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Government News

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Patients, patient advocates, psychiatrists, and mental health professionals gathered on Capitol Hill last month to demand that Congress pass legislation requiring parity coverage for treatment of mental illnesses. See story at right and photos on page 17.

Advocates Rally To Demand Passage of Parity Bill

A large crowd of parity supporters turned out on a steamy June day at the U.S. Capitol to cheer the sponsors of the Mental Health Equitable Treatment Act and urge Congress to pass the bill now.

BY CHRISTINE LEHMANN

"Pass parity now!," chanted a crowd of patient advocates sprinkled with psychiatrists and mental health professionals at a rally last month on the lawn of the U.S. Capitol.

The Mental Health Liaison Group, with more than 190 member organizations including APA, organized the event to push for Congressional passage of the Mental Health Equitable Treatment Act (S 543, HR 4066).

The bill requires employers that offer mental health coverage to do so at the same level as for other illnesses, that is, without discriminatory copayments, deductibles, and out-of-pocket maximums.

Last year the Senate passed S 543, sponsored by Sens. Pete Domenici (R-N.M.) and Paul Wellstone (D-Minn.), as an amendment to an appropriations bill. House Republicans ultimately defeated the bill, however, during a joint conference in December. The bill has 66 cosponsors in the Senate.

In March Reps. Marge Roukema (R-N.J.) and Patrick Kennedy (D-R.I.) introduced HR 4066 in the House. The bill was referred to two subcommittees, but neither has acted on it yet.

Roukema told the crowd that 226 members of the House—a majority—have cosponsored HR 4066. "This overwhelming support follows President George Bush's call for mental health parity and establishment of the President's New Freedom Commission on Mental Health on April 29," she said. (*Psychiatric News*, May 17).

Domenici praised the patient advocates in the crowd for their willingness to talk about stigma and discriminatory insurance policies. "We as a nation have decided to leave mental illness out. I say it's time to put mental illness back in and insure it at the same level as other medical illnesses."

Domenici also thanked Bush for calling on Congress in April to pass parity legislation this year and for promising to sign the bill.

Wellstone said, "This legislation says

see ***Parity*** *on page 40*

Professional News

Drug Industry Responds to Complaints About Marketing

A set of voluntary guidelines from the pharmaceutical industry's largest trade organization is aimed at eliminating some questionable marketing activities between the industry and physicians.

BY JIM ROSACK

Those pens, pads, and stethoscopes emblazoned with company logos and bold product names are all still O.K., but not the concert or baseball tickets. And all-expenses-paid "educationally oriented" long weekends in Puerto Rico or Las Vegas are most likely out as well, according to the pharmaceutical industry's new guidelines for interacting with physicians during its marketing activities

The new "marketing code" was promulgated by the pharmaceutical industry's largest member organization, the Pharmaceutical Research and Manufacturers of America (PhRMA), which represents the country's leading research-based pharmaceutical and biotechnology companies. PhRMA "strongly encourages" its member companies to "adopt procedures to assure adherence" to the voluntary code, which went into effect July 1.

"The new code makes it crystal clear that the interactions of company sales representatives with health care professionals are to benefit patients and enhance the practice of medicine," said PhRMA President Alan F. Holmer in a prepared statement. "It explicitly spells out that all interactions should be focused on informing health care professionals about products, providing scientific and educational information, and supporting medical research and education."

APA President Paul Appelbaum, M.D., told *Psychiatric News*, "The new PhRMA guidelines, if consistently followed, will represent a clear advance over the status quo in which physicians are offered money and gifts in an obvious effort to persuade them to prescribe a company's medications." Appelbaum emphasized, however, that "these guidelines do not remove the necessity for psychiatrists and facilities to draw their own lines about pharmaceutical company practices."

While Holmer believes the guidelines are "crystal clear," there may be room for differing interpretations. For example, the code indicates that an all-expenses-paid trip to a resort location for a large number of physicians to "discuss company products" may not be appropriate, but that there may be situations in which "compensation and reimbursement that would be inappropriate in other contexts can be acceptable for bona fide consultants in connection with their consulting arrangements."

The code defines "bona fide consultants" as physicians who have a written contract with the company to provide services that

see ***Drug Industry*** *on page 41*

Congress Shifting Position on Medicare Payment Increases

Having heard from their constituents, Congressional Republicans have abandoned the Bush administration's effort to play a "zero-sum game" for Medicare providers.

BY KATE MULLIGAN

Congress is moving toward an increase in Medicare payments for doctors, hospitals, and health maintenance organizations.

The Bush administration's insistence that any increase in Medicare reimbursement rates for physicians must result in corresponding decreases in other Medicare provider spending had the potential for pitting various segments of the health care system against each other (*Psychiatric News*, March 1, April 5, May 3).

