Volume XXXVI
Number 19
October 5, 2001

Newspaper of the
American
Psychiatric
Association

PSYCHIATRIC NEWS

Community news

"See" references can be found on pages 8, 16, 24, 25, 31, 32

Psychiatrists Rush to Aid of World Trade Center Victims

This is the first in a series of articles on psychiatrists who provided professional help to people affected by the attacks on the World Trade Center and the Pentagon last month. Additional news stories related to the terrorist attacks appear on pages 12, 16, 17, and 24.

BY CHRISTINE LEHMANN

Tuesday, September 11, began like any other day in Manhattan for psychiatrists at St. Vincent's Hospital. But within minutes, everything changed.

8:48 a.m.: The first hijacked American Airlines passenger jet crashes into the north tower of the World Trade Center.

8:50 a.m.: St. Vincent's Hospital in lower Manhattan, which operates the trauma center closest to the World Trade Center, is notified of the crash and immediately mobilizes.

8:55 a.m.: Brian Ladds, M.D., walks outside the hospital to look at the World Trade Center buildings to decide whether he should reschedule his 9 a.m. appointment with a patient. Ladds is director of the psychiatric residency training program at St. Vincent's Hospital.

"What I saw was a massive, disastrous fire consuming the upper floors of the north tower. I was stunned because we thought it was a small fire. A few minutes later—9:03 a.m.—I saw the second plane pass overhead and crash into the south tower, which then burst into flames," Ladds told *Psychiatric News*. "I rescheduled my patient."

9: 10 a.m.: St. Vincent's staff anticipates receiving thousands of victims given the estimated 15,000 people working in the two towers. CNN estimated that 50,000 people worked in all seven buildings that make up the World Trade Center.

Photo: AP Worldwide/Jim Collins

The south tower of the World Trade Center in New York City collapses as the north tower continues to burn on Tuesday, September 11.

Physicians, residents, medical students, and other health professionals line the hallway from the emergency room to the cafeteria/lounge area to help, said Ladds, who

continued on page 13

Professional news

Minorities Face Inadequate MH Care, Unequal Access, Satcher Says

"Our work has not been in vain," proclaims a prominent APA member in response to U.S. Surgeon General David Satcher's new report on mental health, culture, race, and ethnicity.

BY KATE MULLIGAN

"Culture counts." That was the succinct message U.S. Surgeon General David Satcher, M.D., delivered to a standing-room-only crowd of APA members and staff at APA's fall component meetings in Washington, D.C., on September 8.

That simple phrase is at the heart of "Mental Health: Culture, Race, and Ethnicity," a report the surgeon general issued August 26 that documents the glaring disparity in access, quality, and availability of mental health services faced by Americans who are members of racial and ethnic minority groups.

Satcher went on to describe the complex implications of that statement. "We don't notice much difference in severity or prevalence of mental illness across ethnic and minority groups," he said. "In fact, there is as much variation within groups as across groups."

The clash of cultures, however, can be extremely damaging to the provision of mental health services because rapport between a psychiatrist and patient is critical for successful treatment.

Culture, according to Satcher, affects how patients communicate and manifest their symptoms, how they cope, the range of their family and community supports, and their willingness to seek treatment.

In addition, clinicians' own cultures and the service system also influence diagnosis and treatment. Psychiatrists and mental health professionals need to know how to build upon the cultural strengths of people in their care.

The report analyzes data about four racial and ethnic groups: African Americans, American Indians and Alaskan natives, Asian Americans and Pacific Islanders, and Hispanic Americans. The data are organized around five broad service issues: need, availability, access, utilization, and appropriateness and outcomes.

The groups share problems resulting from having unequal access to treatment and services compared with the white majority in the United States. Minority groups have less access to services, often receive a poorer quality of services, and are under-

see ***Satcher*** *on page 32*

Surgeon General David Satcher, M.D., holds the Presidential Commendation given to him by APA President Richard Harding, M.D., last month in Washington, D.C.

Medical Association Challenges Legality of Medical-Privacy Rule

One state medical association is angry enough about the way the federal government developed the new medical-privacy regulations and what those rules will mean for physicians and patients that it has gone to federal court to try to get them thrown out.

BY KEN HAUSMAN

President George W. Bush may be satisfied with the federal government's recently approved medical privacy rules, but the members of one state medical organization are so dissatisfied that they have turned to the courts for relief.

The South Carolina Medical Association (SCMA) announced in July that it was filing a lawsuit to challenge the constitutionality of the new privacy regulations.

The development of regulations to govern the circumstances under which patients' medical-record data could be released and who would be eligible to receive that information was mandated by a 1996 law known as the Health Insurance Portability and Accountability Act (HIPAA). That health-reform legislation instructed the Secretary of Health and Human Services to draft regulations that would comply with the privacy objectives described in the law if Congress did not do so on its own within three years.

The SCMA's court challenge questions the legality of a section of the law, Section 264, which allowed the HHS Secretary "to create patient-privacy regulations with virtually no congressional guidance, not even the legislative establishment of a federal patient-privacy program," according to an SCMA statement. The medical association emphasizes that its members are particularly concerned because federal law requires administrative agencies such as HHS "to exercise no more power or authority than that authorized by Congress," and thus the agency exceeded its constitutional mandate by acting as federal legislators and violating the separation-of-powers requirement.

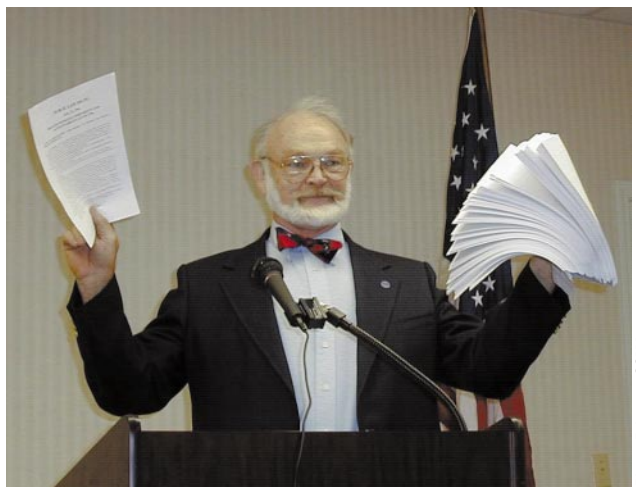


Photo: Driggers, SCMA

At a news conference announcing that the SCMA is suing the federal government over medical-privacy regulations, SCMA President J. Capers Hiott, M.D., displays the one-page enabling legislation and the 1,500 pages of regulations that HHS produced in response.

The SCMA, whose legal challenge has been joined by several individual South Carolina physicians and the Louisiana Medical Association, does not, according to the suit, "dispute the benefits of protecting the privacy of individually identifiable health information." What it does object to is that in the absence of guidance from Congress, HHS took it upon itself to promulgate complex regulations that go well beyond the initial goal of regulating electronic communication of patients' medical information and in fact include "all forms of speech involving individually identifiable health information."

In addition the SCMA is challenging the scope of the regulations' reach, which, the suit notes, "go beyond HIPAA's regulation of health care providers, health plans, and health care clearinghouses to regulate all persons doing business with such entities who would receive either electronic or non-electronic communications" of these medical records.

see ***Medical Privacy*** *on page 31*

Association News but doesn't have to be in box

APA Election 2002

Campaign News

- Area 5 has announced that Anita S. Everett, M.D., of Charlottesville, Va., will run against Jack Bonner, M.D., of Greenville, S.C., for Area trustee.

- The Elections Committee urges members who wish to undertake any activities on behalf of a candidate for APA office to contact the candidate first to learn of any election guidelines that may apply. Information is also available from Carol Lewis at APA headquarters by phone at (202) 682-6063 or by e-mail at clewis@psych.org.

Psychiatry Answers Call After Terrorist Attacks

BY RICHARD HARDING, M.D.

Thursday, September 13

As I write this presidential column for the October 5 issue of *Psychiatric News*, I am feeling overwhelmed by the enormity and savagery of the last 48 hours. For the first time since Pearl Harbor, our nation has been attacked with a loss of life that will be measured in the thousands.

You should know that on Tuesday, September 11, many of our new and senior staff at APA headquarters remained in place all day answering requests from the media and government officials regarding information and psychiatric advice to inform the public—this on a day where the news was full of more hijacked planes inbound to Washington and other rumors. Their service to our patients and our profession is nothing short of heroic. We will be forever grateful.

The psychiatrists from the New York County District Branch, Washington Psychiatric Society, and faculty and residents at training programs in New York City and and the Washington, D.C., area are brave and exhausted, providing psychiatric care to victims and family members who are desperately searching for clues to the fate of their loved ones.

I am impressed that there are few things about this situation that are clear or will be quickly dealt with. President Bush is talking about "war," which implies something different from surgical-strike revenge. Recovery of the dead in the World Trade Center and the Pentagon will take time. As psychiatrists, we know that the emotional scars, panic, and grief that we will deal with will perhaps be the most profound and long lasting of all the sequelae.

It is hard to be forward thinking on a day like today. Allow me to think through the task each of us faces in providing care to our individual patients and improving the public's health in this country and beyond.

As national leaders talk of quick revenge and "war," we must be thinking of how we will create the healing environment and systems of care to aid the millions of citizens who will be psychiatric casualties of these events.

We must improve and redesign systems for children who have repeatedly watched horrific events on TV over which they have no control and refocus them on schoolwork and other positive activities over which they can gain control and mastery.

We must be realistic about our demands for individual privacy during wartime while continuing to protect the population and our patients from overreaction to the fear we each face. We must continue to champion the principles that protect our civil liberties and medical privacy. It will not be popular, but it will be right.

We must lead in preventing anger that brings out prejudice and hate against Arab Americans and Muslims. We can ill afford

see ***From the President*** *on page 31*

Govt. to Extend Protections To Patients in Medicaid Plans

The federal government releases proposed regulations that will make it easier for managed care plans to participate in Medicaid and will give patients in these plans more rights.

BY CHRISTINE LEHMANN

An estimated 20 million Medicaid patients in managed care and mental health carveout plans will be guaranteed new protections under a federal rule proposed in August.

Health and Human Services (HHS) Secretary Tommy Thompson praised the proposed rule for providing needed patient protections and giving states flexibility in implementing them, according to an HHS press release.

Thompson promised to have the rule finalized by early next year, although it does not go into effect until August 2002. APA will send HHS its comments on the new rule by the end of this month, which is the deadline for the public comment period.

"Medicaid beneficiaries deserve the same rights and protections as all other Americans enrolled in managed care plans," said Thompson in the statement.

The rule is designed to mirror many of the patient protections in legislation before Congress (*Psychiatric News*, August 17). A major difference is that the rule doesn't give patients the right to sue managed health care plans, provisions for which are included in both the Senate and House versions of managed care reform legislation.

The proposed rule requires managed Medicaid plans to do the following:

- Pay for emergency room care regardless of place or time.
- Provide beneficiaries access to a second opinion from a qualified health professional.
- Provide direct access to a woman's health specialist in the network for routine and preventive health care services.
- Not interfere with provider-patient communication.
- Document their capacity to serve the expected number of enrollees in their service area.
- Establish a grievance and appeals process. Grievances must be resolved within 90 days and appeals within 45 days. If a patient's health or life is in danger, the timeframe is shortened to three business days, but two weeks is allowed if requested by an enrollee or managed care plan.
- Provide enrollees with easily understood information about their managed care plan.

Congress authorized the creation of regulations as part of the 1997 Balanced Budget Act to establish patient protections and make it easier for managed care plans to participate in Medicaid by eliminating certain restrictions. For example, under the proposed rule, states do not have to obtain federal waivers to enroll beneficiaries into managed care plans and can impose cost-sharing requirements, according to the press release.

States also have more flexibility to decide "how best to provide patient protections and use managed care in their Medicaid plans," said Thompson.

The Medicaid rule was proposed by the Clinton administration in 1998 and finalized in January just before the Bush administration took office. The Bush administration, however, delayed its effective date twice this year to gain time to review the rule and make changes.

Thompson said the revised proposal is "more concise and understandable" than its predecessor and "will reduce the regulatory burden on states and health plans," according to the press release.

HHS was lobbied aggressively by state health plans and governors who complained that implementing the previous "Clinton" rule would be burdensome and expensive, according to an August 17 article in the *Washington Post*.

Critics of the revised rule have included some senior Democrats in Congress and patient advocacy groups who complain that the patient protections have been weakened.

For instance, HHS changed the expedited grievance and appeals timeframe from three days to three "working days" and up to two weeks if requested.

The proposed rule will also loosen requirements that health plans communicate effectively with patients with limited English and omit a previous requirement that states publish names of health plans with poor performance ratings in local newspapers, according to the *Washington Post*.

The proposed rule also requires states to submit plans to HHS for providing beneficiaries with high-quality health care and how health plans will measure that quality. The Clinton administration required HHS to decide which quality-of-care measures should be used by health plans, according to the press release.

Thompson justified the changes on the grounds that the previous rule "went far beyond what Congress intended in the 1997 Balanced Budget Act. Its excessive mandates actually threatened beneficiaries' access to care under Medicaid," according to the press release.

The proposed federal rule was published in the August 20* Federal Register *and is posted on the Web at <www.hcfa.gov/medicaid/cms2104p.pdf>. Comments should be sent to the Center for Medicare and Medicaid Services by October 20. The CMMS address and other instructions are available on the Web. ■

Moms In Drug Abuse Treatment Have Healthier Children

A government study says alcohol, drug abuse, and crime decline dramatically when women with children complete residential substance abuse programs. Kids benefit as well.

BY JIM ROSACK

Drug- and alcohol-dependent women who are pregnant or who have children significantly reduce their alcohol or drug use as well as criminal behavior following treatment in a residential substance abuse treatment program, according to a report from the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT).

The report also found that the rates of premature delivery, low birth weight, and infant mortality rates were significantly improved for women who participated in long-term residential substance abuse treatment while they were pregnant.

The report, released by CSAT last month, evaluated the effectiveness of programs specifically designed for substance abuse treatment in women who were pregnant or had children.

"There's no question that treatment provides a second chance to mothers and children," said Tommy G. Thompson, secretary of Health and Human Services, at a press conference announcing the release of the report. "And we need to do everything we can to give them that opportunity. We must continue to make effective community-based treatment programs available to those who need it."

The project involved 50 CSAT-funded residential substance abuse treatment facilities. Each facility received a five- or six-year grant that provided funding and technical assistance for development of facilities tailored to provide long-term (six to 12 months) residential treatment for pregnant and postpartum women with children under one year old or women with children over one year of age.

Healthier Moms, Healthier Kids

Use of crack cocaine declined from 51 percent of the women studied six months before treatment to 27 percent six months after treatment. Similar reductions were noted in use of several other substances, including powder cocaine (from 34 percent to 9 percent), marijuana (from 48 percent to 15 percent), methamphetamine (from 21 percent to 6 percent), and heroin (from 17 percent to 6 percent).

Alcohol consumption was similarly significantly reduced; 65 percent of the women had reported drinking alcohol six months prior to starting treatment, compared with 27 percent six months after treatment.

