makes them overall over their lifetime more likely to either experience suicidal ideation or even make a suicide attempt. So for example, that could be something like a person with a higher lifetime history of depressive symptoms, is probably more likely to have suicidal thoughts over their lifetime than someone who doesn't have those symptoms. But what we're really interested in is those within person changes. So a within person change would be not just what makes somebody more or less likely to have suicidal thoughts than someone else, but what makes one person more or less likely to have those thoughts today or tomorrow or next week, than they were on a prior day.

So really getting at the question that Jackie mentioned of we don't know why or when people who are already prone to suicidal thoughts, are at risk of those worsening or those turning into actions. So for us, we look at the menstrual cycle as a within person factor. So we're very interested in understanding for someone experiencing suicidal thoughts, who has a natural menstrual cycle, are they more or less likely at certain points in their menstrual cycle to experience worsening in their suicidal symptoms?

And can we then use the menstrual cycle as a time varying factor that could someday help us predict for individual patients, when they might be more at risk of their own symptoms worsening? So the way that we look at this statistically for us is that you'll hear us mention or you'll see in the paper that our models test for something called fixed effects or the overall effects. Basically saying on average, we know that we found that the symptom of maybe depression, increases surrounding menses compared to the early luteal phase. But then we look at the random effects or the individual differences, which really let us look at those within person trajectories and how they differ from person to person. To say that when we look at the raw data, one person might be most sensitive to symptom exacerbation in a mid luteal phase, while the other person might not have symptom exacerbation until after their menses has started. And those types of differences are really where we're looking at with within person associations.

Aaron van Dorn:

The idea of hormonal changes and the impacts from the menstrual cycle on women has often been used as a joke or a hacking cliché, and has unfortunate cultural baggage rooted in misogyny and not taking women's experiences seriously. Did that background cultural setting influence your thoughts on the design of your study and in your decision to investigate this phenomenon?

Dr. Tory A. Eisenlohr-Moul:

Yeah. So as a researcher working in this field for over 10 years now, I can say that when I bring up the menstrual cycle and mental health to the average person, I usually get a pretty extreme response in one direction or the other. I get either someone saying, "PMS is made up. This is a cultural ...", as you said, "Cultural misogynistic, cliché. Why do we treat women as though they're crazy because they have hormone fluctuations? This is made up by the patriarchy." So that's one kind of response that I get, is people are like, "This is made up and it hurts people assigned female at birth, it hurts women." The other response that I'll get is someone saying, "Why don't the doctors take PMS seriously? It can be so severe and so awful. And my mom had severe PMS, my sister had severe PMS." People will say things like that to me and say, and they couldn't get help from their doctors.

Their doctors didn't listen to them when they told them, that this was really severe and affecting their lives and we need more research on women's mental health and we need to solve this problem. So you can see that depending on the experiences somebody has had in their lives, depending on maybe their own experience or the experiences of people who are genetically related to them, because that's where we usually talk about this kind of thing, it's a stigmatized thing ... So we only talk about it within our families, usually. Depending on that, people have extremely different views on it. And so as a girl, I felt that PMS was made up and this misogynistic thing. And then as I grew and learned about the experiences of other people, I found that for other people, it was very real and it was really disabling and upsetting and even destroying their lives in some cases.

So as a scientist in this area, I really try to hold both of those truths at the same time and say most people assigned female at birth, most people who menstruate, do not have significant changes in their emotions, in their thoughts, in their behaviors across the menstrual cycle. They function just fine on any day of the cycle and maybe even better than some of the men around. And we don't need to worry about it for the vast majority of women.

However, there is a subset of women or people assigned female at birth that really have extreme changes in their symptoms across reproductive transitions, whether that's the menstrual cycle or pregnancy or menopause or even puberty. And for those people, we need to take it very seriously, especially because we've been finding consistently now across several studies that having these

hormone sensitive changes in your mood across the menstrual cycle is really associated with suicidality. So it's a really serious thing that we need to take seriously when someone says that they have these changes, because we know that they can actually be dangerous. But at the same time, we need to approach our interactions with women and other people who menstruate in the world, not assuming that they have this disorder in relation to their hormones.

Aaron van Dorn:

It's been reported that women are more likely to die in car crashes, perhaps in part because some of the safety features that cars themselves have been designed with were designed with an average man in mind. Form of unconscious bias with a deadly edge. Is the same true for suicide interventions and other treatments for suicidal ideation?