Health care professionals, however, worked together to pressure Republicans to renounce the Bush administration's insistence on budget neutrality.

Sam Goldreich of *CQ Daily Monitor* told www.kaisernetwork.org that the reversal came about because "House Ways and Means Chair Bill Thomas [R-Calif.] and House Energy and Commerce Chair Billy Tauzin [R-La.] decided not to play Bush's zero-sum game for Medicare providers.

"Instead, they promised rank-and-file Republicans that not only would hospitals get increases, but they would change current law that would have cut [payments to] doctors, nursing homes, and home health operators."

Hospitals Fight Back

Last March Tommy Thompson, secretary of the Department of Health and Human Services, and Mitchell Daniels Jr., director of the Office of Management and Budget, proposed that increases to physicians be offset by "savings from. . .measured changes in hospital payment updates" *(Psychiatric News*, May 3).

In a response dated March 26 to the administration's proposal, a coalition of eight organizations representing hospitals wrote, "More than half [the hospitals] lose money treating Medicare patients. Fully one-third are losing money overall. And, without corrective action, $21 billion in additional reductions will be implemented by October 1, 2002."

The June 5 *New York Times* reported that a "quiet rebellion by rank-and-file House members, including many from New York, forced House Republican leaders to reverse themselves [about the proposed cut]."

The *Times* reported that Republican leaders had reached an agreement to increase Medicare payments to hospitals by $9 billion over the next 10 years instead of cutting payments by $17 billion.

On June 5 www.kaisernetwork.org reported that hospital groups had written letters in praise of the agreement.

An analysis by the AMA, however, points out that the Thomas-Tauzin proposal would only slow currently scheduled reductions in payments for graduate medical education.

More Money for Doctors

Thomas and Tauzin have also proposed increasing Medicare payments to doctors by $20 billion over five years.

According to an analysis of the proposal by the AMA, beginning in 2003 and extending through 2005 physicians would receive annual payment increases of approximately 2 percent, as compared with the current projected cuts of 5.7 percent in 2003, 5.7 percent in 2004, and 2.8 percent in 2005.

The 2002 payment cut of 5.4 percent would remain unchanged.

In 2006 physician payments would again be cut, as the proposal is now constituted. According to the AMA, Thomas and Tauzin have agreed to work toward a more permanent solution that would avoid those cuts.

The AMA is continuing to urge the Centers for Medicare and Medicaid Services to make administrative changes that would eliminate or soften cuts under the current formula. For example, in 1998 and 1999 Medicare officials set spending targets too low and left the costs of more than 1 million beneficiaries out of the system. They also erroneously include the costs of physician-administered drugs when calculating costs of services *(Psychiatric News*, June 7).

Fixing those errors could restore $62 billion over 10 years to the pool available to make payments to physicians, according to the AMA analysis.

Jay Cutler, J.D., director of APA's Division of Government Relations, said, "The AMA deserves thanks and praise for helping to demonstrate what a powerful force medicine can be when its practitioners present a united front. The proposal is a good step in the right direction, although it does not offer all that medicine deserves."

Other winners in the Thomas-Tauzin proposal are managed care companies. The proposal would increase payments to insurance companies that administer Medicare+Choice, the Medicare managed care option.

AARP, formerly the American Associa-

see ***Medicare*** *on page 40*

Throw Them Out?

BY PAUL APPELBAUM, M.D.

"The annual meeting is visibly different in today's environment. Pharmaceutical logos seem to be everywhere. The exhibit hall is usually centrally located and huge, with gigantic display booths crammed not only with product information but also with interactive computer programs, mini-lectures by experts (either live or recorded), food, and a wealth of takeaway items."

For anyone who has been to a recent APA annual meeting, the description might sound familiar. In actuality, this excerpt is from an editorial in a recent issue of the journal *Neurology*, depicting the scene at the annual meetings of the American Academy of *Neurology* (AAN). Though readers of recent articles in the *Washington Post* and the *Boston Globe* critiquing the pharmaceutical presence at this year's APA meeting in Philadelphia might have assumed that this phenomenon was unique to psychiatry, the Neurology editorial makes it clear that the influence of the pharmaceutical industry is something with which all of medicine must cope.

Sometimes members ask why APA has any relationship with the major pharmaceutical companies. The answer for us, as for AAN and other medical groups, is that the industry provides APA with funding for key projects that are of value to our members, as well as unrestricted support for other activities. Scores of residents, for example, are chosen each year to attend APA meetings and to participate in component activities as part of fellowship programs funded by the pharmaceutical industry. Although the companies provide financial support, the recipients are chosen by APA committees entirely independent of any industry input. Similarly, member newsletters such as the ones APA produces on managed care and on research are published with industry support, but without control of content.

