We regret the inadvertent ambiguity, but we had not suggested that the measurement of interpersonal difficulties was developed or marketed by Weissman or the other developers of interpersonal therapy. Clearly Weissman has not profited financially. We merely stated that instruments that assess processes putatively targeted by a particular intervention are “often created by the intervention developers” and “usually marketed by for-profit entities.” The second part fully applies to the Inventory of Interpersonal Problems, a widely used measure of “a person’s most salient interpersonal difficulties,” often used in trials of interpersonal therapy as a measure of mechanisms of change. All elements of the Inventory of Interpersonal Problems, including the manual, individual reports, or multiple applications necessary for research, are commercialized by a for-profit corporation, Mind Garden. Consequently, as other similar instruments measuring components or processes of psychosocial interventions, it entails both a cost and a corresponding payoff. It is likely that anyone standing to gain financially from its sale would have an additional incentive to implement it in research or encourage its use. Our intention was not to single out interpersonal therapy, but to emphasize that psychosocial interventions in general are not immune to potential financial COIs, and that, owing to the complexity of the interventions, there is an often ignored assortment of potential sources of associated financial gain. Hence, we attempted to provide a taxonomy of COIs relevant to psychosocial interventions and advocated for their transparent reporting, as with other treatments in medicine.

Weissman makes a further point that compensation for training activities, at least for interpersonal therapy, is often minimal or generously donated to a professional society. Although this is certainly commendable, we think that compensation should be transparently disclosed. For instance, research on the Open Payments database appears to suggest that while the amount of financial compensation received by physicians does matter, even small payments can have a biasing effect. As we emphasized, disclosure should not be seen as a weakness of the investigator, and researchers with comprehensive disclosures might even be more unbiased than those with none.

Psychosocial researchers have long agonized over intellectual COIs, such as researcher allegiance, the potential bias stemming from investigators believing in the superiority of one treatment over another. Our Viewpoint aimed to highlight that there is a larger unknown with regards to financial COIs. Although there is nothing intrinsically wrong with an industry being lucrative, as psychotherapy and psychosocial interventions clearly are, we would argue that when money changes hands and decisions related to treatment and care are involved, transparency is needed.

Letters

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CORRECTION

Errors in Statistical Test Results, Figure 2, and eFigure 3: In the Original Article titled “Addiction Potential of Cigarettes With Reduced Nicotine Content in Populations With Psychiatric Disorders and Other Vulnerabilities to Tobacco Addiction,” published October 1, 2017, there was an error in calculating the overall demand curve measure in the cigarette purchase task and test statistics corresponding to that measure. The second and third sentences in the Simulation subsection of the Results section should have read as follows: “The estimated rate of smoking decreased as a function of decreasing nicotine dose (F(2,16) = 3.04; P < .002). No population differences were found except at the 2.4-mg/g nicotine dose (F(2,16) = 8.80; P < .001), at which smoking rate was greater among those with opioid dependence than among smokers with affective disorders (F(1, 16) = 15.62; P < .001) and disadvantaged women (F(1, 16) = 38.97; P < .001) (eFigure 3A in the Supplement).” The plots in panel A of Figure 2 depicting the effect of nicotine dose on overall demand and panel A of eFigure 3 depicting population differences in the effect of the 2.4-mg/g nicotine dose on overall demand were incorrect. The fourth sentence of the figure caption accompanying eFigure 3 should have read as follows: “Overall demand among those with opioid dependence was significantly more inelastic (greater persistence in demand) than among disadvantaged women (F(1, 16) = 38.97; P < .001) or those with affective disorders (F(1, 16) = 15.62, P < .001)” This article was corrected online.


Error in Table 2: In the Original Investigation by Grisanzio et al titled “Transdiagnostic Symptom Clusters and Associations With Brain, Behavior, and Daily Function in Mood, Anxiety, and Trauma Disorders,” published online December 3, 2017, in JAMA Psychiatry, 2 numbers in Table 1 were incorrect. In the row labeled “Anhedonia” and the column labeled “Tension,” the number −0.047 should have been −0.471; in the column labeled “Depression,” the number −0.304 should have been −0.304. Both numbers have been corrected.


Error in Figure: In the Special Communication titled “The Development of Kraepelin’s Mature Diagnostic Concepts of Paranoia (Die Verrückheit) and Paranoide Dementia Praecox (Dementia Paranoica): A Close Reading of His Textbooks From 1887 to 1899,” published September 19, 2018, there were errors in the Figure. The arrow connecting the Persecutory form Fourth edition box labeled “Referential subform” to the Grandiose form Fifth edition box labeled “Fantastical form” should instead have connected “Referential subform” to the Persecutory form Fifth edition box labeled “Referential form.” In addition, the arrow connecting the Persecutory form Fourth edition box labeled “Fantastical subform” to the Persecutory form Fifth edition box labeled “Referential subform” to the Grandiose form Fifth edition box labeled “Fantastical form.” The Figure has been corrected.

1. Kendler KS. The development of Kraepelin’s mature diagnostic concepts of paranoia (die Verrückheit) and paranoid dementia praecox (Dementia Paranoica): a close reading of his textbooks from 1887 to 1899 [published online September 19, 2018]. JAMA Psychiatry. doi:10.1001/jamapsychiatry.2018.2377

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