Dr. Tory A. Eisenlohr-Moul:

That's an interesting question. There are complicated sex differences in suicidal thoughts and behavior. So men are actually more likely to die by suicide. And the prevailing understanding of this at the moment is that men are really socially trained to use dangerous objects like guns, and they're socially brought up to normalize violent behaviors in some contexts. And so men really learn how to use lethal means in a way that then increases their risk of death. Because instead of using, say, poisoning or something that's a less reliable way of killing oneself, they use guns, which are much more deadly. So men are more likely to die. And the prevailing wisdom is because they use these more lethal, dangerous means, than women. However, women make about three times as many suicide attempts as men, and they have about three times the suicidal thoughts. So in terms of the amount of suffering across one's lifespan, due to thoughts about death, planning suicide attempts, making suicide attempts that maybe don't result in death but do result in damage to the body or the brain, women suffer more in that regard.

So it's an interesting paradox and I think that the answer is that we need to address suicidal thoughts and behaviors across the spectrum of severity and across the spectrum of lethality. We need common sense gun control, absolutely, to prevent mostly suicide deaths but also other deaths. And then we need treatments for chronic suicidal ideation and behavior that will be applicable to both men and women. So we need treatments that address both the more stereotypically or typically male and the more stereotypically or typically female ways that suicidality looks.

Aaron van Dorn:

What were the limitations of your study?

Ms. Jordan C. Barone:

There's two limitations I'd like to highlight, one in terms of interpretation of our studies. So the first is our sample, which for a lot of reasons is a strength. We recruited participants who had natural menstrual cycles and reported past month suicidality, and we did not limit what that meant for if they had a depressive disorder or a minor substance use disorder, anxiety disorders. We allowed all of that in our study. That is a limitation for interpretation though, because what we didn't recruit for was anyone with specific measurable, what we call hormone sensitivity, someone with severe PMS or premenstrual dysphoric disorder.

So we do think that we got a lot of real world comorbidity and a lot of understanding about how suicidality is a trans diagnostic phenomenon. It doesn't only occur in psychiatric diagnosis and not another. But this does mean that we definitely need future work to see if these menstrual cycle related

patterns, where we saw perimenstrual worsening and we saw that the early luteal phase was usually the lowest, if those translate to the same effect size and to the same time trajectories and with the same amount of individual difference in people with those menstrual cycle mood disorders like PMDD. Or if the relationships are a little bit different, maybe a little less individual variability, maybe more that we are not thinking of, in those other populations.

The second limitation I do want to highlight is everything we talked about when Jackie was going over our findings was about same day fluctuation. So for example, did today's hopelessness fluctuate alongside with today's suicidal thoughts? But what we're really curious about is if any of these symptoms predict later suicidality. So maybe does today's hopelessness actually predict even stronger tomorrow's suicidality? And then way down the line, could interventions help with, oh, if someone's feeling a certain symptom for them at a certain time, when can we predict that some of these more risky life-threatening symptoms will pop up? So we would love it if future studies could maybe include either more frequent assessments. Maybe that means couple times a day asking people about their symptoms, not just once a day. Or including in their modeling strategies ways to look at time lags or different spacing between the symptoms you're interested in and the outcome as well.

Aaron van Dorn:

Are there immediate clinical implications for your findings?

Dr. Jaclyn M. Ross:

Yes, absolutely. And there's a nice bridge here because I think through all of the work we were doing in the research context, I felt particularly inspired to translate some of these cutting edge findings to the treatment of specifically for premenstrual disorders. So I actually opened a private practice called the Chicago Premenstrual Disorders Clinic here in Chicago, but we do serve people around the country. And the two things from this particular study that I think about the most in my clinical work there is first about the importance of psychoeducation on the menstrual cycle and its evidence-based treatments. Some people just might not realize the potent impact that the menstrual cycle can have on the daily fluctuations in their emotional symptoms and in their suicide risk. So giving them just that knowledge and making them aware of some of these pretty straightforward, easy to access evidence-based treatments for menstrual cycle related difficulties, is really important.

Another big piece here is emphasizing for people the importance of daily ratings, both in terms of assessment and intervention. So if people can complete daily ratings of their symptoms, we can start to detect these patterns for an individual and start to understand those critical high risk phases for them and intervene accordingly. Deliver the skills based intervention that is going to be most useful given that fluctuation of a certain symptom on a certain day.