Industry-sponsored symposia (ISS)—often highly touted and featuring some of the biggest names in psychiatry—are a prominent part of the annual meeting program. Pharmaceutical companies pay APA a fee to obtain one of a limited number of slots for such programs and then spend many times that amount to produce and promote them. Doesn't having these symposia on the program compromise the scientific integrity of the meeting? Although you wouldn't have known it from reading the *Post* or the *Globe*, protecting the integrity of the information to which attendees at the meeting are exposed is precisely why these events are on the program.

Were we to expel ISS sessions from our meeting, the pharmaceutical companies would hold them anyway, concurrent with our sessions and at nearby hotels. In this scenario, which is acted out at the meetings of other medical organizations, we would have absolutely no control over the material presented. By incorporating these symposia into the scientific program, as we do, we can take steps to ensure the objectivity of the sessions. Proposals for ISS sessions are developed by APA members, and they are submitted to and reviewed by members of the APA Scientific Program Committee. Those that pass muster are presented to the companies for support.

Of course, the companies are largely interested in sponsoring programs that highlight pharmacologic treatments. But in recent years, with encouragement from APA, support has been obtained for programs dealing with such topics as the ethics of psychiatric research and psychosocial approaches to the rehabilitation of persons with serious mental illnesses. APA has

see ***From the President*** *on page 40*

Psychiatrists Offer Lessons In Healthy Grieving

Losing a loved one can be wrenching. Yet there are ways to ease the pain and promote normal grieving, two psychiatrists who helped 9/11 victims maintain.

BY JOAN AREHART-TREICHEL

John O'Brien, M.D., a child psychiatrist and clinical professor of psychiatry at Mount Sinai School of Medicine in New York City, will never forget the two weeks following the terrorist attacks on September 11. He had been hired by three companies that had lost some 1,000 employees to counsel their spouses on how to help their children through the tragedy.

Helping the survivors, whom he met in the Pierre and Plaza hotels, was an incredible experience, he said at the annual meeting of the American Academy of Psychoanalysis in May in Philadelphia. The hotels' plushness provided an ironic contrast to the survivors' emotional pain.

One woman in a ballroom screamed at O'Brien, "I am not crazy. I don't want to see you!" One surviving husband confessed to him, "I will never know the smell of my wife again." O'Brien knew exactly how the husband felt since his own wife had died several years earlier. At one point, O'Brien admitted, "It was so bad for me that I hid in the bathroom for 25 minutes. My son was also incredibly supportive of me at this time. I came to realize that he was doing psychotherapy with me."

But there are ways to lessen the pain of losing a loved one, and there are ways to promote a normal grieving process. And that is what O'Brien wanted to impart to the survivors of 9/11 and share with his analyst colleagues at the session, which was titled "Innovations in the Grieving Process."

When a parent dies, the other parent needs to know what children's normal reactions to death are. With young children, some regressive behavior—say thumb sucking—is normal for a while. Children through the age of 7 generally do not view death as final, and this concept is reinforced by television programs they watch. Children aged 7 to 10 tend to view death more as a monster than as something to be denied. Children 10 and older may handle death by eating more or by not paying attention in school.

The surviving parent needs to remain physically close to the children at this time, because children feel so insecure. Youngsters may also need to be accompanied to school. Having physical contact with objects that belonged to the dead parent can comfort children. O'Brien told one mother that it was all right for her daughter to sleep next to her in bed for a while, just as the father had once done.

The surviving parent also needs to impress upon the children how much they were loved by the dead parent, and as O'Brien stressed, "reassure, reassure, reassure them." Children also need to understand that a sight, sound, or smell that reminds them of the dead parent may rekindle their sense of loss and that such rekindling may occur indefinitely.

It also helps children who have lost a parent to get back to a normal routine as soon as possible. "I hate cell phones," O'Brien said, "but they are wonderful at this time."

A funeral may assist the grieving process more than a memorial service in cases where people are religious or where the death of a loved one is not 100 percent certain. Take the case of a woman of Irish descent whose husband had presumably been killed in the terrorist attacks but whose body had not been found. She asked O'Brien whether she should hold a memorial service or a wake for him. O'Brien advised her that a wake might be better, not just because of her religious beliefs but also because it would help her and her daughter mourn with friends and accept the death of their husband and father.

In the two weeks after September 11, John O'Brien, M.D., "learned about courage and bravery in some wonderful people."

In contrast, some people may use memorial services as a way to avoid facing up to the death of a loved one, Grace Bellotti, M.D., a New York University psychiatrist and psychoanalyst who helped families deal with 9/11 reported at the AAP session. She cited the case of "Stella" and "Jeff," an older couple whose daughter "Gloria," a bond trader, had disappeared in the 9/11 disaster. Stella and Jeff decided to hold a memorial service instead of a funeral for Gloria because they refused to accept that she had died.