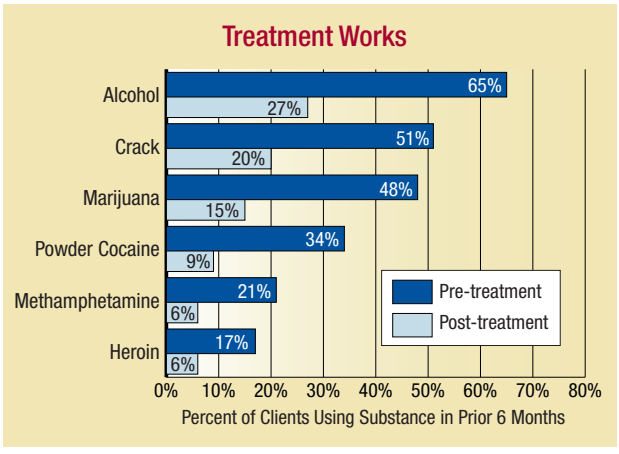
The programs achieved a rate of premature delivery during treatment of 7.3 percent, 70 percent lower than the expected 24 percent rate of premature delivery seen among untreated alcohol or drug abusers (based on recent hospital-based studies). The incidence of low birth weight was reduced to 5.7 percent, 84 percent below the expected 35 percent seen in untreated alcohol or drug abusers and the infant mortality rate experienced by the mothers in treatment was 0.4 percent, 67 percent lower than the 1.2 percent expected in this population.

These rates for adverse outcomes in the treatment programs among pregnant women who abuse substances are not only much lower than would be predicted in untreated substance abusing women, Thompson said, but they are also lower than the rates reported for all American women in U.S. vital statistics.

Unique Pilot Program

Each of the programs was uniquely structured to provide gender-specific and culturally appropriate treatment services; on-site residential care for the patients' infants or young children to allow patients to maintain supervised parenting relationships throughout their treatment; and comprehensive services for both the patient and their infant/children—substance abuse treatment and prenatal, pediatric, medical, and mental health care. In addition, vocational, parenting, legal, nursery/preschool, and transportation services were provided through each of the 50 programs.

The number of children a woman had at the time of acceptance into the treatment program was not limited; the number of children for each mother ranged from one to seven. When possible and appropriate, the children's fathers, if willing, were included in the treatment protocol as well.



The benefits of residential substance abuse treatment for women who are pregnant or have children are shown in data from a SAMHSA study involving 50 treatment programs across the United States.

Reducing Overall Costs

"These programs indicate that substance abuse treatment can save taxpayers money that otherwise would be spent on other medical costs," said H.Westley Clark, M.D., J.D., M.P.H., CSAT director. "Data in a 1998 study on drug-exposed infants indicate that it cost an additional $7,700 in medical care before these babies could leave the hos-

see ***Treatment*** *on page 32*

SSRIs Called on Carpet Over Violence Claims

A flurry of recent legal activity has reignited the controversy surrounding antidepressants' ability to cause aggressive or violent behavior. Among the cases is an Australian one in which an SSRI is blamed for a man's fatal attack on his wife.

BY JIM ROSACK

Psychoactive medications, and the drug companies that make them, have been having a bad year in court. In fact, following several recent legal rulings involving different psychoactive drugs, some industry analysts are hinting they would not be surprised to see the drugs' sales—and also their makers' chief executives—a bit depressed.

The most recent legal assault against a psychoactive medication came in August when a Los Angeles law firm filed a complaint against international drug conglomerate GlaxoSmithKline PLC (GSK), maker of the SSRI Paxil (paroxetine). The suit contends that not only was GSK aware of data that indicated that the antidepressant can be "addictive," resulting in severe withdrawal reactions, but also that the company concealed the "evidence," failing to warn both physicians and patients about the potential for the reactions.

The lawsuit, which seeks class-action status and unspecified damages, was filed on behalf of 35 Americans from across the country who claim that they suffered symptoms ranging from "electric-like shocks" to suicidal thoughts after they stopped taking the drug. In asking for damages, the suit alleges "fraud, deceit, negligence, liability, and breach of warranty" by GSK.

Introduced in the U.S. in 1992, the drug is approved by the FDA for the treatment of depression, obsessive-compulsive disorder, panic disorder, and social anxiety disorder.

Wyoming Verdict on Appeal

The drug has been the center of legal controversy before. Earlier this summer, a jury in U.S. District Court in Wyoming ordered GSK to pay $6.4 million to the family of a man who killed his wife, daughter, granddaughter, and then himself after taking two paroxetine tablets in February 1998.

The wrongful death suit was filed in civil court on behalf of surviving family members. Attorneys for the family successfully argued that Donald Schell had told people that he hallucinated when he had previously taken paroxetine's chemical cousin, fluoxetine (Eli Lilly and Co.'s Prozac), and that most likely the same had occurred with the paroxetine he took on the day he shot his family before turning the gun on himself.

Harvard psychiatrist John Maltsberger, M.D., testified that the SSRI manufacturers should warn prescribing physicians—in particular family and primary care physicians like the one who prescribed paroxetine for Schell—that SSRIs can cause a vulnerable minority of patients to experience akathesia and mania, which, he told the court, can induce violence and even suicide.

Testimony was also introduced from a psychiatrist and outspoken critic of SSRIs, David Healy, M.D., director of the Sub-Department of Psychological Medicine at the University of Wales College of Medicine.

Healy testified that GSK's studies showed that, as early as 1989, SSRIs (including paroxetine) can cause 1 in 4 healthy volunteers to exhibit moderate to severe agitation, which, he said, could lead to violent behavior. Healy added that his studies have since shown that another SSRI, sertraline (Pfizer's Zoloft), when given to healthy volunteers, made two subjects "acutely and seriously suicidal after just being on the normal dose for two weeks."

The drug company's attorneys argued that the medication had not had time to work and that it was Schell's out-of-control and escalating depression that caused his violent behavior.

The Wyoming civil court jury found that the drug was "80 percent responsible" for the deaths, with Schell being 20 percent responsible, and awarded a total of $8 million in damages. GSK was ordered to pay 80 percent of that total, or $6.4 million.

Spokespersons for GSK had previously indicated in press releases that the company intended to appeal the verdict.

Murder Down Under

Healy also testified this summer as an expert witness in a case that resulted in a ruling by a New South Wales, Australia, Supreme Court judge who determined that a 76-year-old man accused of strangling his wife of 50 years did so because he was taking sertraline.

"I am satisfied," said Australian Supreme Court Justice Barry O'Keefe, "that but for the Zoloft he had taken, he would not have strangled his wife."

The defendant in the Australian murder case, David J. Hawkins, pled guilty to the reduced charge of manslaughter on the grounds of diminished responsibility. His defense attorney successfully argued that the retired mechanic would not have killed his wife if he had not taken 250 mg of sertraline, five times the recommended dose, the morning of the murder.

The judge agreed, saying in his verbal ruling, "The killing was totally out of character for the prisoner, inconsistent with the

see ***Violent Behavior*** *on page 31*

Al-Anon Celebration Spotlights Importance of Family Involvement

Are we in denial about the impact of alcoholism on children? Claudia Black, Ph.D., offers hope about the value of intervention and some disheartening statistics about the mental health of children of alcoholics.

BY KATE MULLIGAN

Al-Anon, the support program for families and friends of alcoholics, celebrated its 50th anniversary with a Capitol Hill luncheon on September 6. Today there are more than 24,000 Al-Anon groups worldwide.

At times, the event had the spirit of the joyous reunion of a particularly happy family. The two congressional sponsors of the luncheon, Sen. Paul Wellstone (D-Minn.) and Rep. Jim Ramstad (R-Minn.), lauded each other's efforts on behalf of the federal mental health parity bill that has been introduced in Congress (*Psychiatric News*, September 7). Wellstone described Ramstad as "someone who had lived through the struggle" with alcoholism and was now using that struggle to inform his ability as a legislator.

Ramstad, in turn, spoke of the pleasure of "working in a nonpartisan way" on the legislation. He said that in 1981, he had awakened in a jail cell because of his alcoholism and added, "I'm here today, alive and sober. I couldn't have recovered without my family."

The congressman continued his remarks by offering good news about advances in treatment. "Treatment does work. Families can recover. I tell my colleagues that chemical dependency treatment is more effective than treatment for cancer, and it's cheaper."

He went on to describe a bleaker picture of how few people actually get that treatment. "Only 5 percent of addicts and alcoholics are in recovery," he said. "Eighty-two percent of people in jails are there because of addiction."

Keynote speaker Claudia Black, Ph.D., a writer and clinical consultant to the Meadows Treatment Center in Wickenburg, Ariz., offered a disheartening list of statistics about the prevalence of alcoholism and its impact on children. Forty-three percent of the U.S. adult population has been exposed to alcoholism in the family. There are an estimated 26.8 million children of alcoholics (COAs) in the United States. Preliminary research suggests that more than 11 million are under the age of 18.

Black, founder and past chair of the National Association for Children of Alcoholics, described the psychological fallout for children living in a family with this disease. "The children wake up in a world that does not take care of them. They learn not to show their feelings, not to talk honestly, not to pay attention to what's happening around them."

She cited study data available from the National Clearinghouse for Alcohol and Drug Information that support the anecdotal evidence of damage she observed in her therapeutic work with families. Children living with a nonrecovering alcoholic person score lower on measures of family cohesion, intellectual-cultural orientation, active-recreational orientation, and independence.

COAs have more physical and mental health problems. For example, the rate of total health care costs for children of alcoholics is 32 percent greater than for children from nonalcoholic families. Inpatient admission rates for mental disorders are almost double those for other children.

Hope lies in the many possible points of intervention. Children respond positively to support groups, she said. They can be reached through faith communities and identified by primary care physicians and child welfare workers.

Black added, "We are in denial ourselves if we don't also focus on the family as a key element in recovery. We know we must retain a patient in a treatment program to get full benefits. A family can provide the necessary motivation, but it can also be the embryo for recidivism. Too often, families are not expected to be part of the recovery process in federally funded programs for people with addiction."

Related information can be found on these Web sites: National Association for Children of Alcoholics at <www.nacoa.net> and the National Clearinghouse for Alcohol and Drug Information at <www.health.org>. ■

Last month about 600 APA members came to Washington, D.C., to conduct the work of the Association through its committees, councils, task forces, and other components. This year's special guest was Surgeon General David Satcher, M.D., who addressed a plenary session on his recent report "Mental Health: Culture, Race, and Ethnicity" (see page 1).

APA Works for You

Washington, D.C. Fall Component Meetings September 3 - 9, 2001

Members of the Joint Commission on Government Relations discuss legislative and regulatory issues that affect psychiatrists and their patients. From left are Janis Chester, M.D., Robert Pyles, M.D., and Barry Perlman, M.D.

Surgeon General David Satcher, M.D., notes that striking disparities in mental health care are found for racial and ethnic minorities.

Surgeon General David Satcher, M.D., is joined by (from left) Megan Marumoto, M.D., APA/Astra Zeneca fellow; Pedro Ruiz, M.D., APA secretary; Albert Gaw, M.D., speaker-elect of the Assembly; Nada Stotland, M.D., speaker of the Assembly; Silvia Olarte, M.D., chair of APA's Council on National Affairs; Altha Stewart, M.D., chair of APA's Council on Psychiatric Services; and Jeffrey Akaka, M.D., chair of the Assembly Committee of Representatives of Minority/Underrepresented Groups.

APA President Richard Harding, M.D., tells Satcher and the assembled group that APA is prepared to offer its expertise, resources, and testimony to support the goals and recommendations outlined in the Surgeon General's report.

Carl Bell, M.D., presents a baseball cap to Surgeon General David Satcher, M.D. Stitched on it is "CMHC," which stands for Community Mental Health Council of Chicago; Bell is the organization's president and CEO.

Jerald Kay, M.D. (at far end of table), chair of the Commission on Psychotherapy by Psychiatrists, leads a discussion on confidentiality and psychotherapy issues and possible revisions to the previously published COPP resource document.

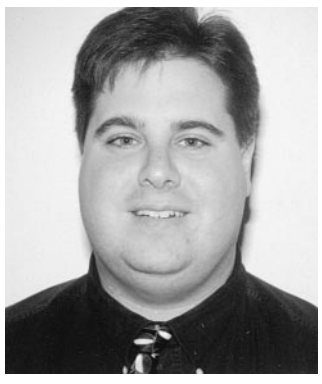
Silvia Olarte, M.D., chair of APA's Council on National Affairs, leads a discussion of the surgeon general's report and recommendations for implementation within the U.S.'s diverse communities. Pictured with her are (from left) Megan Marumoto, M.D., Debbie Carter, M.D., and Cherry Chevy, M.D.

Members of the Committee on Psychiatric Administration and Management discuss how to streamline the application process for APA certification in that field. From left are Veena Garyali, M.D., Gary Miller, M.D., and chair William H. Reid, M.D., M.P.H.

BY CHRIS BOJRAB, M.D.

Gambling on a Career Choice

We frequently hear about the difficulties faced by psychiatrists starting their careers. Being at the start of your career, however, may also provide the chance to take advantage of opportunities that would be more difficult to consider later in one's professional life.



Shortly after entering private practice, a newly formed company, Trimeridian Inc., approached me about working for them. The company is dedicated to the evaluation and treatment of patients with gambling addictions. The CEO and principal owner of the company was acquainted with the CEO of the hospital where my practice hospitalized our inpatients. Trimeridian was searching for a medical director and attending psychiatrist for the inpatient unit, the Dr. Robert and Lillian Custer Center in Indianapolis, where I practice.

Of course, accepting this position was a risk. I would be giving up 30 percent of my practice time and income to work at the new unit. The opportunity was certainly interesting—the chance to serve as medical director of the only JCAHO-accredited psychiatric hospital specializing in the treatment of gambling addictions.

The Custer Center is named after the late Robert Custer, M.D., and his wife. Dr. Custer, a psychiatrist, was chief of treatment services of the Mental Health and Behavioral Science Service of the U.S. Veterans Administration. In 1972 he founded the first treatment center for compulsive gamblers in Brecksville, Ohio. Due in large part to his efforts, in 1980 APA officially recognized pathological gambling as a disorder.

The Congressional National Gambling Impact Study, released in June 1999, estimated that there are 2 million to 5 million Americans who meet *DSM-IV* criteria for pathological gambling. The study also suggested that another 15 million Americans may be "problem gamblers." Legalized gambling, including lotteries, is available in 48 states and the District of Columbia.

Between 1976 and 1997, legalized gambling grew by 1,600 percent. Since the mid-1970s, gambling has grown from a $17 billion a year to a $1.4 trillion a year business. Last year, Americans spent more on gambling than on movies, sporting events, theater, concerts, theme parks, and cruises combined.

The Custer Center is a JCAHO-accredited psychiatric hospital that opened in September 1998. The center has treated patients from 40 states as well as abroad. The inpatient program combines a multidisciplinary treatment team consisting of psychiatrists, psychologists, nurses, certified gambling therapists, peer counselors, and consulting primary care physicians. Length of stay depends on each patient's individualized treatment plan, but averages 21 to 24 days. The program includes group and individual therapy, a strong emphasis on Gamblers Anonymous, and pharmacological treatment. In addition to working with the patient, extensive work is done with the patient's family and, as appropriate, employers, consumer credit-counseling groups, the courts, bookies, and so on.