And that paves the way for I think the importance of this individualized approach. The fact that we saw these really significant random effects, so this really significant individual variability in all of our findings pretty much across this study, highlights that clinical work really does require an individualized approach that focuses on when an individual is most vulnerable in the cycle and which symptoms are most closely linked with suicidal ideation and suicidal planning for them, because it might be a little different for each person. So if we can understand that when and which, that when in the cycle and which symptoms, then we can really introduce skills that target the specific processes that elevated suicidality for that individual during this critical high risk phase for them.

Aaron van Dorn:

Ms. Barone touched on this a little bit earlier, but what's next for your research?

AJP Audio – Ross, Barone, Eisenlohr-Moul – January 2023

Dr. Jaclyn M. Ross:

I can speak a little bit to the clinical work that I think is coming next. So first, I think when we're thinking about how to continue to translate this for clinical questions about intervention, I think what we're realizing is that we need a stronger behavioral intervention that can really target suicide risk in this population. The work we're discussing here suggests that the menstrual cycle can modulate suicide risk, which of course has implications for individuals with premenstrual disorders, so PMDD and premenstrual exacerbation of underlying disorder.

So I'm really thinking about those populations as I consider what comes next in terms of clinical intervention research, and it tells me that we need a behavioral intervention that works. So given the elevated suicide risk in this population, it seems like dialectical behavioral therapy interventions, which were originally designed for chronically suicidal individuals, are likely very well suited to meet the needs of these individuals. So I know a future direction here is we really want to test dialectical behavioral therapy, DBT, and an adaptation of this treatment package for premenstrual disorders with specific consideration for how to insert specific DBT skills across the cycle to pin it, to mitigate suicide risk. And just emotional affective ability across the cycle.

Ms. Jordan C. Barone:

And then I can add to another future direction, unless you wanted to take it, Tory?

Dr. Tory A. Eisenlohr-Moul:

No, go ahead. I'll go after you.

Ms. Jordan C. Barone:

I was just going to mention that our lab, so Tori's lab, does where our day-to-day projects are really focused on randomized clinical trials for hormonal interventions, so that we can start to understand ... Jackie talked about when, she talked about which symptoms. And I think another huge piece of future research is why. So if we can start to unravel the mechanisms that are biologically potentially causing or leading to these psychiatric symptom changes, I know that's an area of research a lot of us are extremely interested in.

Dr. Tory A. Eisenlohr-Moul:

Yeah, my laboratory focuses on both behavioral and biological mediators of these effects, so that we can understand which people might benefit from an SSRI for suicide prevention across the cycle, for example, who might benefit from learning skills to tolerate intense negative emotions or advocate for their needs, who might actually need something more significant like a chemical menopause treatment or GnRHa, a mechanism. So I think we are interested in all these individual differences and how they eventually will inform which treatments people need, and how we can most efficiently provide those interventions.

Aaron van Dorn:

Well, Dr. Ross, Ms. Barone, Dr. Eisenlohr-Moul, thank you for taking the time to join us today.

Dr. Tory A. Eisenlohr-Moul:

Thank you.

AJP Audio – Ross, Barone, Eisenlohr-Moul – January 2023

Dr. Jaclyn M. Ross:

Thank you.

Ms. Jordan C. Barone:

Thank you so much for having us.

Aaron van Dorn:

Up next, Dr. Ned Kalin. Dr. Kalin, welcome to the first AJP Audio for 2024.

Dr. Ned H. Kalin:

Thank you, Aaron. It's a pleasure to be here.

Aaron van Dorn:

Earlier in this episode, I spoke with Dr. Ross, Ms. Barone and Dr. Eisenlohr-Moul about their study of looking at the effects of the menstrual cycle on suicidal ideation and planning in psychiatric patients. What else can you tell us about it?

Dr. Ned H. Kalin:

Aaron, this is an interesting study and reveals a linkage between an increase in psychiatric symptoms with women's menstrual cycles, and also links this to suicidal thinking and suicidal planning. Now, it's probably not a surprise to all of us that women are sensitive to changes in their hormonal status during the different phases of their menstrual cycle. What this study really pins down is that it's the perimenstrual phase that seems to be critical as a period across all women in which there is an increase in psychiatric symptoms, and also suicidal thinking and planning. This study was done in 119 women of reproductive age, all of which had psychiatric illnesses, but this was done across various diagnoses. So findings were not diagnosis specific, suggesting that this relation between menstrual phase, increase in psychiatric symptoms and suicidal ideation and planning, is independent of diagnosis in women.