Stella and Jeff, Bellotti indicated, also illustrate how refusing to let other people into your life at the time of the death of a loved one can impede rather than promote the grieving process. On the day after the terrorist attacks, Stella and Jeff refused to receive visitors and were angry at reporters who wanted to talk with them. They stood in stark contrast to "Helen,"

see ***Grieving*** *on page 38*

Patients May Need Treatment For Comorbid Migraines

Migraines are more than just headaches, and they often co-occur with psychiatric disorders. Correct diagnosis and treatment of both conditions can mitigate the double whammy.

BY CHRISTINE LEHMANN

It can strike anywhere, any time—that pounding, throbbing headache that brings daily activities to a complete stop and can last anywhere from four to 72 hours.

But what sets migraine headaches apart from, for example, the more common tension headache is its severity, its tendency to produce nausea or vomiting, and the sufferer's sensitivity to physical movement, light, and sound, said Stephen Silberstein, M.D., at APA's 2002 annual meeting in Philadelphia in May.

"Migraines restrict people's ability to function in daily activities, resulting in lost economic, social, and educational opportunities," said Silberstein, who is a professor of neurology and directs the Jefferson Headache Center at Thomas Jefferson University Hospital in Philadelphia.

Migraine headaches have a prodromal and a postheadache period. The prodromal signs may include short-acting depression, irritability, euphoria, restlessness, sensitivity to odors, difficulty concentrating, sluggishness, and food cravings, he said.

When the migraine ends, patients often feel exhausted and may have impaired concentration, muscle aches, and occasionally mild mania, said Silberstein.

What Are Migraines?

A migraine is a neurological disorder that begins when blood vessels to the head constrict. This triggers various symptoms, ranging from visual, sensory, or motor distortions (aura) to a headache. The constricted blood vessels then overcorrect by dilating, which causes an increase in blood flow to the head. It is this increased flow of blood into the head in a short period that triggers a full-blown migraine.

The aura can occur even without a headache, said Silberstein. The aura symptoms typically develop in five to 20 minutes and last less than an hour. Common visual symptoms include flashing lights, blind spots that move across the visual field, and blind spots shaped liked jagged crescents called "fortification spectra," all of which can temporarily obstruct a person's vision, said Silberstein.

Hallucinations can also occur with migraines. Lewis Carroll, the author of *Alice in Wonderland*, is believed to have had migraine attacks that inspired his writing, said Silberstein.

Migraines affect roughly 28 million Americans, three times as many women as men, and they can begin in childhood.

Psychiatric Comorbidity

Migraines are frequent in people with mood disorders, said Silberstein. Researchers have found that people with major depression are three times more likely to have migraines than the general population, and people with migraines are three times more likely to develop major depression than the general population.

Panic attacks are another risk factor for developing migraines. Migraines are a risk factor for developing social phobia, generalized anxiety disorder, and bipolar disorder, he added.

Despite the strong link to mental illness, most psychiatric patients fail to mention that they have headaches or migraines unless they are asked, said Silberstein.

For moderate to severe headaches, Silberstein's first choice of medications is the triptans, including sumatriptan, zolmitriptan, and rizatriptan, followed by ergotamine and, lastly, analgesics.

Silberstein cautioned that triptans, which are selective serotonin receptor agonists, are contraindicated in people who have frequent headaches and/or who have cardiovascular disease, because they prolong the constriction of the blood vessels. Similarly, for patients who experience an aura with their migraines, triptans are likely to prolong the aura, but they do prevent the full-blown headaches.

The use of these medications should be monitored carefully to avoid overuse, which can cause intractable headaches, said Silberstein. Overuse occurs when the patient takes simple analgesics on a daily basis, combination analgesics or triptans more than three times a week, or ergotamine tartrate or opioids more than twice a week, said Silberstein.

He recommended that physicians discontinue the overused medication before trying new medications. "But be aware that the patient's symptoms, including headaches, may worsen before improving," he warned.

"My observation has been that analgesic overuse is one of the causes of refractory depression, and when the headaches improve, often so does the psychiatric condition," said Silberstein.

The first step in making a diagnosis is ruling out secondary causes, such as brain tumors and meningitis. "Be careful not to assume that the treatment response establishes a diagnosis." For example, Silberstein explained that he saw a patient in the emergency room who was responding to triptans based on a diagnosis of migraine, but who actually had a subarachnoid hemorrhage.

Treating Comorbid Conditions

Medication overuse can be a form of self-treatment for a comorbid mood disorder,

see ***Migraines*** *on page 40*

Awards Honor Psychiatrists Who Confront Obstacles to Patient Care

Recipients of the Moffic Award for Ethical Practice in Public Sector Managed Behavioral Health Care are proof that psychiatrists are willing to fight for quality patient care when times are tough.