Part of what made this opportunity attractive to me, especially as an early career psychiatrist, was the chance to become involved in a relatively new field and create a niche for myself. It is exciting to be able to work with some of the "thought leaders" in the field as we develop a better understanding of the epidemiological, biological, and psychosocial factors involved in this disorder.

It also provides me with the ability to work with colleagues in other disciplines as part of a truly comprehensive treatment team. I have found that this is something that is increasingly rare on most traditional inpatient psychiatric units due to the short lengths of stay and significant time pressures.

This interaction with the other members of the treatment team has become an important part of my continuing education and professional development. Having patients on an inpatient unit for three to four weeks allows us to do more dynamic, interpersonal, and cognitive-behavioral work than is usually possible in most short-stay inpatient settings. The concept of a "clinical formulation" has gone from an intellectual exercise in residency training to a very practical part of the process of creating a comprehensive assessment and recovery plan for our patients. It has provided a nice balance with the rest of my clinical work, which is primarily a psychopharmacology practice.

My position as medical director for the Custer Center has become the most interesting and rewarding part of my private practice. I sometimes wonder whether I would have taken advantage of this opportunity if presented with it a couple of years later. Being early in my career and having a schedule that was not yet full made the risk involved in taking this position more palatable.

Had I been in practice longer, I might not have been comfortable with the risk inherent in giving up such a large percentage of my clinical time. As early career psychiatrists, we may be more "risk tolerant" than our more senior colleagues who are further along in their careers. This may provide a greater variety of practice opportunities in our rapidly changing field. ■

Dr. Bojrab is in private practice and medical director of the Dr. Robert and Lillian Custer Gambling Treatment Center in Indianapolis.

Early career psychiatrists are invited to submit articles for this column on any topic they think will be of interest to ECPs. Forward ideas to Tony Robucci, M.D., at t.robbuci@worldnet.att.net. Submissions should be no longer than 750 words, and authors should be prepared to submit a recent photo if their article is accepted for publication.

APA's Campaign Guidelines Emphasize Dignity, Courtesy, and Fairness

With the announcement of the Nominating Committee's selection of candidates for the 2002 election, the campaign season is officially under way, and members, particularly those wishing to support a candidate, will want to be familiar with the campaign guidelines.

The APA Elections Committee is charged with establishing procedures, with the approval of the Board of Trustees, for equitable voting of the membership. These procedures are documented in the election guidelines section of the *Operations Manual.*

Guidelines prescribing members' election-related activities were established by the Board in the early 1970s, when APA began having contested elections. Restrictions on campaigning were initially adopted as an attempt to address at least four major concerns: (1) to guard against massive campaign efforts "buying" an election win, particularly if those efforts were financed by resources from outside the membership; (2) the revulsion against campaign committees, war chests, and unwelcome bids for public support; (3) the growing distress of the membership at being deluged with campaign materials; and (4) a feeling held by an unknown proportion of the membership that large-scale campaigning was unseemly and inconsistent with their conception of APA's professional image. The concerns are as valid today as they were in the '70s, and the guidelines continue to address them.

There are three sections to the guidelines: guidelines for the candidates and supporters; guidelines for those holding appointed or elected positions in APA/Area Councils/district branches; and guidelines for the use of electronic media.

The intent of the guidelines is "to encourage fair and open campaigning by APA members on a level playing field; foster opportunities for candidates to educate their colleagues about the issues and about their experiences and views; keep costs down; and maintain dignified and courteous conduct appropriate to the image of a profession." Challenges to candidates' records are permitted, but not to their character or institution.

Of utmost importance is the stipulation that candidates and their supporters must use their own resources for election activities (A.1 below). The limits on the number of letters that each person may write were established because the committee believes that 400 letters (or 100 for Area office) is a manageable number for any member wishing to support a candidate (A.2 below).

There are some important changes this year, approved by the Board of Trustees in June. While there are no limits on the number of campaign messages that may be sent by e-mail (A.3, first paragraph below), members wishing to support candidates in this way must include the words "APA Campaigning" in the subject line.

Further, the only APA-supported list serve that may be used for campaigning is Member-to-Member (A.3, second paragraph). List serves of other psychiatric organizations may be used for campaigning only if permitted by those organizations. These changes were recommended by the Elections Committee based on APA members' responses to the campaign guidelines poll conducted by the Ad Hoc Committee to Review Election Policies and Procedures in September 2000 *(Psychiatric News*, November 17, 2000).

APA's Web site will once again contain information about candidates, with links to the homepages of candidates who have Web sites.

The Elections Committee recognizes that there have been problems (and always will be) in implementing the guidelines and in creating guidelines that are inherently equitable, given the diversity of APA's membership and candidates. However, the majority of members responding to the campaign guidelines poll indicated their satisfaction with the current guidelines. Members and candidates alike believe that the guidelines have achieved the objectives for which they were designed.

The Elections Committee encourages members to get involved in the election process, to support the candidates of their choice, and to encourage others to do so by writing personal letters to friends and colleagues or by personal contact. The committee is open to any suggestions the membership has to improve or change the guidelines. Most importantly, we encourage you to vote and to urge your colleagues to do the same. Ballots will be mailed January 7, 2002. Election information will be included in the December 7 issue of *Psychiatric News.* ■

This article was prepared by APA's Elections Committee.

APA Campaign Guidelines

A. Guidelines for APA Candidates and Supporters

The intent of the guidelines is to encourage fair and open campaigning by APA members on a level playing field; foster opportunities for candidates to educate their colleagues about the issues and about their experiences and views; keep costs down; and maintain dignified and courteous conduct appropriate to the image of a profession. Candidates' records may be challenged but not their character or institution.

Campaigning (written or e-mail solicitation of votes or support) is permitted only after Nominating Committee nominations are reported to the Board of Trustees. Members circulating petitions may not use the petition process for campaign/electioneering purpose beyond asking for signatures on petitions.

1. Money/resources: Candidates/supporters must use their own resources for election activities. Fund raising is not permitted, nor is sharing of materials, such as letters, postcards, stamps (with the exception of mailing address labels or disks of mailing address labels). Candidates/supporters may not organize campaign committees and candidates may not enter into agreements to campaign together.

2. Letters: Election "letters" include letters, postcards, and faxes, asking for a member's election support. Follow-up mailings of a c.v., fact sheet, bio are permitted and are not included in the letter limits. Handouts may be made available at meetings attended by the candidate.

- Each candidate/supporter generates his/her own "letters" with his/her own personal resources; no APA/Area/district branch resources may be used.
- Each candidate/supporter may write up to 400 letters for candidates for national office or 100 for candidates for Area trustee.
- Mailing address labels or disks of mailing address labels may be purchased from APA/Area Councils/district branches and may be shared.
- Third-party endorsements are not allowed.
- Duplicated material may accompany each letter as a single attachment, but not multiple copies of attachments intended for further distribution.
- Candidates are encouraged to send a copy of these guidelines to members they ask for support.

3. E-mail: E-mail used for campaign purposes must comply with the intent of the guidelines with regard to content and must contain the words "APA Campaigning" in the subject line. There are no limits on the number of campaign messages sent by e-mail. Obtaining e-mail addresses is the responsibility of the candidates and their supporters; such addresses may not be as readily available as mailing addresses. See also Section C.

APA list serves created for conducting business of an APA component or list serves using APA technology (except Member-to-Member) may not be used for campaigning. List serves of other psychiatric organizations may be used for campaigning if permitted by those organizations. See also Section A.5 below.

4. Debates/appearances: Candidates may attend no more than four mutual presentations with their opponent(s). If all candidates have been given equal opportunity to attend and one cannot attend, the other candidate(s) may present. In addition, grand rounds, lectures, presentations at APA meetings, and other kinds of presentations made in one's professional capacity should be limited to no more than eight during the campaign period. Running for office should not inhibit or prohibit candidates from conducting their usual professional business; every effort should be made to define "usual professional business" in the narrowest sense.

5. APA members in other organizations: All APA members are expected to abide by the APA election guidelines in APA elections, including in their capacity as officers and members of other organizations. APA requests that other organizations adhere to the intent of the campaign guidelines and provide fair and equitable coverage of opposing candidates.

6. Compliance: Each candidate receives a copy of these guidelines and a statement to sign, certifying that he/she has read the guidelines; promises to abide by them; will immediately report any deviations of which he/she becomes aware to the Elections Committee; and will notify and try to correct any supporter upon learning of an actual or potential deviation. The Elections Committee investigates any potential violation of which it becomes aware, and reports violations to the Board of Trustees. The procedures used by the Elections Committee to investigate and report campaign violations are in Chapter 2 of the *Operations Manual* and will be sent to candidates with these election guidelines.

B. Guidelines for Those Holding Appointed or Elected Positions in APA/Area Councils/District Branches

1. Money/resources: APA/Area/district branch funds or services cannot be used to endorse, support or promote any candidate; however, district branch or Area funds may be used to support the expenses of candidates invited to the branch/Area meeting for election purposes (see #3 below). APA/Area/district branch or APA organizational stationery cannot be used. Candidates/supporters who hold appointed or elected APA/Area/DB positions may refer to their titles in the body of the letter, but if they choose to sign the letter, they may not do so over their APA organizational title. Likewise, e-mails should not be "signed" using an APA organizational title.

2. Newsletters: District branch or Area newsletters may announce as news items of up to 150 words per candidate the candidacy for national office or Area trustee of member(s) of that district branch/Area, with pictures. Editorial endorsement of candidates is prohibited, as are letters to the editor in support of or opposition to candidates. Newsletters may print statements or other materials by or about a candidate only if they give equal opportunity to opposing candidates. Newsletters cannot be distributed beyond the usual newsletter distribution.

3. Meetings: Candidates invited to attend district branch meetings to campaign may do so only if their opponent is also invited to the same meeting. Candidates invited to make scientific presentations at district branch meetings may not discuss election issues unless their opponents have been given an equal opportunity to do so.

C. Guidelines for Use of Electronic Media

Candidates and their supporters using electronic media for campaign purposes are expected to comply with the guidelines set forth in Section A and Section C.

1. APA's Web site: APA will include information on all candidates (the photos, biographies, and statements printed in *Psychiatric News)* and on the election itself (campaign guidelines, ballot mailing and return dates, etc.) on its Web site. This election information can be accessed through the election logo and linked to other information as appropriate.

2. Candidates' homepages: APA will provide links from its Web site to the individual homepages of the candidates. Each candidate is responsible for setting up and financing his/her own homepage. There will be a disclaimer on APA's Web site stating that candidates' homepages are their own creation and responsibility, and that APA takes no responsibility for information posted on them. APA reserves the right to cut the link between its Web site and a candidate's homepage if a candidate violates the campaign guidelines. No other individual, institutional, or organizational homepages will be used for campaigning.

APA Provides MH Expertise In Wake of Terrorist Attacks

APA quickly comes to the assistance of three district branches affected by the attacks of September 11 and mobilizes an outreach effort to the media and general public.

BY KEN HAUSMAN

Immediately after the terrorist attacks on the World Trade Center and Pentagon on September 11, APA staff began to mobilize in an effort to share its members' expertise with the public and the press to help them understand the emotional and psychiatric consequences that people who live through traumatic events often endure.

Despite being just across the river from the Pentagon and only four blocks from the White House, and not knowing whether the attacks were in fact over, a substantial number of APA staff remained in the headquarters building to respond to phone calls hours after the building owners closed the building at about noon that day.

APA Medical Director Steven Mirin, M.D., quickly sent a set of "talking points" to all member list serves to help them prepare for media inquiries. These points included recommendations for individuals on what they should do when disaster strikes, suggestions for talking with children about the traumatic events, and the psychological problems that trauma survivors and witnesses often experience.

The APA information also described treatment interventions that can help people process and deal with the sequelae of a disaster and emphasizes that these consequences "are not limited to individuals directly in the traumatic event." This "secondary traumatization," APA points out, can impact such at-risk groups as family members, police, firefighters, and health care professionals who respond to the disaster.

This information, in language geared to a nonprofessional audience, was also added—along with other helpful information about responding to traumas and disasters—to the APA Web site at <www.psych.org> under the new heading "When Disaster Strikes. . . ." One section provided guidance on how to help children process the events of September 11, emphasizing how important it is to "listen to children, accept their fears, and talk with them." It offered the following advice:

- Reassure your child that he or she is safe from harm and is being protected.
- Reassure the child that the state and federal government, police, and doctors and hospitals are doing everything possible to help the people hurt by this tragedy.
- Listen to your child's fears and concerns and encourage him or her to talk to you and other family members about fears and anxieties related to the traumatic events.
- Let your child know that in time the United States will recover from this disaster.
- If you are frightened, tell that to your child—don't minimize the danger, but also talk about your ability to cope with your own fear and anxieties and to continue with your life.

That same day the staff of APA's Division of Communications and Marketing issued a press release to more than 2,500 members of the press that provided much of the same information available on the Web site and in Mirin's message to the member list serves about coping with trauma and getting help for the psychological consequences.

Within one week of the attacks, that office had fielded about 160 calls from large and small media outlets asking for information about the mental health consequences of trauma, how these problems are treated, and the names of members who are expert in this area of psychiatry. Media inquiries came from the country's leading newspapers, including the *Washington Post*, *New York Times*, *USA Today*, and *Boston Globe*, as well as a few smaller ones. Cable news channels such as CNN also contacted APA as did ABC's "Good Morning America" and several local television stations. Interest in contacting APA was not limited to U.S. media outlets. The communications division also heard from the Paris-based newspaper *Le Figaro* and from a paper in Greece. The BBC in London also asked APA for information on the mental health aspects of disasters.

On September 13 APA President Richard Harding, M.D., issued a statement that offered advice and reassurance. He urged people to acknowledge their fear and anger and to discuss their emotions with others. He also suggested that participation in community activities such as remembrance ceremonies can be an important step on the road to healing, as can contributing time, money, or other assistance to those on whose lives the disaster had a direct impact. Harding urged people to draw as much strength as possible from their spiritual or religious beliefs and to resume their normal routines as quickly as possible.

"Understand that strong feelings of grief can resurface sporadically even months after the events," Harding noted, "and that such feelings are normal." He advised people to consult a physician or mental health professional "if feelings of grief and loss or fears stemming from the traumatic events become chronic or impair your daily activities and relationships."

Within days of last month's tragic events,

see ***APA Expertise*** *on page 32*

Psychiatrists Play Critical Role in Response to New York Attacks

continued from page 1

is also associate chair for education and training in the department of psychiatry at New York Medical College. The college is affiliated with St. Vincent Catholic Medical Centers (SVCMC), which operates eight hospitals in New York including Manhattan.

Approximately 9:45 a.m.: The first casualties begin arriving in ambulances at St. Vincent's Hospital.

10 a.m.: The south tower collapses, followed by the north tower at 10:28 a.m.

"During the next four hours, we began to notice that far fewer patients were coming through our doors than we expected. We began to consider the possibility that many did not survive," said Ladds.

2:30 p.m.: St. Vincent's decides to focus on providing information and support to families, coworkers, and friends of missing victims. Due to the overwhelming need, a family support center is set up at a nearby school campus and staffed by St. Vincent's general hospital and psychiatric clinicians and volunteers from the New York City area.