And it's a well done study. Lots of measures were taken throughout the menstrual cycle in women to ensure that the investigators were accurate in knowing where the women were in their menstrual cycles. And one of the outcomes of this study was that it appeared that an increase in depressive symptoms that was associated with the menstrual cycle, especially the perimenstrual period, was what was mediating the increase in suicidal ideation and planning. When you think about it, that's not particularly surprising. But this is important further information that is beginning to get more specific about pinning down where and when during the menstrual cycle, women may be more vulnerable if they already have psychiatric problems and if they have a tendency to have some suicidal ideation or thinking.

Aaron van Dorn:

Next, we have a paper by Najar and colleagues, looking at the trends in body mass index between people with bipolar disorder in the general population.

Dr. Ned H. Kalin:

We have two papers in this issue that are related to body weight and increases in body weight in psychiatric patients. This is a research paper that we have. We also have a really nice review by Roger McIntyre and colleagues from the University of Toronto, that provides an overview in psychotropic drug

related weight gain and its treatment. In that review, and I would encourage our readers to take a close look at this because it's got a lot of practical information, clinically in that review, the authors go over the incidents of psychotropic drug related weight gain, how common it is, some of the current treatments that may be useful, which drugs are more associated with weight gain. And then finally, getting into the possibility of new medications for looking at treating drug induced weight gain, including some of the newer drugs such as the GLP-1 agonists and also the GLP-1 glucose dependent insulinotropic polypeptide co-agonists, as ways to mitigate some of this weight gain that can be so critical for patients.

In the research paper that you alluded to, and that is in the journal, this specifically looks at bipolar patients. It's valuable because it's done in an extremely large sample. It's data that was collected over about a 10-year period and included over 22,000 individuals with bipolar disorder. And they were compared to roughly 70,000 individuals that did not have bipolar disorder that were comparison individuals. These data are from the Swedish National Registry for Bipolar Disorder and also from another cohort in Sweden. Again, not surprisingly because we know this clinically in general, men and women with bipolar disorder had higher body mass index measures and more obesity than what was observed in comparison to general population. Women with bipolar disorder had the highest levels of obesity. When looking at one year, for example, in this case, in the year 2013, they did a comparison of what was the 50th percentile body mass index for men with and without bipolar disorder, and what was the 50th percentile BMI for women with bipolar disorder as compared to women that did not have bipolar disorder.

And there again, you see an increase in one to approximately two and a half points, 2.3 points greater for men with bipolar disorder in the 50th percentile. And then when you look at the 85th percentile of BMI, it's 2.3 points greater for men. In women in the 85th percentile, it's actually 4.1 points greater for women with bipolar disorder than those that don't. So showing that this illness, Bipolar 1 and Bipolar 2 disorder, are associated with increased weight gain in men and women, that it's significant, it's reflected in BMIs. And also they found a trend over time that this tended to even increase further in individuals with bipolar disorder.

Aaron van Dorn:

Following that, Ishtiak-Ahmed and colleagues have a paper looking at the clinical outcomes of commonly used antidepressants on older adults in Denmark. What did they find?

Dr. Ned H. Kalin:

So this is a study that is clinically relevant to treating patients who are older who have depression. We have another paper in the journal using TMS, which I'll come to in a minute for geriatric depression. In this particular paper that's focused on antidepressants, this also was done in a very large sample, over 93,000 individuals that were diagnosed with depression and that were 78 years or older. They're on average 78 years of age, I should say. This is from the Danish registry. And patients here were observed. It was a registry that looked at depressed patients over about a 10-year period. What they found was that ... And the questions that they asked really were focused on the first year of treatment. What were the side effects? What was the likelihood of stay on medication? What was the likelihood of being switched or discontinued from the medication that individuals were started on, from the standpoint of antidepressant treatment?

What they found was that over this first year of treatment for an individual, that roughly 44% of individuals stopped treatment. They also found that roughly 5% of individuals switched to another antidepressant during that time. And roughly 20% of the sample received another antidepressant as an

augmentation strategy. Now, it's important to keep in mind that these are patients that were treated in Denmark, and there are certain guidelines there for treatment. And so this may or may not be generalizable to patients in other countries or in the US. But nonetheless, it's still helpful information. Amitriptyline was the antidepressant that had the highest discontinuation rate of all the antidepressants that were used, and the most switching was seen when venlafaxine, duloxetine, or amitriptyline or mianserin, a drug that is currently not used in the US for depression, were started. Sertraline was the most started drug, drug that was most likely to be started.