BY EVE KUPERSANIN

Many psychiatrists who work at the intersection of public psychiatry and managed care find themselves in an environment in which cost concerns often appear to trump patient care. For those psychiatrists who have found innovative ways to put their ethics and patients' needs first—sometimes at great risk to their careers—there is the Moffic Award for Ethical Practice in Public Sector Managed Behavioral Health Care.

The award, established by H. Steven Moffic, M.D., and the American Association of Community Psychiatrists (AACP) in 1998, is presented each year at APA's fall meeting, the Institute on Psychiatric Services. The AACP Ethics Committee reviews nominations and designates one or more winners, presenting a certificate and $2,000 to each. Although psychiatrists have most often won the award, mental health professionals and organizations can be recipients.

Moffic, who is executive vice chair for managed care in the department of psychiatry and behavioral sciences at the Medical College of Wisconsin, decided to recognize psychiatrists who work in the public sector under managed care because "the ethical risks seem even higher for the poor, and the most seriously ill are seen so often within that sector."

When confronted with managed care systems that sometimes threaten the quality of patient care and patients' right to confidentiality, none of the award winners to date has quit his or her job or passively accepted the system. Instead, each has found ways to work under new constraints.

As the first Moffic Award winner, in 1998, Clifton Tennison Jr., M.D., is a good example. When Tenncare Partners, Tennessee's mental health carveout Medicaid waiver program, brought managed care to Tennessee in 1994, many community mental health centers in that state closed because of cost restrictions that resulted in a drastic reduction of services.

Tennison, with a 19-year tenure at the Helen Ross McNabb Center in Knoxville, where he is now the chief clinical officer, wouldn't give up so easily. "Our jobs, our professional interests, and our personal lives changed dramatically during this time of change, doubt, self-assessment, and renewal," Tennison told *Psychiatric News*. "Coping with the massive losses in resources required not only organizational survival, but also the development of strategies grounded in professional ethics."

Clifton Tennison Jr., M.D.: "The award was a meaningful and timely recognition of hard work, perseverance, and difficult decision making."

Adaptation became the status quo for staff at the McNabb Center. "We adjusted our hours, our expectations, and our staffing patterns, withstanding losses of 50 percent to 60 percent in funding and staffing of most programs—others were eliminated entirely," he said.

Tennison avoided closure of the McNabb Center with the help of his staff by aggressively pursuing other sources of funding to reduce dependence on Medicaid funding and creating new services as the old ones disappeared. These included five Medicare-based, partial-hospitalization programs and a new alcohol and drug abuse program, which came about as a result of a merger with the Detoxification and Rehabilitation Institute in Knoxville.

The staff also created new interagency collaborations with local training and advocacy programs, for instance, to develop alternative ways to serve the community.

Tennison consistently served as a voice for his patients, according to Moffic. Tennison "returned patient phone calls promptly, referred clients to advocates when a dispute in treatment arose, and took patient appeals as far as they would go," he said. In other words, when TennCare did not authorize a treatment plan for one of Tennison's patients, he pursued all paths available to him to get each patient the care he believed was necessary.

When he accepted the Moffic Award for himself and the McNabb Center, Tennison credited the center's staff, management, and board of trustees.

"The award was a meaningful and timely recognition of hard work, perseverance, and difficult decision making," Tennison said. "It recognized what is for me the most important set of concepts and dilemmas in the whole struggle to cope with sudden and terrifying changes in our service delivery system."

Tennison also said that although there have been improvements in TennCare's services, "there remain awful deficits in psychosocial intervention, rehabilitation, recovery, and prevention."

Andres Pumariega, M.D., the 1999 award winner, called attention to yet another problem with managed behavioral health care systems—the lack of attention

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Responding to Distraught Families Crucial to Nursing Home Care

Angry, acting-out family members can present a greater challenge to psychiatrists practicing in nursing homes than the residents themselves. Also challenging is making sure they comply with recent federal regulations regarding psychoactive medications in nursing homes.

BY KEN HAUSMAN

It is a mistake for psychiatrists and mental health professionals who work in or consult to nursing homes to assume that the nursing home resident is going to be their sole focus. Many of these clinicians and other nursing home staff find they spend as much—or even more—time responding to the emotional needs and psychological stresses of the resident's family members.

For Nancy O'Dowd, a clinical nurse specialist in geriatric psychiatry who consults to several New Jersey nursing homes, more than 10 percent of the consultation visits turn up no new problem with the resident, but serious problems being caused by his or her family "driving the staff crazy."