The clinicians, mainly psychiatrists, psychologists, nurses, and social workers, worked around the clock, some for 36 hours straight, said Spencer Eth, M.D., medical director of behavioral health services at SVCMC and professor and vice chair of the department of psychiatry at New York Medical College.

Crisis Intervention Mode

Former APA President Joseph T. English, M.D., chair of psychiatry at SVCMC and professor and chair of the department of psychiatry and associate dean of New York Medical College, told *Psychiatric News* that the Greater New York Hospital Association compiled a database of patients who were brought to hospitals in Manhattan and New Jersey from the World Trade Center. The staff had those lists available at the family support center, said English.

A 24-hour mental health help line was also set up at St. Vincent's in Manhattan for people having trouble coping with the emotional trauma caused by the disaster, Eth told *Psychiatric News*.

"We have been primarily in crisis-intervention mode, offering information or one-time counseling to the large numbers of people who have come in person to the family support center or have called our mental health help line," said Eth, an expert in posttraumatic stress disorder.

"In addition, our attending and resident psychiatrists have dispensed psychotropic medications as needed. We are now transitioning to grief counseling and brief therapies," Eth added.

English said, "The most moving thing for me was seeing family members desperate for information about their loved ones, pleading with anyone they could find on the streets to take Xeroxed pictures of their relatives. We encouraged the family members to go to the family support center," said English.

Eth and English praised the outpouring of volunteer professionals who participated in the mental health response at St. Vincent's Hospital in Manhattan. He also credited the staff at St. Vincent's Medical Center in Staten Island with assisting local rescue workers and their families and the staff at St. Vincent's Medical Center in Westchester County with helping with the mental health help line.

English mentioned that a psychiatric resident from as far away as Massachusetts General Hospital arrived at the family support center within a day of the attack to offer his assistance.

St. Vincent's Hospital in Manhattan has also sent mental health teams to local schools and businesses that have suffered traumatic losses, said Eth. "We have done several consultations to companies that have lost employees in the disaster."

At press time, more than 6,000 people in the two towers had not been accounted for.

"The first week of the disaster, we also met with a large group of teachers from an elementary school overlooking the World Trade Center to discuss how to talk to the students. We are planning to do more school consultation services in the weeks ahead," said Eth.

Responses From Other Institutions

Psychiatrists at several institutions in Manhattan responded to the attacks on the World Trade Center by providing crisis counseling to survivors, relatives, friends, employers, and schools affected by the tragic events.

Among those institutions were Bellevue Hospital, Lenox Hill Hospital, New York Presbyterian Hospital, New York Psychoanalytic Institute (NYPI), and New York State Psychiatric Institute (NYSPI) at Columbia University College of Physicians and Surgeons.

Herbert Pardes, M.D., CEO and president of New York Presbyterian Hospital, told *Psychiatric News* that the psychiatry departments of Weill-Cornell and Columbia-Presbyterian Medical Centers have helped counsel many of the estimated 500 survivors brought to their facilities. That number included 25 burn patients taken to the Weill-Cornell Burn Center. Psychiatrists have also counseled people at the Armory, which set up a center for missing persons; the World Trade Center; and other public places, said Pardes.

"I have visited some of the patients including the burn victims who told us stories of unimaginable horror," said Pardes.

One woman said she was on the 70th floor of the north tower right before it collapsed. She was trying to help her boss, who had suffered a broken leg. As she waited for an elevator, the doors opened and a fireball incinerated several people waiting to get on. Badly burnt, she managed to escape before the tower collapsed. "She felt enormous guilt that she got out and her boss apparently didn't," said Pardes.

"Our hospital also lost three emergency services medical workers who rushed to the World Trade Center when the planes crashed and were inside rescuing people when the buildings collapsed. In addition, some of our medical colleagues lost friends and family members in the WTC attack," said Pardes.

While their morale was shaken, they kept working. "I know of firefighters and emergency medical technicians who sought cover from the debris but kept trying to rescue people despite the black soot filling the air and irritating their eyes and lungs," said Pardes. "Meanwhile, they are worried that some of their colleagues didn't make it.

"I was also impressed with the housestaff who gave up their vacations to help at the hospitals and the numerous people who donated blood, food, and clothing," he continued.

John Oldham, M.D., acting chair of the department of psychiatry at Columbia University College of Physicians and Surgeons and director of NYSPI, told *Psychiatric News* that the psychiatry department has been providing counseling to numerous victims and people who lost relatives and friends, including medical colleagues.

Photo: AP Worldwide/Shawn Baldwin

Gloria Gorbea and her husband Onix of Brooklyn react as they see the remains of the World Trade Center complex in New York for the first time on September 24. Workers continue clearing debris from the site of the September 11 attack.

"We have also sent trauma experts to meet with the police, firefighters, and unions," said Oldham, who is also chief medical officer for the New York State Office of Mental Health.

"In addition to responding to the acute psychiatric crisis, loss, and bereavement, we want to identify people who are at risk of developing unresolving posttraumatic stress disorder and provide them with appropriate counseling. People who are at particular risk include those with a previous psychiatric history and survivors who were in the building and witnessed the horror," said Oldham.

About 100 of NYPI's psychiatrists and psychologists, mainly in private practices, volunteered to staff the institute's crisis counseling center and help line and participate in outreach to businesses, fire stations, schools, and public places such as bookstores, according to Gail Saltz, M.D., chair of public information for NYPI.

Saltz told *Psychiatric News* that some NYPI members have also talked to distraught relatives of employees missing in the WTC attack. "For example, Cantor Fitzgerald, a large securities firm on the top floors of the north tower, lost 700 employees. The firm rented space at a Manhattan hotel, where our members talked informally to relatives, many of them young wives with children, who were still in shock," said Saltz.

Saltz and other members have visited local fire stations in their communities. "I spent a couple of hours recently listening to firemen who lost seven of their colleagues responding to the WTC attack. They seemed relieved when I told them that it was normal to have feelings of fear and aggression toward the perpetrators and to imagine and relive how their coworkers and others died," said Saltz.

The NYPI also sent members to Barnes and Noble bookstores in Manhattan on several afternoons to talk informally to interested people about their reactions and concerns. The chain of bookstores agreed to provide free books on trauma and grief and hot chocolate, said Saltz.

Disaster Psychiatry Outreach (DPO), which is based in Manhattan, has also worked around the clock since the attacks occurred. Anand Pandya, M.D., secretary and vice president for external relations, told *Psychiatric News* that the DPO was asked by the New York City Department of Mental Health to coordinate and deploy dozens of volunteer psychiatrists to various sites. These include ground zero, the Armory, and a community center, said Pandya.

"Many city hospitals and the New York State Office of Mental Health have loaned us their workers to help families search for their loved ones, support rescue workers, and staff various hotlines," said Pandya. "We have also provided medications as needed and hospitalized a few rescue workers."

At press time, the psychiatrists interviewed for this article said that they planned to continue providing services as long as they are needed. "In the next few weeks, we will see more cases of acute stress disorder, adjustment disorder, and major depression and eventually cases of posttraumatic stress disorder," said Pandya.

The DPO may still need volunteers. Those interested are asked to contact Pandya by e-mail at anandpandya@hotmail.com or by phone at (212) 659-8773. DPO is a nonprofit volunteer organization committed to providing high-quality disaster mental health services. Its Web site is <www.disaster-psychiatry.org>. The Web address of St. Vincent's Hospital is <www.svcmc.org/portal/default.asp>. New York Presbyterian Hospital's Web address is <www.nyp.org/news/2001/disaster/crisis.html>.

A number of APA district branches sprang into action immediately following the attacks on the World Trade Center and the Pentagon. The next issue will report on their activities. ■

Federal Government Moves Fast With MH Funding, Experts

The federal government responds to the terrorist attacks in New York City and Washington, D.C., by sending millions of dollars and experts to help provide short- and long-term mental health and trauma services.

BY CHRISTINE LEHMANN

The psychological impact of the terrorist attacks on World Trade Center and the Pentagon is expected to be felt for months, even years.

Health and Human Services Secretary Tommy Thompson responded to concerns expressed by state and local officials in New York, Washington, D.C., and Pennsylvania last month by sending each a portion of $28 million earmarked for mental health services. The funds are part of a $126 million disaster-relief package primarily for New York City, which has suffered the most casualties and subsequently experienced the highest health care costs in responding to the World Trade Center attacks last month, according to HHS.

John Oldham, M.D., chief medical officer for the New York State Office of Mental Health (OMH), told *Psychiatric News* that days after the attacks the state had received $1 million from HHS and distributed it to New York City to support emergency mental health services.

Of the $28 million designated for mental health services in affected states, $6.8 million will be used for crisis mental health services beyond the initial counseling services supported by the Federal Emergency Management Agency (FEMA) and to assess long-term needs. The remaining $21.2 million will be used to bolster the existing mental health and substance abuse system.

FEMA funds the Crisis Counseling Assistance and Training Program administered by the Center for Mental Health Services Emergency Services and Disaster Relief Branch. CMHS in conjunction with other agencies helps states and communities meet the mental health needs of disaster survivors and rescue workers, according to CMHS.

"We learned from experience with the Oklahoma City bombing that relief workers are at risk for depression, suicidal ideation, and divorce."

U.S. Surgeon General David Satcher, M.D., told *Psychiatric News* that because rescue workers face unique psychological challenges, 43 members of the Commissioned Corps Readiness Force (CCRF), created by the surgeon general in 1994, were deployed last month to monitor and meet workers' medical and mental health needs at ground zero in New York City, the area surrounding the World Trade Center. The CCRF medical team includes psychiatrists, psychologists, psychiatric nurses, and psychiatric social workers, said Satcher.

The CCRF is a group of U.S. Public Health Service officers who can be mobilized in times of disaster or public health emergencies.

"Some mental health specialists have also been deployed to the USNS Comfort, a ship being used for recreation and recovery for the rescue workers," said Satcher.

The goal is to provide 24-hour physical and mental health care for rescue workers, including those who work in search and rescue, law enforcement, and emergency medical services, and construction workers.

"We learned from experience with the Oklahoma City bombing that relief workers are at risk for depression, suicidal ideation, and divorce," said Satcher.

He added that 250 CCRF psychiatrists, psychologists, psychiatric nurses, and social workers have offered their assistance, if needed.

New York City has been inundated with volunteers who are health and mental health professionals (see page 1), Satcher noted. However, he expects the need for mental

see ***Federal Government*** *on page 30*

D.C. Psychiatrists Gear Up For Long-Term Response

Psychiatrists in the Washington, D.C., area take a long view about the need for support to a community that is trying to define normality in the face of unsettling new realities about daily life.

BY KATE MULLIGAN

As New York City struggled to deal with the shock and aftermath of the terrorist attacks that decimated lower Manhattan and took thousands of lives, the situation in Washington, D.C., unfolded somewhat differently.

The attack on the Pentagon, while devastating to the Washington area population, was such that loss of life and damage to buildings and roads was far less than in New York. Unlike the World Trade Center towers, the building is spread out horizontally, hunkering close to the ground, so the plane flown into it destroyed only a portion of the building. That portion had recently undergone renovations and wasn't fully repopulated yet. Moreover, the building sits essentially by itself across the Potomac River from the many federal buildings and tourist sites in Washington, D.C., and is surrounded by acres of parking spaces.

While psychiatrists in the area quickly mobilized to provide assistance immediately after the disaster, they also began planning for residents' long-term mental health needs. Among the stresses with which residents are grappling are worse-than-usual traffic jams because of streets blocked for security reasons; frequent bomb scares; war planning involving themselves, friends, or neighbors; the drone of military planes; and fears that more terrorist attacks—not necessarily involving airplanes—could happen at any moment.

Phone Bank

Former APA President and former Washington Psychiatric Society (WPS) President Harold Eist, M.D., quickly responded to the immediate needs of the public to find ways of dealing with the crisis by organizing a phone bank of local psychiatrists to answer calls from worried viewers of the news at the local CBS-TV station.

"The doctors all acknowledged in their conversations with callers that many uncomfortable feelings—stress, numbness—were normal and that it's important to seek further help, if necessary," Eist said in an interview. The effort was so successful that the station repeated the phone bank the next day.

Primary Care Physicians

In the meantime, the WPS's Executive Committee, in conjunction with its members and Executive Director Walter Hill, began developing a strategy that acknowledges the need to prepare for a sustained effort in helping area residents deal with a changed reality about their safety. Hill said, "We are reaching out to the medical societies in Maryland, the District, and Virginia to let them know that we can provide help to their patients and to help the doctors themselves with what expertise we have. We decided that primary care physicians will be the point of access for many people seeking help."

WPS President-elect Catherine Stuart May, M.D., said, "School nurses are already seeing an increase in stomach aches and other physical complaints. It's important to reach the primary care physicians because we know that somatic complaints are frequent presenting symptoms for PTSD." WPS is preparing a one-page handout for all primary care physicians that will help them recognize symptoms of PTSD and offer opportunities for help from WPS members.

The WPS is also making certain that its own members have up-to-date information about how to deal with patients who may be suffering from trauma. "We are fortunate to have members like Jerrold Post and Robert Ursano, who are national experts on the impact of terrorism and trauma," said May. "But we all will need to become experts." Training sessions about PTSD and other responses to terrorism will be offered to WPS members.

Forums

WPS also organized a series of forums where members of the public met with psychiatrists to discuss their experiences and feelings and identify sources of help. A child psychiatrist was present at each forum to help parents understand how to talk to their

*see **D.C. Response** on page 32*

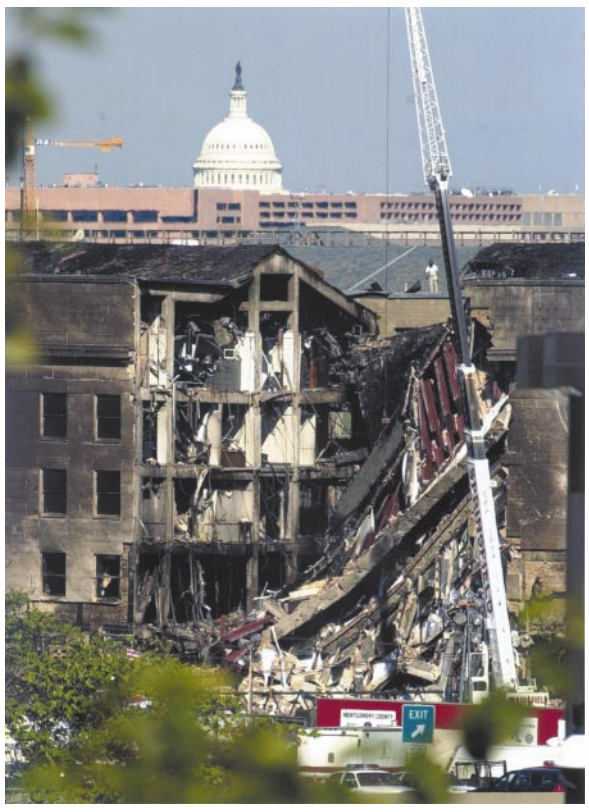
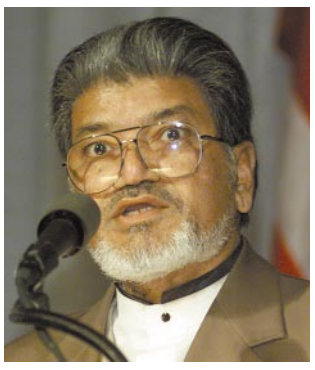


Photo: AP Worldwide/Steve Helber

Days after a hijacked airliner crashed into the Pentagon on Tuesday, September 11, searchers were still hoping to find more survivors.