This isn't surprising because the guidelines in Denmark suggest that SSRIs, especially sertraline, should be the drug of choice. So this gives us some insight into what happens during the first year of treatment and patients who are older. In this case, on average 78 years of age. It's useful, but it also should be, I think, taken with a grain of salt in relation to how generalizable this is. We have a really nice editorial that accompanies this paper by Dr. Art Walaszek from the University of Wisconsin. He discusses the findings of the paper, but also again, from a clinical standpoint, provides a general overview of treatment of depression in the elderly, which I would encourage our readers to take a close look at, again, from the standpoint of clinical practice.

Aaron van Dorn:

The January issue also contains two priority data letters looking at theta birth stimulation in the treatment of depression.

Dr. Ned H. Kalin:

So the first one is really germane to the treatment of depression in the elderly. And this is a small study. It's basically taking a look at 14 depressed patients who were 60 years of age or older that were treated in other earlier protocols, and then culling the data from those patients out and doing a post hoc analysis on those patients. Now, what's interesting about this is that these patients were treated with the theta-burst accelerated protocol for TMS. We've talked about theta-burst before and published some papers in the journal related to this. But just to review for folks, theta-burst stimulation is a type of TMS that uses a frequency that attempts to mimic naturally occurring electrical frequency of waves in the brain. And particularly, these frequency of waves occurs in the hippocampus and in cortical regions, is thought to be related to enhancing neuroplasticity.

So the frequency of stimulation, with intermittent theta-burst, is trying to mimic this more naturalistic theta wave that is associated with neuroplasticity. Evidence has demonstrated that theta burst is as effective as regular TMS and the FDA has approved theta-burst treatment for depression. What's important to keep in mind is that in one of the non-inferior trials that was used for FDA approval, it was demonstrated that you only needed three minutes per day of theta-burst compared to 37 and a half minutes per day of typical or standard TMS, to be effective when administered over a four to six-week period. Now, what's different about what was used here and what has been found is that you can also give theta-burst in a very accelerated protocol, giving lots of stimulations within a day over a five-day period. And that's called accelerated theta-burst protocol. And that was what was used in the 14 patients from which the data was analyzed that were 60 years of age or older in this particular paper.

And the findings were quite dramatic. These patients had dramatic responses from the standpoint of the reduction of their rating scales for depression. In this case, the Montgomery and Asberg depression rating scale was used. In a separate letter actually by the same group, not related per se, to geriatric depression, the investigators looked at whether or not re-treatment with accelerated theta-burst would be effective in patients that were initially treated with that protocol but then relapsed.

AJP Audio – Ross, Barone, Eisenlohr-Moul – January 2023

And what the investigators found was that they found 27 patients from their studies that relapsed and were treated on average roughly 26 days later, with a second accelerated theta-burst paradigm. And what they found was of the 22 patients that initially were remitted when they were treated, 20 of those individuals also remitted from their depressive symptoms when re-treated. So both of these papers support the use of the accelerated theta-burst protocol. And for further detail about this, would refer the readers to earlier papers in our journal that talk about this. But this looks like a very promising treatment. And what's exciting about this is that not only does it appear to work in older individuals with depression. But also it's a rapid effect, which obviously is something that we are excited about, from the standpoint of our clinical approaches to treating depression.

Aaron van Dorn:

Finally, the January issue contains a letters' column with a number of responses to Goodwin and colleagues commentary that's also in the issue, looking at the role of psychotherapy and the psilocybin trials. What can you tell us about that?

Dr. Ned H. Kalin:

Yeah, so this is again, I think worthy of taking a look at in detail. Goodwin and colleagues, and in this case, Dr. Nemeroff, write a commentary where they challenge the concept of psychotherapy being used with psychedelic treatments. In particular, they focus on psilocybin treatments and ask the question of whether or not the type of interaction that is associated with that treatment, by individuals supporting patients going through this, is truly psychotherapy. And they argue that this is not truly psychotherapy, that this is support that is given to patients and should not be called psychedelic assisted psychotherapy. Now, this raises a number of issues about how you think about psychotherapy being combined with psychedelic types of treatments, and whether or not they're necessary and how they should be used. And this stimulated a lot of interest from our readers. As you pointed out, we received a number of letters to the editor, and Goodwin and MRO do a really nice job of responding to those letters, which is quite interesting and informative.

Aaron van Dorn:

Dr. Kalin, thank you once again for joining us.

Dr. Ned H. Kalin:

Thank you, Aaron.

Aaron van Dorn:

That's all for the first AJP Audio of 2024. I hope you'll join us again next month when we'll continue to look at the highest quality psychiatric research available. Until then.

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