Speaking at an APA annual meeting session in Philadelphia in May, O'Dowd identified several factors that lead to the frequent stress-related outbursts that family members direct at nursing home staff.

Nancy O'Dowd: Nursing home staff should be trained to focus on families' emotional needs and how to respond to them.

Paramount among these are the "trap of cognitive impairment"—frustration at not being able to find a way to respond to or communicate with a loved one shifting between lucidity and dementia—and trying to cope with the "ambiguous loss" they feel when their impaired relative no longer recognizes them or mistakes one of them for another person.

She also urged psychiatrists confronting emotionally distraught relatives to be aware that aggressive or unreasonable behavior might be symptoms of the "constant and evolving grief cycles" relatives go through as the resident stays in the home much longer than the relatives had anticipated. Such behavior may also be arising from guilt over decades of family conflict and the relatives' inability to discuss or resolve the issues now with their cognitively impaired relative.

The emotional expressions that signal relatives grappling with grief reactions are often far from insignificant, O'Dowd pointed out. These include statements accusing the staff of unprofessional behavior or poor decision making, yelling and cursing at the staff, and even verbal or physical threats. Inappropriate behaviors by residents' relatives are also common, and nursing home staff needs to be alert to them, she advised. In one case she cited, a family who thought they were being helpful handed out sweets to all the residents in the relative's area, including those who were diabetic and on restricted diets.

Help Families Adjust

When nursing homes' mental health staff and psychiatric consultants can educate families and attend to their emotional needs—that is, "teach them how to visit"—many of the problems can be avoided or reduced, O'Dowd emphasized. Constructive strategies include acknowledging all that the families have done for the person, "communicating honestly" with them about the factors related to their relative's care, and allowing them the opportunity to feel useful to the resident and others, she noted.

She said it is important that staff convey the message that despite the guilt families may feel, it is "permissible to withdraw" to some extent from their relative's care, that is, to take some time off. "A resident will adjust to the nursing home better" if relatives don't come every day, she observed.

Nursing home staff can and should be trained to focus on families' emotional needs and how to respond to them, she stressed. Among the advice she gave was "Don't get defensive!" Doing so in the face of relatives' criticism or accusations will just leave the staff looking guilty, she said. If relatives are abusive or out of control, staff should just walk away until they cool down, she advised.

It is critical that staff at all levels are aware that they "have the right not to be abused by either residents or their family members," O'Dowd said.

She also cautioned against nursing home staff expecting to be the recipients of obvious expressions of a family's gratitude.

Staff Education Important

Psychiatrist Istvan Boksay, M.D., oversees a program to educate nursing home staff about mental health concerns. Boksay, the director of the Center for Aging and Dementia at New York University Medical Center, said that education is such an important element of staff training that his program conducts such sessions two to three times a year.

"It can't work if it's a one-shot deal," Boksay stressed. Developments in geriatric mental health are occurring regularly, and turnover of nursing home staff is considerable, he said.

One development of which it is especially important for psychiatrists to be aware, Boksay said, is that nursing home patients with a faster course of dementia have on average 50 percent more medical problems than patients with a slower course—six serious problems versus four. It is thus crucial that psychiatrists and nursing home staff carefully monitor—and get treatment for—these faster-deteriorating patients, who are at more risk for experiencing medical complications.

Since 1987 psychiatrists and mental health professionals who treat or consult on nursing home residents, along with the administrators who operate the facilities, have had to make sure that whatever serv-

see ***Nursing Homes*** *on page 40*

Film Depicts Mother's Search For Compassion in MH System

A film documents the unconditional love that brings hope to a troubled boy and contrasts it with the indifference of a state mental health system, which may have contributed to his deterioration.

BY EVE KUPERSANIN

James is a 12-year-old boy who has spent half of his life in institutions. He has been rejected by his father, sexually abused by a cousin, and abandoned by the mental health system. Tracy Marasco, his mother, endured similar trauma as a youngster and now fights to keep her son out of a mental hospital, where she fears he will be more likely to be restrained than helped.

Their story is captured in a new documentary film, "If I Could," which the filmmakers hope will spur a national crusade to improve mental health care for youth in this country.

Patti O. White produced and directed "If I Could," with her film company, Filmsters Inc., based in Annapolis, Md., and Los Angeles.

A diverse group of legislators, psychiatrists, mental health professionals, students, and family advocates attended a screening of the award-winning film at the Center for Strategic and International Studies in Washington, D.C., in May and contributed to a lively panel discussion after the screening.

The film opens with Tracy Marasco driving her son, James, from their home in Denver to a treatment program in Oklahoma. This is one of many journeys they have made together in search of help. "We have been in and out of treatment centers, hospitals, here and there," Marasco says. "James is well on his way to juvenile lockups. I'm very scared that he is going to commit a very serious crime."