Lessons Amid Tragedy

BY ARSHAD HUSAIN, M.D.



On September 11 our nation experienced unprecedented death and destruction as terrorists flew hijacked planes into the World Trade Center in New York City and the Pentagon in Washington, D.C. Millions watched their TV sets in dismay as the World Trade Center towers burned and collapsed onto fleeing occupants and rescue workers, and a section of the Pentagon smoldered.

The national reaction understandably has been one of alarm, anguish, and outrage at the carnage and destruction resulting from these acts of terror. There is also an outcry from Americans to identify, capture, and bring the culprits to justice as soon as possible. When the terrorists were identified as members of a fundamentalist Islamic group, a few people engaged in aggression against fellow countrymen who are either of Arab descent and or are Muslims.

Islam is being projected by some as a religion that encourages violence through Jihad (holy war) and terrorism, thus spreading outrage and suspicion against the approximately 9 million Muslims in the United States. This view, although held by only a few, is based on a lack of knowledge and misinformation about Islam and Muslims.

In the ensuing paragraphs I would like to summarize the basic tenets of Islam for the benefit of APA members, many of whom are Muslims and are of Arab descent, and make a few suggestions to address the current needs of Muslims in this country.

Islam is the last of the great Semitic religions, which include Judaism and Christianity. The Muslims believe that Mohammad was the last but not the only prophet who reinforced and immortalized the eternal message of God, which was revealed to many prophets before Mohammad, including Abraham, Isaac, David, Moses, and Jesus. The Quran asserts, "say: we believe in God and that which was revealed to us and that which was revealed to Abraham, and Ishmael and Isaac and Jacob and the tribes and that which was given to Moses and Jesus and to the prophets from their Lord: we make no distinction between any of them and to Him we submit" (Quran 3:83).

The word "Islam" in Arabic means "peace" and "submission to the law of God." These laws were revealed to Mohammad over a period of 23 years beginning in the year 610 AD and are preserved in the Quran. Only through the submission to the will of God and by obedience to His law can one achieve true peace and enjoy lasting security. Three key terms in the Quran (Islam, Iman, Taqwa), which relate to human conduct, mean "to be at peace and safe and to be integral and sound." The task of the Islamic community is defined as "commanding good and forbidding evil with faith in God" (Quran 2:142:110).

Equality in Islam is not just a matter of constitutional right; it is an article of faith that is deeply rooted in the tenets of Islam. The Quran states that all humans are equal in the eyes of God. "O'mankind verily, we have created you from a single pair of male and female (Adam and Eve) and have made you into nations and tribes that you may know each other. Verily the most honored of you in the sight of God is the most righteous" (Quran 49:13).

The Quran asserts that all humans are created by one and the same God, who is just and kind to all his creatures. The Quran states that all humans are equal in the eyes of God. He is not partial to any race, age, sex, or religion. The Quran proclaims "one God and one humanity."

Islamic civilization was therefore the first international civilization on an almost global scale involving people of different faiths, races, and nationalities. As such Islam is the genuine precursor of modern Western civilization. It is not surprising to find striking similarities between Quranic laws and the U.S. Constitution. This is also why Muslims seek to migrate to the United States, where they can practice their religion freely. Many Muslims see the United States as a country of people who naturally live out the Islamic principles.

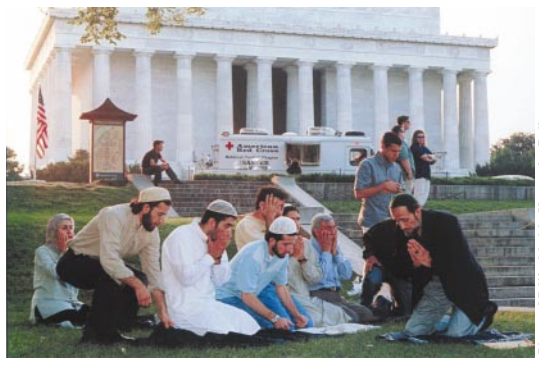


Photo: AP Worldwide/Kamenko Pajic

Muslims offer prayers in front of the Lincoln Memorial in Washington, D.C., on September 23. The prayer session came during an Afghan-American fund raiser for the American Red Cross in response to the terrorist attacks.

Jihad (holy war) in Islam mostly refers to fighting against one's own temptations and evil desires that would compromise one's values. Jihad is not intended to mean war with other countries. Such war is allowed only for self-defense. Islam strongly prohibits terrorism and mandates the preservation of soul, bodies, and property and warns against any transgression upon any human. Islam considers this preservation as a covenant that always exists between Muslims and non-Muslims. The Quran dictates, ". . .and seek not mischief in the Earth; Indeed God loves not those who commits mischief" (28:77).

Suicide under any condition is prohibited in Islam. The Quran emphatically

*see **Viewpoints** on page 28*

Dr. Husain is a consultant to APA's Committee on Psychiatric Dimensions of Disasters and president-elect of the World Islamic Association for Mental Health.

Training Near Ground Zero

BY AVRAM MACK, M.D.

Letterman: So what are these terrorists all about? Is it just mental illness?

Gumbel: I don't know. . . . I just don't know.

David Letterman and Bryant Gumbel, "The Late Show," September 18

As our national and civic leaders have told us in the week since the terrorist attacks on New York City and Washington, D.C., we are stronger now than before. The proof has been the wonderful ways in which Americans have demonstrated a zeal to come together, to help, and to offer their resources, their energies, and their effort.

On Tuesday, September 11, the entire nation was afraid of what might come next. For the first time in my memory the skies were completely clear—there were no airplanes approaching New York's LaGuardia Airport. And then suddenly the sound and sight of a military jet would rattle everyone reeling with anxiety about "other planes." But we pushed on, with courage and dedication to the society and civilization we have built.

This was true for doctors too. Doctors flocked to the scene or to their own emergency departments. And although the injured did arrive in droves at St. Vincent's and Bellevue hospitals, the scene was different elsewhere. Other hospitals geared up, and whole surgical teams waited outside the emergency departments. But few ambulances came. There has been a great deal of frustration on the part of physicians in New York City. The rubble holds more than 6,000 lost.

Psychiatrists have a special role to play in any disaster, especially a violent one like this, and it is not necessarily an immediate role. Over time the public's psychiatric needs will evolve according to the natural histories of PTSD and grief and bereavement.

Similarly, the place of psychiatry in war is a topic about which books and dissertations have been written. We psychiatrists do have a major role to play, and our national and local APA leadership has demonstrated what we can do and what we all must continue to do—organize for the prevention of mental disorders and for care for those affected. In fact, many of those we will meet will never have been in contact with psychiatry before.

But what should we not do? We should not be politicians, no matter how tempting. Consider the period following World War II: Before the war, American psychiatry was clinically oriented, and almost all of its focus was on the severely ill. With the successful application of dynamic psychiatry in the care of combat trauma (60 percent of neuropsychiatric casualties returned to their units within two to five days), it was then applied to homeland psychiatry too, and the purview of psychiatry expanded to comment on the psychopathology of everyone's everyday life. This move was challenged by some APA leaders, such Clarence O. Cheney, M.D., a member of the APA Council (the predecessor of the current Board of Trustees), who wrote to Francis Burlingame, M.D., in 1948, "APA needs at this time [to] uphold the traditions of the Association as a scientific group and not one that is trying to tell people how to live." But his words were ignored, and soon after that time, APA presidential addresses promised that dynamic psychiatry and its study of human motivation would be able to settle the Cold War.

We can help people cope with feelings, but what should we say about anger? Is anger alright? In the days after the attack we psychiatrists heard about "anger." A psychiatrist speaking on television advocated that professional football should be played that weekend so that men's aggressions could be taken out. Some clinic supervisors advocated that we help our patients "understand" the terrorist acts. Anger that is associated with vigilante attacks on persons who appear Middle Eastern may be criminal and require punishment before treatment.

But if psychiatrists work to reduce anger, aren't we effecting a change on the national will? We must not tell normal people what to think about why these events occurred. Similarly, we needn't speculate about the psychopathology of suicide attackers. We should focus on victims and listen to their stories.

On the cold, rainy Friday after the attack, I went to the Lexington Avenue Armory to offer help. The Red Cross asked me and other mental health professionals to sit in a room to which families that had filled out missing-person reports could come to look over the lists of known wounded or hospitalized patients. Those in charge thought that as professionals, we would be most able to inform these families that their loved ones were, in effect, killed. This was entirely new territory for me, sitting across from non-ill, grieving family members and friends of the lost. It was an immense challenge. I could only fall back on attempts to make connections. But these individuals did not wish for connection, they wanted answers. Walking home past the many color copies of pictures of the lost, I felt the day had been an inscrutable experience, but I know that it is one that I will never forget. ■

Dr. Mack is APA's member-in-training trustee. He can be reached by e-mail at avram_mack@hotmail.com.

Job Picture Begins to Brighten For Those With Severe Mental Illness

Employment opportunities for persons with serious mental illness are expanding beyond the 4F jobs: food, filth, filing, and flowers.

BY KATE MULLIGAN

"Too often, people with serious mental illness are relegated to 4F jobs: food, filth, filing, and flowers," said Ray Bridges, president of the board of directors of the Laurie Mitchell Employment Center, a consumer-run jobs training program in Virginia. He explained that those job categories refer to "hamburger flipping, janitorial work, clerical work, and landscaping."

Actually, according to some advocates, it is more likely that a person with a serious mental illness will have no job at all. In 2000, the National Alliance for the Mentally Ill (NAMI) claimed that more than 85 percent of persons with severe mental illnesses were unemployed.

The National Mental Health Association (NMHA) offered a similar analysis, stating that only 10 percent to 15 percent of those with severe mental illness are competitively employed.

Signs of hope are visible, however, in this bleak picture. The need for more employment opportunities is being recognized at the federal level, where the Center for Mental Health Services (CMHS) and the Presidential Task Force on the Employment of Adults With Disabilities at the U.S. Department of Labor are cosponsoring a national summit on employment of persons with psychiatric disabilities.

Psychiatrist Bernard S. Arons, M.D., CMHS's director, told *Psychiatric News*, "A number of factors led to the convening of this summit. In our conversations with consumers, they always rank employment opportunities at the top of their list of needs. And we know that more people are becoming capable of work because of improvements in psychosocial therapy and medication."

"Also, CMHS is just completing our five-year Employment Intervention Demonstration Program in which we looked at innovative employment models combining vocational rehabilitation with clinical services and supports. Finally, on June 18, President Bush issued an executive order that commits the United States to community-based alternatives for individuals with disabilities."

The summit, which was scheduled to take place October 9, is projected to draw 500 representatives from business, government, consumer groups, and the health care professions. Attendees will learn about model projects, recruitment techniques, consumer-operated businesses, skills necessary for supervisors, and issues related to health insurance and Medicaid.

Meanwhile, at the local level, Bridges and others have long been engaged in daily struggles to identify and implement strategies that address some of the problems to be considered at the summit. At the Laurie Mitchell Employment Center, for example, program developers steered clear of any of the 4Fs. Instead, they offer a training program in computer use that combines class instruction with self-paced learning modules.

They also provide a supportive environment and highly visible role models. Most of the members of the board of directors have had some form of mental illness, as have all of the program's staff members. The program requires no fees or referrals and has no restrictions based on income or residence and no time limit in terms of program completion. It is open during the evening and on weekends and is funded with state, county, and private grants.

Moe Armstrong, who has been diagnosed with schizophrenia and spent several years living on the streets, helped initiate an early effort to employ consumers in mental health agencies. He was recruited by Vinfen in 1991, a not-for-profit human services agency based in Cambridge, Mass., when that organization made a commitment to hire consumer staff members for a project to serve people being discharged from a state mental hospital. Armstrong serves as director of consumer and family affairs and codirector of the peer education project.

He and others found that effective training of both supervisors and consumers was critical to the project's success, as were efforts to take steps to reduce role conflict. Recruitment turned out to be surprisingly difficult because many consumers were suspicious of the organization's motives and intimidated by the prospect of employment.

Armstrong identified another problem, noting that "Living with this condition is a full-time job." The evening before his telephone interview with *Psychiatric News*, for example, he said he had awakened at 2 a.m. and been unable to get back to sleep. "Job sharing and part-time work are extremely important, because consumers are not always able to hold full-time positions," he added.

Consumers, however, bring important strengths to mental health agencies. "We've had to learn coping skills, which we can share with others," he said. In fact, Armstrong recently admonished a consumer in one of his support groups who was threatening another group member. "We can be mentally ill, but we don't have to act crazy."

Richard Baron, M.A., former executive director of the Matrix Research Institute, sounded a similar cautionary note in a report delivered at a 1998 conference sponsored by the University of Illinois at Chicago National Research and Training Center for Psychiatric Disability.

"Many consumers have been encouraged to believe that the only goal worth achieving is for them to function 'just like everyone else' on the job—and to make the leap to that kind of normality very quickly."

He wrote that careers might be characterized by part-time work, intermittent work, supported employment, and significant accommodations on the job. Baron believes that success might be better defined as "dealing well with your individual challenges: working as hard as you can work, staying on the job as long as you can manage. . . ."

Arons pointed out that the needs of persons with mental illness for flexible employment opportunities are no different from those of the rest of the population. "When I entered the workplace more than

see ***Job Picture*** *on page 30*

Traumatic Events More Disabling Than Previously Thought

In the wake of last month's terrorist attacks on America, a new study should especially impress upon clinicians the importance of being sensitive to persons who have experienced traumatic events.

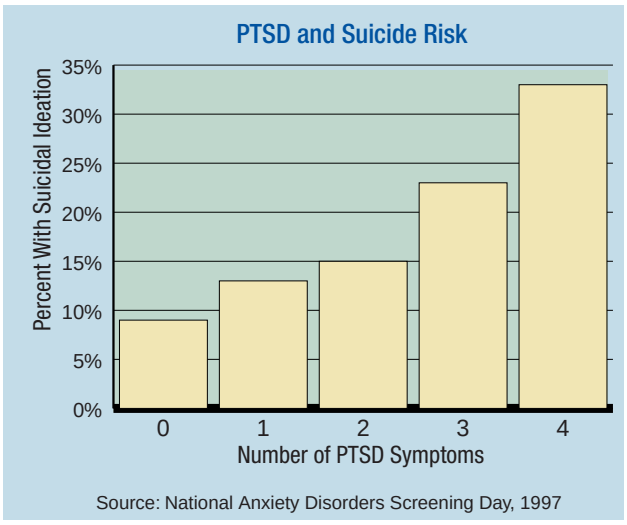
BY JOAN AREHART-TREICHEL

The tragic and frightening events last month at the World Trade Center and the Pentagon raise many questions about the long-term impact of trauma. Results from a new study may help answer some of those questions.

The study suggests that the number of Americans who are psychologically impaired in the wake of highly traumatic events may be much higher than previously thought. The study was conducted by Randall Marshall, M.D., director of trauma studies at the New York State Psychiatric Institute, and colleagues and reported in the September *American Journal of Psychiatry*.

Marshall and his team focused on 9,358 persons who visited one of 1,521 sites that participated in National Anxiety Disorders Screening Day in 1997. Undoubtedly, these individuals did not constitute a cross sample of the American population since they sought out anxiety testing; nonetheless, the sample size was large and broadly distributed throughout the United States.

The 9,358 persons at the sites were asked whether they had ever experienced a highly traumatic event, such as being the victim of a serious crime, being in a bad car accident, seeing someone seriously injured or killed, being sexually assaulted, and so forth, and if so, whether they had experienced at least one month later one or more of the following symptoms: re-experiencing the trauma through recurrent dreams, preoccupations, or flashbacks; insomnia; trouble concentrating; having a short temper; avoidance of any place or of anything that reminded them of the original traumatic event; withdrawal or loss of interest in important things; or inability to experience or express emotions.



A linear association was found between the number of PTSD symptoms that subjects reported and whether they had been contemplating suicide in the previous month.

Twenty-eight percent of the 9,358 persons reported that they had experienced such an extremely disturbing event and had experienced at least one or more of the mentioned symptoms at least one month later. Nine percent of the 28 percent reported that they had experienced all four symptoms and thus met the criteria for full posttraumatic stress disorder (PTSD). The remaining 19 percent of the 28 percent reported that they had experienced anywhere from one to three of the symptoms and thus had what the researchers considered to be subthreshold PTSD.

"The important public health implication of these findings," Marshall and his colleagues wrote in their report, "is that substantially greater numbers of individuals experience disability after trauma than is suggested by simply considering rates of full PTSD."

What's more, the many Americans who are psychologically disabled by traumatic events may be susceptible to anxiety disorders and depression, the study suggested. Specifically, the greater the number of PTSD symptoms that subjects reported, the greater their chances of also suffering from anxiety disorders and/or major depressive disorder, the researchers found.

The many Americans who are psychologically crippled by traumatic events may also be at risk for suicide, the study implied. Specifically, a linear association was found between the number of PTSD symptoms that subjects reported and whether they had been contemplating suicide during the previous month. For instance, whereas only 13 percent of those with one PTSD symptom had been thinking about suicide in the past month, 15 percent with two symptoms had, 23 with three symptoms had, and 33 with four symptoms had (see chart).

If psychological incapacitation in the wake of traumatic events is a much greater health problem than previously thought, and if subthreshold PTSD as well as full PTSD are often accompanied by anxiety disorders, major depression, and/or thoughts of suicide, what can clinical psy-

Ethnic Variations in Depression, Suicide Rates Puzzle Researchers

American ethnic groups differ in their vulnerability to major depression, a new study suggests. Yet the reasons for these differences are not very apparent from the study data.

BY JOAN AREHART-TREICHEL

Are certain American ethnic groups more susceptible to major depression than others? The answer is yes, according to a study conducted by Maria Oquendo, M.D., a psychiatrist at the New York State Psychiatric Institute, and her colleagues and reported in the October *American Journal of Psychiatry*.

Oquendo and her colleagues gathered data about the depression status of various American ethnic groups from two surveys that had been conducted during the 1980s, the Epidemiological Catchment Area Study, conducted by the National Institute of Mental Health, and the Hispanic Health and Nutrition Epidemiologic Survey (HHNES), conducted by the National Center for Health Statistics. The investigators used the one-year prevalence rates of major depression for African Americans, whites, and Hispanics in Los Angeles from the ECA study, which was conducted in five sites in the United States. The investigators used one-year major depression rates for Puerto Ricans on the mainland United States, Mexican Americans, and Cuban Americans gathered by the HHNES in geographic areas where these Hispanic groups were most concentrated.

The one-year prevalence rates for major depression, Oquendo and her team found, were 2.5 percent for Cuban Americans, 2.8 percent for Mexican Americans, 3.5 percent for African Americans, 3.6 percent for whites, and 6.9 percent for Puerto Ricans living on the mainland United States.

When *Psychiatric News* asked Oquendo whether these results, which are based on 1980s data, apply to the present, she replied: "That is a very difficult judgment. Obviously they are dated information. . . . So I am not sure we can extrapolate directly about what's happening today." However, if the findings *are* still relevant today, one can conclude that Cuban Americans and Mexican Americans have a modestly lower prevalence of major depression than whites and African Americans, yet the prevalence of major depression among Puerto Ricans living on the mainland United States is about double that for whites and African Americans.

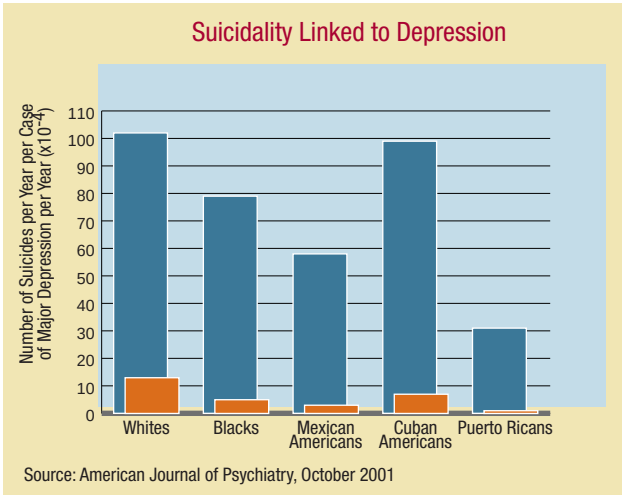
The reasons for these similarities and differences are not so apparent from the study. One possible explanation, the researchers suggest in their study report, is that "since the rates of major depression in Puerto Rico have been shown to be the same as in the general U.S. population, perhaps the migratory process selectively involves Puerto Ricans with higher levels of psychological distress."

Even more baffling is why the prevalence of major depression among the various ethnic groups was not always found to coincide with the prevalence of suicide among the same groups, since major depression is well known to be a significant contributor to suicide.

The investigators used 1986-88 suicide data from the National Center for Health Statistics to determine the annual suicide rate relative to the one-year prevalence of major depression among the five ethnic groups and found that the rate was highest for whites, followed by Cuban Americans, African Americans, Mexican Americans, and finally Puerto Ricans on the mainland. This was the case for both men and women in each ethnic group, although suicide rates were higher among men in each group (see table).

When *Psychiatric News* asked Oquendo why depressed Mexican Americans and depressed Puerto Ricans on the mainland appear to be especially buffered against suicide, she replied: "It may have to do with cultural issues such as relationship with the family and the extended support network, but also with the concept of fatalism. This concept is prevalent in these two cultures. The concept is that things will not necessarily go smoothly—you kind of expect that adversity will occur, and you have to tolerate it and deal with it. I think religion may be related to that as well. But these are just speculations on my part because we didn't have data to analyze that."

see ***Ethnic Variations*** *on page 30*



Five ethnic groups studied by researchers at the New York State Psychiatric Institute had notable differences in their rates of suicide relative to one-year prevalence of major depression.

Thompson Forced to Defend President's Stem-Cell Decision

HHS Secretary Tommy Thompson responds to concerns from members of Congress about the number and viability of stem-cell lines on which President Bush has allowed research to proceed.

BY CHRISTINE LEHMANN

Health and Human Services Secretary Tommy Thompson insisted at a Senate committee hearing in early September that despite media reports to the contrary, at least 64 embryonic stem-cell lines meet the president's criteria of having been created before August 9, when President George W. Bush announced his decision on federally funded stem-cell research.

When pressed by members of the Senate Health, Education, Labor, and Pensions (HELP) Committee, Thompson conceded that only about 25 of the 64 cell lines are developed enough to be of use to researchers in the near future.

Thompson was grilled in August by the Senate committee about the implications of the president's announcement allowing federal funding for research on stem-cell lines derived from human embryos before the date of his announcement.

Thompson reassured committee members that researchers can work with a limited number of stem-cell lines. "University of Wisconsin scientist James Thomson was the first to isolate human embryonic stem cells and has done nearly all his research on just two stem-cell lines," said Thompson.

HELP committee chair Sen. Edward Kennedy (D-Mass.) praised Bush for opening the funding door to stem-cell research and recognizing that embryonic stem cells may be valuable in treating and curing a range of diseases including Parkinson's, Alzheimer's, and certain forms of cancer.

But Kennedy and other committee members questioned whether Bush opened the door wide enough when he chose to limit the supply of stem-cell lines to those in existence prior to August 9.

Deadline Arbitrary

Sen. Arlen Specter (R-Pa.), whose bill, S 723, would allow researchers unlimited access to discarded or destroyed human embryos (*Psychiatric News*, September 7), said the deadline was arbitrary given that the president made his decision without all the facts.

"We know very little about the quality of the existing stem-cell lines, their owners, and their willingness to share, and what the effects are of contamination with mouse cells. We will need to conduct an independent review of all the facts," said Specter. He and Sen. Tom Harkin (D-Iowa) conducted two additional hearings on stem-cell research last month.

Thompson was clear that the president has no intention of reconsidering the August 9 cutoff date. The HHS secretary repeatedly told the senators that questions about the quantity and quality of stem-cell lines will be answered only through conducting basic research.

Thompson added that a registry of stem-cell lines that meet the president's criteria will be available on the National Institutes of Health (NIH) Web site sometime this month. To qualify, the cells must have been taken from human embryos created for reproductive purposes and destroyed before August 9. The donors must have provided informed consent and received no financial incentives for donating embryos, according to Thompson.

The NIH registry will provide information on how to contact the owners, which are 10 companies or laboratories in Sweden, Israel, India, Australia, and the United States, said Thompson.

The NIH may also provide information in the future about how the stem cells were derived, the culture conditions, growth characteristics, and quality assurance data, said Thompson.

Proprietary Issues

Douglas Melton, Ph.D., chair of the department of molecular and cellular biology at Harvard University, testified at the Senate HELP committee hearing last month that he is concerned that the NIH plans to require scientists to negotiate directly with the owners to obtain access to their cell lines.

"Most of the entities that have isolated the 60-plus human embryonic stem-cell lines are companies with proprietary and commercial interests. In addition, there are relevant patents on some of the cells that may further restrict their distribution and use," said Melton.

Thompson reassured members of the Senate HELP committee that HHS was tackling proprietary issues. He announced that an agreement was signed in September between the NIH and the WiCell Research Institute licensed by the Wisconsin Alumni Research Foundation to distribute stem cells. The agreement gives NIH-funded researchers access to WiCell's five stem-cell lines, said Thompson.

"Researchers can access these lines for their own research and freely publish the results. The agreement also allows the NIH to retain its ownership of any intellectual property that might arise from its research on these cell lines," said Thompson.

"This is a groundbreaking agreement

see ***Stem Cells*** *on page 30*

Bona-Fide Hypochondriacs A Rare Breed, Study Finds

Although many people appear to be worried about their health, very few seem to qualify for a full-fledged diagnosis of hypochondriasis, a Canadian study suggests.

BY JOAN AREHART-TREICHEL

Henry, a 50-something-year-old from Dayton, Ohio, grumbled to his wife: "Every time I go to my doctor about this or that symptom, he checks me out and says that he can't find anything wrong with me! It happened with my night sweats, it happened with the pain in my lower abdomen, it even happened with the mole on my chest. I guess I'm just a hypochondriac!"

Chances are, however, that Henry isn't a hypochondriac at all since a study published in the May issue of *Psychological Medicine* suggests that bona-fide hypochondriacs are rare indeed. However, Henry may well be one of those health worriers—health worrywarts if you like—since the study suggests that there are considerably more of them around.

The study was conducted by two Canadian psychiatrists—Karl Looper, M.D., and Laurence Kirmayer, M.D. They are affiliated with the Institute of Community and Family Psychiatry at the Jewish General Hospital in Montreal and with McGill University.

Looper and Kirmayer recruited subjects for their study from the Montreal area. Subjects were randomly selected from the phone book and also chosen from census tracts that included three of Montreal's immigrant populations—Vietnamese, Filipino, and Caribbean. Their final sample included 533 individuals.

During phone interviews with these 533 persons, the researchers asked questions designed to reveal whether the individuals might have a diagnosis of hypochondriasis or be modified illness-worriers. To be considered a hypochondriac, an individual had to believe persistently for at least six months that he or she had a serious physical illness, to experience such psychological distress from this conviction that it interfered with his or her life and prompted physician visits, and to refuse reassurance from physicians that he or she was not ill—in other words, meet the *DSM-IV* criteria for hypochondriasis.

An illness-worrier, in contrast, had to answer "yes" to the question, "In the past 12 months have you had a period of six months or more in which you worried about having a serious illness most of the time?"

Only one of the 533 subjects interviewed, that is, 0.2 percent of the sample, turned out to be a full-blown hypochondriac, Looper and Kirmayer report. In contrast, 33 of the 533 subjects, or 6 percent of the sample, turned out to be illness-worriers. And Canadian-born subjects and non-Canadian-born subjects had similar numbers of the illness-worriers among them.

Further, of the 33 illness-worriers, 17 actually had the illness about which they worried. Four had arthritis, two had diabetes, and the others had illnesses such as asthma, ulcers, multiple sclerosis, or Raynaud's disease.

As for the 16 illness-worriers who did not have the medical condition they worried about, their anxieties concerned such illnesses as cancer, AIDS, and gastrointestinal disorders or fears described by phrases such as "Something inside my head might break" or "I think I'm going crazy."

But perhaps the most interesting study result had to do with the extent of psychological anguish that illness-worriers experience, and how that anguish in turn disables them mentally and physically and prompts them to seek medical help. In other words, Looper and Kirmayer compared the psychological distress, bodily symptoms, disability due to bodily symptoms, and health care use of the 33 illness-worriers in their study with the psychological distress, bodily symptoms, disability due to bodily symptoms, and health care use of the 499 subjects who were free of illness worries.

The illness-worriers scored higher than the nonworriers on all counts. For instance, illness-worriers, regardless of whether they had an underlying medical disease, visited general practitioners, medical specialists, and hospital emergency rooms more than the nonworriers did.

When *Psychiatric News* asked the researchers whether their findings hold any particular implications for psychiatrists, Kirmayer replied: "Maybe there is an argument for trying to think about dimensions of illness worry rather than looking at hypochondriasis as a distinct disorder."

Looper added, "What our study found is that it may be important to look more broadly at the idea of illness worry as opposed to simply this more extreme form of hypochondriasis, and also to look at illness worry in the cases of patients who actually have a medical problem, because the worrying may be making their problem even worse." ■

M.D.s May Halt Alzheimer's Medication Too Soon

Most clinicians believe that there comes a point in the treatment of Alzheimer's disease when standard medications no longer provide any benefit, and they stop prescribing them. A new study refutes this common practice.

BY JIM ROSACK

Acetylcholinesterase inhibitors (AchEIs) are commonly prescribed to patients with mild to moderate Alzheimer's disease, with most clinicians believing they are helpful in the vast majority of cases. However, it has been common practice that as the disease progresses, the medication is discontinued, under the assumption that the disease process has advanced beyond the ability of the medications to provide any further benefit. New evidence now indicates that these drugs may indeed be of benefit, well into the advanced stages of the disease.