She has reason to fear the worst, for in addition to the fact that her oldest son explodes in fits of rage with some regularity, she recently discovered James with a loaded handgun. It is then that Marasco decides to deliver him to the program that made such a profound difference in her life when she was James's age—Vision Quest.

Wagon Train

"We are giving you the right and responsibility to enter your own adulthood without anyone in control of you but yourselves!", Vision Quest founder Bob Burton yells to a group of adolescents, many of whom have been court-ordered into his alternative treatment program. "We are going to confront your weaknesses and promote your strengths."

It is 1979, and a defiant 14-year-old Tracy Marasco is among Burton's charges. A judge has ordered her to Vision Quest's Wagon Train program after a series of arrests for prostitution, weapon possession, and theft. Marasco's long journey to recovery begins on the horse-drawn covered wagon that takes her from the Arizona desert, over the Colorado Rockies, and back home to Denver. Marasco's journey is chronicled in a CBS documentary, "The Wagon Train Trial," produced by filmmaker Patti O. White.

White, who also produced "If I Could," dug through CBS's vaults to find the 1980 documentary and juxtaposed certain scenes featuring a young Tracy Marasco interacting with Burton with scenes from "If I Could."

As an adult, Marasco sheds some light on the role Burton played during her stint at Vision Quest."Bob was the stop sign in my life," recalls Marasco. "I never had any stop signs in my life until I met Bob. He gave me the opportunity to be a kid—to look to a parent for direction like a kid."

Burton founded Vision Quest in 1973 after growing disillusioned with his work as a corrections officer in the juvenile justice system. He created Vision Quest to offer youth an alternative to incarceration. He named his program after a rite of passage practiced by the Plains Indians, who send their adolescents into the wilderness on a "vision quest" to enable them to overcome the challenges found in nature and discover a view of their futures.

The philosophy of Burton's program isn't much different. In Vision Quest, youth engage in rigorous outdoor activity while working closely with counselors who serve as parent figures.

Cycle of Abuse

In the film, James tells Burton about what it was like to witness physical abuse between his parents, to watch his father walk away from the family, and to shuffle around juvenile detention centers with metal shackles around his ankles and waist. After encouragement from Burton, James talks about an incident that occurred when he was 4 that led to his first psychiatric treatment—sexual abuse by his father's cousin. When he does mention the incident, James refers to himself in the third person.

Tracy Marasco: "It is very important for our nation to understand what trauma is."

"The effects of trauma are written all over this kid," Burton says of James. "It is very unsettling to see how high the wall of secrecy is."

Together, Marasco and Burton decide that it might help James to see footage of "The Wagon Train Trial" so that he might better understand his problems in the context of a troubled family history and see how his mother eventually triumphed over her problems. Marasco was a single mother of four who supported her family while working part time and finishing a degree at the University of Colorado.

"I'm freaked out about letting James see what happened to me as a teenager," Tracy says, "but I think he really needs to know the truth."

While watching the 1980 documentary, James learns that his mother experienced many of the same hardships as a youngster. He also hears for the first time that his mother is an incest survivor and that his grandfather had abused her sexually and eventually forced her into prostitution.

Mental Health Roller Coaster

James thrives on the structure, adventure, and highly individualized attention he receives in various programs at Vision Quest. After spending several months there, he becomes more self-confident and less angry, and develops a number of important relationships with staff and peers.

After leaving Vision Quest, however, James flounders. His county's mental health services cannot meet his needs, and he begins to revert to the troubled existence he led before entering Vision Quest. At one point, he is expelled from school for cursing and sits listlessly at home for nine weeks. Marasco says she contacted the county mental health system repeatedly during this time, but no one returned her calls.

She then re-enrolls James in Vision Quest, and he ends up in a specialized program for traumatized adolescents. There, he undergoes intensive individual and family therapy, which leads to significant improvement in his mental health.

The film ends on a positive note. As James graduates from Vision Quest, all smiles, his mother and Burton look on with pride. James is once again on the road to recovery.

Unfortunately, James's life took yet another downward spiral after the cameras stopped rolling. ■

Director Hopes Disturbing Film Will Lead to Better MH Care for Children

Panelists comment on a poignant documentary about a troubled youngster and a mental health system in crisis that is allowing such youngsters to continue suffering.

BY EVE KUPERSANIN

After a Washington, D.C., showing of the documentary film "If I Could" (see story above), the mental health problems that James Marasco, an adolescent who is the film's subject, continues to experience were the topic for a panel discussion on the state of mental health services for troubled youth.

Tracy Marasco, James's mother, and Bob Burton, founder of the program Vision Quest, joined a panel moderated by psychiatrist Deborah Peel, M.D., president of the National Coalition of Mental Health Professionals and Consumers.