In the new report, which appeared in the August 28 issue of *Neurology*, Howard Feldman, M.D., director of the University of British Columbia Hospital's Clinic for Alzheimer's Disease and Related Disorders, investigated with his colleagues in the Moderate to Severe Alzheimer's Disease Study Group (MSAD) the efficacy and safety of continuing donepezil (Aricept) in patients with moderate to severe symptoms. The research was funded by Pfizer Pharmaceuticals, which markets Aricept along with Eisai Co., Ltd.

"We already know that treatment with [donepezil] for people with mild to moderate Alzheimer's disease slows progression of symptoms such as [a decline in] cognition and loss of function and may be associated with a delay in nursing home placement, allowing loved ones to stay at home longer," Feldman said in a press release announcing publication of the report. "These findings further reinforce the significance of [donepezil] as an important choice to preserve patients' independence longer while they live with the disease."

Approved for the treatment of mild to moderate Alzheimer's disease, donepezil is the leading AchEI in the global market. No medications are yet approved for the treatment of moderate to severe Alzheimer's disease.

Feldman's group looked at nearly 300 patients who were diagnosed with mild to moderate Alzheimer's and were randomized to a 24-week, double-blind trial of either donepezil or placebo. Those receiving the drug started with 5 mg a day for the first 28 days, at which point the medication could be increased to 10 mg a day per the clinicians' judgment.

Only patients in assisted-living and community-based residential programs were enrolled in the study. No patients requiring full-time nursing care were included. All patients were rated at baseline and scored an average of 11.7 using the standardized Mini-Mental State Examination (sMMSE). All patients in the study had a Functional Assessment Staging score of less than or equal to 6 at the start of the study.

Patients who received donepezil not only remained stable, but also showed statistically significant benefits on the Clinician's Interview-Based Impression of Change with Caregiver Input ($p < 0.001$). Sixty-three percent were rated as improved or having no change on the CIBIC+, compared with 42 percent of the placebo group at week 24.

In addition, the group taking the drug showed less decline on average compared with placebo-treated patients on both instrumental and basic activities of daily living. The group receiving donepezil also showed statistically significant overall improvement versus the placebo group in behavioral problems, especially apathy, depression, and anxiety.

At week 24 the donepezil group scored an average of 1.79 points higher on the sMMSE than did the placebo group ($p < 0.0001$). Total scores on the Neuropsychiatric Inventory improved 4.6 points for the donepezil group versus a decline of 1 point for the placebo group. This resulted in a difference of 5.6 points in favor of the group that received treatment ($p = 0.0005$).

Eighty-four percent of the donepezil subjects and 86 percent of the placebo subjects completed the trial. Adverse events were experienced by 83 percent of the donepezil subjects and 80 percent of placebo subjects; 8 percent of donepezil patients and 6 percent of placebo patients dropped out of the study due to those adverse events. The most commonly reported side effects for donepezil reported during the study included diarrhea (12.5 percent for donepezil and 4.8 percent for placebo), headache (11.8 percent versus 4.1 percent), arthralgia (6.9 percent versus 1.4 percent), and vomiting (6.9 percent versus 2.7 percent).

According to Feldman, he and his colleagues are continuing to look at using donepezil in patients in the more advanced stages of Alzheimer's and comparing the drug with other members of its class. They are also looking at larger sample sizes and adding more sensitive measures, such as the ADAS-cog.

An abstract of "A 24-Week, Randomized, Double-Blind Study of Donepezil in Moderate to Severe Alzheimer's Disease" is posted on the Web at <www.neurology.org/cgi/content/abstract/57/4/613>. ■

viewpoints

continued from page 18

states, "Do not kill yourself for God is merciful to you."

In summary, Islam offers a comprehensive methodology for solving mankind's spiritual, intellectual, and day-to-day problems. God is the absolute transcendent creator and the master of all things. A total submission to His will and a trust in His mercy provide eternal peace. His laws are aimed at achieving peace, safety, and tranquility and to inculcate a healthy, moral, safe, and peaceful society. Misfortunes may occur as God tests his people, and enduring these misfortunes with patience and piety elevate one's status in His eyes.

In conclusion, the terrorist attacks of September 11 have a profound adverse impact on American Muslims. Like other Americans, Muslim Americans feel vulnerable and enraged at those who brought this horrific calamity upon our nation. But unlike other Americans, they are feeling an additional threat—perhaps more serious than the direct hit—from some of their countrymen, who in their confusion are displacing their anger at them. Muslim Americans have become fearful of the safety of their children and their families. These fears have begun to take psychological tolls on them. Many are reporting anxiety, sleep disturbance, and despondency. Others are concerned about their future in this country.

As psychiatrists and members of APA, we have a duty to ensure that American Muslims do not become victims of prejudice, violence, and hate crimes. We also need to be mindful of Muslims' special psychological needs during this rough time in their lives. District branches that are so admirably engaged in meeting the psychological needs of their local communities should make extra efforts to reach out to their Muslim population. Psychiatrists may use their influence in their communities to mobilize compassionate support from the community, government agencies, and religious institutions.

The plight of American Muslims underscores the need for cultural sensitivity for all ethnic groups living in the United States. This includes the need for better residency training in cultural competence.

Further information about Islam is available in the chapter written by the author in the book* Handbook of Religion and Mental Health, *edited by Harold G. Koenig (Academic Press, New York, 1998). The title of the chapter is "Religion and Mental Health From the Muslim Perspective." ■

letters to the editor

Medication Marketing

The article on the war over side-effect claims regarding atypical antipsychotic medications highlights some important issues concerning the pharmaceutical industry's current role in our mental health care system. In that article, which is in the August 3 issue, Alan Brier, M.D., is quoted as saying that "patients and their doctors will speak with their prescription pads" when it come to choosing which antipsychotic medication is best for a particular patient. This statement is, in fact, only partially true. If pharmaceutical companies get to the individuals who determine which drugs are "formulary" and which ones are not, the deck may be stacked in favor of certain medications before physicians even get their pads out. As a psychiatrist employed by a large, federally funded institution, pharmaceutical company representatives have informed me that they meet regularly with individuals in the department of pharmacy in an effort to ensure that their products are available on the formulary.

I'd be interested in a study of pharmaceutical companies' marketing efforts to pharmacists and individuals who head the departments of pharmacy and formulary in organizations such as VA medical centers, state departments of mental health, and managed care companies, all of whom are in position to affect the composition of formularies. During a conversation regarding the drop of a particular psychotropic medication from the formulary at our VA medical center (a decision in which our department had no appreciable input), a psychiatrist colleague of mine made the observation, "It's their budget, not ours." As long as formulary decisions are made by the people who "hold the purse strings," psychiatrists' ability to prescribe antipsychotic medications according to individual patients' medical needs and clinical response will likely be hampered.

Later in the article, Ira Glick, M.D., does well by emphasizing the need for physicians to make these clinical choices, and for the choices to be made based on research data. Pharmacists, pharmaceutical representatives, and health care administrators do not have adequate expertise to make the sorts of clinical distinctions necessary to select the proper antipsychotic medication for a particular clinical case or clinical subtype. This article reminds us that we need to monitor the marketing efforts of for-profit organizations such as pharmaceutical companies and to view these efforts with caution.

JUDY SIGMUND, M.D.
Dayton, Ohio.

Readers are invited to submit letters not more than 500 words long for possible publication. Submission of a letter implies consent for publication unless otherwise indicated. All letters are subject to editing to meet style, clarity, and space requirements. Receipt of letters is not acknowledged. Send submissions to Letters to the Editor, *Psychiatric News,* at 1400 K Street, N.W., Washington, D.C., 20005; fax: (202) 682–6031; e-mail: pnews@psych.org.

Choosing Terminology

We psychiatrists should use terms or ideas that are more descriptive so that our communications with each other and with the general public are more clearly understood. In 1970 I wrote that the term "guilty by reason of insanity" is more appropriate and realistic than the term "not guilty by reason insanity." In 1976 I wrote that "perpetrators of capital crime often have not been habilitated, so that rehabilitation for this group of criminals is highly improbable or impossible." I now suggest that a more appropriate term for some mothers (or fathers, boyfriends, or other surrogates) who harm a young child could be "postpartum aggression" rather than "postpartum depression."

LEWIS H. RICHMOND, M.D.
San Antonio, Tex.

Trauma

xontinued from page 24

chiatrists do about it?

First off, Marshall explained to *Psychiatric News*, "You really have to ask patients directly about their trauma histories. The reason is that it is not picked up the vast majority of the time even when people are in some kind of a treatment situation...It may be because they are ashamed of bringing it up or because it is the nature of the disorder to be wary of someone who might potentially hurt you or who might seem like a powerful figure."

Secondly, Marshall said, "I think clinicians should consider doing a broader assessment than simply the presence or absence of PTSD. They should also consider that a subthreshold PTSD symptom pattern could also be associated with very serious disability, including suicidal ideation. That is the message there. In other words, do not follow the DSM like a cookbook." This advice, he added, is especially pertinent in view of the terrorist attacks on the World Trade Center and Pentagon, where not just thousands of Americans were directly affected by the events, but where millions of Americans were indirectly affected as well.

Finally, Marshall said, "our assumption, until it is studied, is that you would treat [subthreshold PTSD] the same way you would treat PTSD—that is, you could recommend the range of psychotherapies and medications that have been shown to be effective. And I would suspect that you would see as good a response, or perhaps an even better response, than you see with the full syndrome."

"Comorbidity, Impairment, and Suicidality in Subthreshold PTSD" is posted on the Web at <ajp.psychiatryonline.org> under the September issue. ■

Stem Cells

continued from page 26

that will hopefully serve as a model for making the other lines available," added Thompson. He said that the other nine entities have indicated their interest to the NIH in sharing their stem cell lines but have not entered into any written agreements. "We will continue to work with all stem-cell owners to address proprietary issues," promised Thompson.

Kennedy also complained that the president's August 9 deadline precludes scientists from developing alternatives to growing human embryos in cultures with mouse cells. He noted that a federal guideline prohibits the testing in humans of substances mixed with animal cells because of possible infection or rejection.

Thompson confirmed that all existing stem-cell lines have been grown with mouse nutrients. He reassured Kennedy and committee members that the Food and Drug Administration is willing to approve clinical trials in humans of substances mixed with animal cells and has already done so in investigations of new drugs. He disagreed with Harkin that the human cells were "contaminated" by interacting with the mouse cells but didn't elaborate.

The Human Embryonic Stem Cell Registry will be available sometime in October on the NIH web site at <www.nih.gov>. ■

Ethnic Variations

continued from page 25

However, such data may be forthcoming, she indicated, since "we are currently doing a study looking at reasons for living among the Hispanics compared with non-Hispanics to see whether we can identify the particular things, at least cognitively, that might keep Hispanic people further from suicide, or protect them, if you will."

Identifying psychological factors that protect people against suicide is a major goal of their research, Oquendo indicated.

"Ethnic and Sex Differences in Suicide Rates Relative to Major Depression in the United States" is posted on the Web at <ajp.psychiatryonline.org> under the October issue. ■

Job Picture

continued from page 21

30 years ago, it was full time or nothing," he said. "Today, there is an incredible variety of work schedules and arrangements. People telecommute; offices operate around the clock and offer all kinds of different time schedules."

"For anyone interested in mental health," he added, "it's important to remember that recovery is enhanced by opportunities for employment. And, for the sake of the society, we need to make full use of the skills and talents of all our people."

The Web address of the Matrix Institute is <www.matrixresearch.org>; the Web address for the National Research and Training Center on Psychiatric Disability is <www.psych.uic.edu/uicnrtc> ■

Federal Government

continued from page 16

health services to continue as posttraumatic stress disorder and other psychiatric problems surface.

Satcher noted that Robert DeMartino, M.D., a child and adolescent psychiatrist with the CMHS Program in Trauma and Terrorism, and Brian Flynn, Ed.D., assistant surgeon general and director of the CMHS Division of Program Development, Special Populations and Projects, were among the federal mental health and crisis-response experts sent to New York City last month to support the state and city governments provide mental health services and assist in long-term planning efforts.

Information on HHS health and mental health disaster relief efforts is available on the HHS Web site at <www.hhs.gov/news/press/2001pres/20010920a.html>. ■

Medical Privacy

continued from page 2

The medical association suit maintains that if allowed to stand, the privacy regulations HHS developed will have serious consequences for physicians and patients. The regulations "ignore the realities of current medical practices and will delay and impede critical health care operations," the suit says, through "increased costs of health care, massive new paperwork requirements for all involved in the field of health care, and serious inconvenience to all patients."

"The HIPAA regulations will add huge bureaucratic costs to the health care system, whatever its aims may be. It seems like overkill," James Scully, M.D., told *Psychiatric News*. Scully is chair of the department of neuropsychiatry and behavioral science at the University of South Carolina School of Medicine and immediate past-president of the South Carolina Psychiatric Association.

The SCMA suit indicates that the medical association is troubled by the fact that HHS acted without congressional guidance, because HHS, the agency that drafted the privacy regulations, turns out to be "the only entity that can enforce the privacy provisions," a situation that "empowers the HHS bureaucracy instead of the aggrieved individual. Fines imposed for the improper release of individually identifiable health information are paid to the federal government," the SCMA points out, "and the individual actually harmed by the disclosure is not provided *any* personal relief by the HHS privacy regulations." It labels this regulatory scheme "self-serving" on HHS's part.

The SCMA also maintains that the HIPAA regulations are "flawed" because they allow states with laws that mandate stricter privacy and disclosure requirements than the new federal rules to preempt the federal rules. "The determination of whether state laws are more stringent is no easy task," the SCMA states, and thus the HIPAA regulations are "too vague to be enforced, especially through criminal penalties."

The preemption wording is so vague, the suit states, that no "person of ordinary intelligence" would be able to determine whether state medical-privacy rules are actually more or less strict than the new federal ones, leaving physicians and others covered by the rules at risk of being charged with violating whichever set of rules did in fact hold sway.

The SCMA is hoping that a federal court—the suit was filed in the Columbia Division of the U.S. District Court for South Carolina—will nullify the privacy regulations for being unconstitutional and send the issue back to Congress, where elected representatives who are more accessible to constituents' concerns will be forced to grapple with the development of medical-record rules.

HHS officials had 60 days from the July 16 filing to respond to the SCMA lawsuit.

The SCMA's suit does not reflect any formal input from the South Carolina Psychiatric Association, whose president, J.T. Thornhill, M.D., said he was "disappointed" that the SCMA did not consult with or seek input from the state's primary psychiatric organization.

[*South Carolina Medical Association, et al. v. U.S. Department of Health and Human Services and Tommy G. Thompson, Secretary*, U.S. District Court for the District of South Carolina, Columbia Division] ■

Second Suit Targets Privacy Rules

The South Carolina Medical Association is not the only medical organization turning to the courts to halt the implementation of the HIPAA regulations on medical-record privacy (see story on page 2). On August 30 the Association of American Physicians and Surgeons (AAPS) filed suit against HHS in U.S. District Court in Houston. Based on different grounds than the SCMA suit, the AAPS claims that the medical-privacy regulations are illegal because they violate the First, Fourth, and Tenth amendments of the U.S. Constitution, as well as the law known as the Paperwork Reduction Act.

The organization alleges that the rules violate the First Amendment by interfering with the rights of physicians and patients to speak confidentially to one another about treatment, the Fourth Amendment by requiring physicians "to aid and abet searches of patient medical records" without a warrant to do so, and the Tenth Amendment by "disrupt[ing] traditional state law governing. . .confidential, intrastate activity." The suit contends that the regulations violate the Paperwork Reduction Act by placing a mandatory, unfair regulatory burden on small medical practices without having examined "more cost-effective alternatives."

The AAPS objects primarily to the intrusive nature of the regulations and their potential for breaching patient confidentiality. Its public affairs counsel, Kathryn Serkes, said at a Washington, D.C., news conference announcing the suit, "When it comes to government prying, these rules obliterate any remote notion of patients' rights. [Under the HIPAA rules] doctors are required to disclose all patients' records to thousands of federal bureaucrats—with or without consent. That includes handwritten notes and psychiatric records. . . . While some of the rule's specifics could be ironed out down the road, no amount of fine-tuning can fix a flawed approach. Only a fresh start will head off irreparable damage to patients and their trust in the system."

The suit*, Association of American Physician & Surgeons, et al. v. U.S. Department of Health and Human Services, and Tommy G. Thompson, as Secretary, *U.S. District Court for the Southern District of Texas, Houston Division, can be read on the Web at <www.aapsonline.org> by clicking on the heading "AAPS Docs Sue to Stop HHS Privacy Regs."

professional news

Violent Behavior

continued from page 6

loving, caring relationship which existed between him and his wife and with their happy marriage of 50 years."

In his testimony Hawkins hinted at possible hallucinations, mirroring the Wyoming accounts. "I was looking at my wife, but I wasn't seeing her face," Hawkins told the court, describing the moments in which he strangled her to death. He then attempted to kill himself.

Spokespersons for Pfizer Inc. defended the drug, saying there is no evidence to suggest that it has any side effects of aggression, aggravation, or delusions. William Ketelbey, M.D., senior medical director for Pfizer in Australia, attempted to reassure both patients and prescribing physicians of the drug's track record.

"Only one side—the defense—presented any data about the side effects of Zoloft," Ketelbey said in a prepared statement following the Australian judge's ruling, "and what occurred could hardly be considered a rigorous examination of all the clinical and medical data surrounding this medicine. While we are sympathetic to all parties involved in this tragedy, the public health is best served by accurate information about both this important medicine and the dangers of untreated depression."

A spokesperson for the Australian Therapeutic Goods Administration, the equivalent of this country's FDA, said that this fall the agency would review data on sertraline and violent behavior. She told *Psychiatric News* that the administration would consult regulatory agencies and Pfizer about whether they are aware of other reports attributing serious criminal behavior to the drug.

Do Data Speak for Themselves?

Anecdotal reports of violent and suicidal behavior have been tied to fluoxetine, paroxetine, and sertraline for a number of years. At this point, however, published data do not support the allegations.

Last year Arif Khan, M.D., and his colleagues published a study in the April issue of *Archives of General Psychiatry* looking at suicide risk in antidepressant clinical trials, using the Food and Drug Administration database.

Khan wanted to know whether it was safe, and ethical, to include placebos in clinical trials of antidepressants using actively depressed patients. The review found that among nearly 20,000 participants in clinical trials of SSRIs, a total of 34 had committed suicide, and 130 had attempted suicide. Khan also found that the "rates of suicide and attempted suicide did not differ significantly among the placebo and drug-treated groups." He and his colleagues concluded that it was, therefore, safe to include placebo arms in antidepressant clinical trials.

The University of Wales's Healy has a different point of view. Healy has combined the data looked at by Khan with additional data accessed through the Freedom of Information Act. Healy maintains that his analysis—which is being prepared for publication—of the suicide and suicide attempts shows that a significant number of events occurred during the placebo washout phase in the clinical trials; when patients enter that phase, they may have been taking another antidepressant, which must be washed out of their system prior to the start of the drug trial. Healy noted that some suicides or attempts occurred during the washout, as opposed to occurring when a patient was continuously taking placebo or active trial drug.

"Now, when you strip those out and just look at the true placebo suicides and suicidality versus the true SSRI suicides and suicidality," Healy told *Psychiatric News*, "there's an absolute increase in suicides and suicidal acts on the active antidepressants compared with placebo."

Although Lilly, Pfizer, and GSK did not return phone calls from *Psychiatric News* requesting input for this story, each has publicly said previously that they believe the data show their products are safe.

Revising Labeling

Current FDA-approved labeling of all three drugs includes general warnings about the ability of SSRIs to activate mania and hypomania and about suicide risk being inherent in depression, particularly early in treatment.

Critics of the medications believe that the potential of the drugs to cause violent and/or suicidal behavior is documented well enough to cause the FDA to require stronger warnings to both physicians and patients. However, the FDA has said that it sees "no reason to revise the currently approved labeling at this time."

The British Medicines Control Agency has indicated it is working with the companies concerned to strengthen the current language regarding risks for suicidal thoughts and acts (*Psychiatric News*, December 1, 2000). ■

from the president

continued from page 3

to let our collective anger be misdirected inward toward our own members, many of whom have played key roles in rescue and early intervention efforts in New York City and Washington, D.C. By joining together and refusing to become divided, we attain victory over the cowardly terrorists, who, in my opinion, are no more Muslim than members of the Ku Klux Klan are Christian.

Most APA members are not members of the "greatest generation." We are their children and grandchildren. They were common people asked to do uncommon things for the sake of humanity and history. It is clear that this generation will be asked to make extensive sacrifices over an extended period. Surgical strikes will not be adequate, just as brief counseling will in most cases not adequately deal with the trauma we have experienced. We will set up new programs and treatment methods that will spring from the minds of psychiatrists trained in our traditions of the doctor-patient relationship and psychodynamic principles and honed on the cutting edge of biological science.

This great profession is being summoned by history to take a leadership role in helping a country recover from an unprecedented trauma. The road map is a little unclear 48 hours out, but APA is blessed with experts in responding to disasters, posttraumatic stress disorder, grief, anxiety, and loss. We will borrow ideas from our uniformed services colleagues and help them improve their service to citizens in the military. We will unify our approaches to helping those in this country and our global brothers and sisters. We will use this tragedy to unite ourselves for the good of our patients and improve our treatments for the good of all.

The cowardly terrorists who thought their fanatic actions would divide us, cower us, and bring us to our knees were mistaken. They don't know us. Now we will show them who we truly are. ■

Satcher

continued from page 1

represented in mental health research. Their cultures, however, also differ in ways that influence the efficacy of mental health services.

A disproportionate number of African Americans, for example, are represented in the most vulnerable segments of the population—people who are homeless, incarcerated, in the child welfare system, victims of trauma—all populations with increased risk for mental disorders. Asian Americans, by contrast, earn the highest average income of the four groups, Satcher told the audience. Asian Americans, however, often show the most severe symptoms when they seek help because shame and stigma may discourage them from acknowledging mental illness until their psychopathology becomes severe.

Access for Hispanic Americans is limited by the lack of Spanish-speaking mental health professionals. Clinics and hospitals of the Indian Health Service are located on reservations, yet the majority of American Indians no longer live on them.

The surgeon general also offered a brief overview of the state of Americans' mental health. "Mental disorders are real, and they are common. Every year, 1 in 5 people suffers some form of mental disorder. The good news is that 80 percent to 90 percent of them can be treated and returned to productive lives and relationships. The bad news is less than half ever seek treatment, in part because of the stigma surrounding mental illness."

Satcher concluded with a list of ways APA members could help realize the vision of equality outlined in the report. "Go into your communities to develop mental health systems that are culturally competent. We need more professionals who are members of minority groups, but we can't wait until they are trained. We need to empower people in the communities to work with us."

He also urged the audience to work more closely with primary care clinicians. "They are on the front line and must become more attuned to recognizing the need for mental health services." Financial barriers to equal access must come down, he said, citing the importance of federal legislation for mental health parity. (See box for the report's full recommendations.)

APA Responds

The messages of the report clearly resonated with APA members. Carl Bell, M.D., president of the Community Mental Health Council in Chicago, introduced Satcher to the audience, calling him a "physician's physician" and telling of Satcher's commitment to public health, his sense of strategy, and willingness to take risks.

Bell, who had helped develop the report, expanded on those comments in an interview with *Psychiatric News*. "This report elevates the conversation about racial disparities in mental health services and brings together in one place a great deal of useful information. The recommendations are sound and can be accomplished."

Altha Stewart, M.D., chair of the APA Council on Psychiatric Services, who responded to the surgeon general's presentation at the meeting, said, "We all want to commend Dr. Satcher for his tireless work. The highest-ranking health official in the country agrees with us that it's necessary to acknowledge the role of culture in providing mental health services. To those of us in the room who have been working in the field of cross-cultural psychiatry for more than 20 years, I say, 'We are vindicated.' Our work has not been in vain.' "

APA President Richard Harding, M.D., called Satcher "a personal hero of mine" and said, "Dr. Satcher, we are with you in our commitment and dedication to improving access to quality psychiatric care. . . .in fighting stigma that affects our patients and the professionals who care for them. . . , in eliminating disparities in psychiatric care for members of minority groups, and in using scientific rigor to arrive at credible recommendations."

Harding concluded the meeting by awarding Satcher a presidential commendation in "recognition of his superb leadership in battling against the stigma and prejudice affecting persons who suffer from mental illness" and announcing that he would appoint a work group on the implementation of the report.

The cochairs of that group, named the Steering Committee for Eliminating Disparities in Access to Psychiatric Care, are Altha Stewart, M.D., and R. Dale Walker, M.D. Other members are Harding, Carl Bell, M.D., Edward Foulkes, M.D., Ph.D., Francis Lu, M.D., Patricia Isbell Ordorica, M.D., and Pedro Ruiz, M.D. The staff liaison is James Thompson, M.D., deputy medical director and director of the APA Division of Education, Minority, and National Programs.

The 200-page report is a supplement to the "Surgeon General's Report on Mental Health," issued in 1999. The new report is available on the Web at <www.surgeongeneral.gov/library/mentalhealth/cre/default.asp>. ■

How Can Minorities' Access to Care Be Improved?

In September U.S. Surgeon General David Satcher, M.D., issued a report titled "Mental Health: Culture, Race, and Ethnicity," which identifies barriers to effective mental health care faced by ethnic and racial minority populations. Here are the recommendations in the report:

- Continue to expand the science base of mental illness. In particular, work to resolve uncertainties about the extent of mental illness among different racial and ethnic groups. Examine how factors such as acculturation, stigma, racism, and spirituality provide protection from, or risk for, mental illness. Consider the efficacy of guideline- or other evidence-based treatments.
- Improve access to treatment. Bring mental health services to where people are. Integrate mental health care and primary care. Improve language access. Coordinate care to vulnerable, high-need groups.
- Reduce barriers to mental health care. Work to make services appropriate for minorities and promote mental health coverage for uninsured Americans. Establish parity between mental health coverage and other health care coverage.
- Improve quality of mental health care. Deliver effective treatments based on evidence-based professional guidelines. Individualize treatment in the clinical setting to each patient's age, gender, race, ethnicity, and culture. Continue research on "culturally competent" service models.
- Support capacity development. Develop training programs and funding sources that expand the number of minorities among mental health professionals, researchers, administrators, and policymakers. Promote and develop leadership from within the community in which a mental health care sytsem is located.
- Promote mental health. Work to reduce adverse conditions such as poverty and racism. Build on community strengths such as spirituality, ethnic identity, traditional values, and local leadership. Strengthen families so they can function at their full potential.

community news

APA Expertise

continued from page 12

APA approved grants of $10,000 each to the New York County, Washington, D.C., and Pennsylvania district branches as part of its Erich Lindemann Disaster Grant Program.

APA district branches that want to organize a response to traumatic events such as those of September 11 can apply for a grant through the program, which is named for a Boston psychiatrist, who beginning in the 1940s, contributed considerably to knowledge about disaster psychiatry and coping with grief. Established in 1998, the grant program makes up to $10,000 available to a district branch each year to respond to a disaster occurring in its area. A total of $30,000 is available annually for the program. Grant requests are set in motion when a district branch president forwards a written request to the APA medical director, who consults with the APA president, Assembly speaker, and chair of the Committee on Psychiatric Dimensions of Disasters.

The grants are for funding a mental health response to a disaster and are to pay for such components as educational materials, photocopying, training, consultations, conference calls, transportation, and so on. Funds are not to be used to pay psychiatrists or others for providing psychotherapy, counseling, or other direct patient-care services. ■

D.C. Response

continued from page 17

children about the attack. May said, "We should remember to focus on the resilience of the human spirit and avoid overpathologizing normal responses to an abnormal event. Our job is to help the community find ways of participating in its own healing."

The military is dealing with the mental health needs of survivors of the attack and the families of deceased victims, along with other personnel stationed at the Pentagon and their families. According to a spokesperson for the Society of Uniformed Services Psychiatrists, members were "hard at work" responding to the crisis. Information about specific activities, however, could not be made public until a later date.

More information on the psychiatric response in Washington, D.C., including special efforts to reach out to children and their parents, will appear in a future issue of **Psychiatric News.** ■

government news

Treatment

continued from page 5

pital after being born. The infants in our study, whose mothers were in residential substance abuse treatment, avoided low birth weight, premature delivery, and death at rates that are better than the rates for all U.S. pregnancy outcomes. This saves not only dollars, but heartache and misery for the family, friends, and indeed the community."

H. Westley Clark, M.D.: "Substance abuse treatment can save taxpayers money that otherwise would be spent on other medical costs."

Longer term data indicate that 60 percent of the patients treated through the pilot program remained free of drugs or alcohol six months following discharge from the programs. In addition, six months following discharge, those patients who stayed in treatment longer than three months were more likely to remain alcohol and drug free, less likely to be arrested, more likely to report employment as their main source of income, and more likely to report having custody of one or more of their children.

"These programs are a win-win for everyone," Clark told *Psychiatric News*. "The mothers are able to become and stay drug and alcohol free, their children are born and grow up healthier, and families have a better chance of staying together."

The overall cost of the treatment programs, Clark said, was well worth the investment, given the long-term savings in child health and welfare as well as the criminal justice systems.

The report was released as part of SAMHSA's 12th Annual National Alcohol and Drug Addiction Recovery Month, observed each September to applaud the courage of people in recovery and recognize the progress made in substance abuse treatment services. This year's theme was "We Recover Together: Family, Friends, and Communities."

"Addiction tears families apart," said Joseph H. Autry III, M.D., acting SAMHSA administrator. "We know effective treatment can bring families back together. Our job now is to continue to put what we have learned into the hands of community-based treatment providers. Recovery Month gives us an opportunity to raise awareness that treatment can and does restore hope and reclaim lives."

The report, "1993-2000 Residential Treatment Programs for Pregnant and Parenting Women," is available on the Web from SAMHSA's information clearinghouse at <www.health.org>. ■