Among the participants were mental health experts and others dedicated to ensuring access to better mental health care for youth and their families, including Ivan Walks, M.D., chief health officer of the District of Columbia; Harold Eist, M.D., a past APA president; Timothy Roche, southern bureau chief of *Time* magazine; Emily Brown, L.C.S.W., director of Key Bridge Therapy and Mediation Center; Andrea Karfgin, Ph.D., psychologist and consultant for "If I Could"; and Patti O. White, the film's writer, director, and producer.

"If I Could" had its commercial debut at the Seattle International Film Festival a year ago, where the film was third runner-up for best documentary. The film has also garnered awards at the New York International Independent Film Festival, the WIN Femme Film Festival in Los Angeles, and the Columbus Film and Video Festival.

The film made its unofficial debut as a fundraiser for the Anne Arundel County, Md., Young Women's Christian Association (YWCA). The event raised $70,000 to benefit the violence-prevention programs of the YWCA.

The Washington, D.C., screening marked the first time that a panel of mental health experts joined to discuss the crisis with the mental health system that moved White to make the film in the first place.

"I realized that families with children who have undergone abuse or abandonment really have no voice," said White, who noted that many youth often end up in any number of mental health systems that don't communicate with one another and, as a result, receive inconsistent care. "I also made the film to help the average audience to understand what it is like for families who experience these problems."

The film cost about $650,000 to produce, and donations from an anonymous actress, an independent investor from Denver, and AT&T covered half of this sum. White said she remained hopeful that another corporation or investor would express an interest in sponsoring the remaining costs. An unrestricted educational grant from Pfizer financed the cost of the screening at the Center for Strategic and International Studies in D.C.

To reach a wider audience, White would like to sell her film to local and independent public broadcasting stations nationwide, and she also has plans to sell a videocassette of the film.

Marasco explained that in the year or so since filming ended, James has been struggling, often unsuccessfully, with his mental disorder.

Vision Quest released James back to his home and community, with a guarantee that the Colorado mental health system would have five supports in place for James—school, family therapy, drug treatment, weekly urinalysis, and an ankle bracelet to monitor his whereabouts. State mental health officials agreed to these conditions, and James came home.

It turned out that "not one thing was in place," Marasco said. "James sat at home and was not allowed in public school for six weeks, because the state was reviewing his file. He came home in good shape, but deteriorated because there was nothing there for him."

Marasco hopes the film reaches a wide audience so that more people will join her fight for reform of the mental health system.

"It is very important for our nation to understand what trauma is and to stop la-

see ***Film*** *on page 41*

Psychiatrists Can Help People 'Die Well'

Dying can be a time for tying up loose ends, reconciling with people, and finding meaning in one's life, according to a palliative care authority.

BY JOAN AREHART-TREICHEL

In 1995 a study funded by the Robert Wood Johnson Foundation revealed that the way that many Americans die is far from ideal. They may experience physical pain, or they may spend their last days in an intensive care unit, or they may have physicians who have no idea of their wishes regarding cardiopulmonary resuscitation.

But many Americans also suffer considerable psychological anguish during their final weeks or days, Ira Byock, M.D., director of the Palliative Care Service in Missoula, Mont., and a hospice physician for a decade, reported at APA's 2002 annual meeting in Philadelphia in May. The title of his lecture was "Dying Well: Beyond Symptoms and Suffering—Human Development at the End of Life."

For some Americans, dying entails a loss of meaning and purpose in their lives, Byock said. For others, it is a time to feel guilty about what they have done or not done with their lives. Still others brood about estrangement from family and friends. Also, it is usually not physical pain but anxiety about being a burden on loved ones that drives dying persons to request euthanasia. But dying does not have to be like that, Byock asserted. Dying can be a much more positive experience—a time for psychological and spiritual growth.

"I have seen some people change dramatically during this time," he attested. "Some people change in ways that are important to them and their families."

Byock cited the case of a pediatrician who grew psychologically and spiritually as he was dying. Here is how the pediatrician described the process: "I characterize this time as a gift—a time to tie up the loose ends for my family, to reconnect with people with whom I had become estranged, and also a chance to discover what it is like to have death sitting next to you. I like the person I have become. I now have a spontaneity that I did not have before. Colors, sights, sounds, touches, and hugs are more wonderful than ever before."

Even though Byock is a family care practitioner, not a psychiatrist, he argued that psychiatrists should become more involved in helping people die well psychologically and spiritually.

"We have left dying to the internists!" he declared. "But what do they know about helplessness and hopelessness? It is time for you psychiatrists to play a leading role."

Very few psychiatrists have been involved in this area up to now, he added. So what might psychiatrists do to help the dying become whole, to die well on their own terms? Byock offered some suggestions from his own experiences with dying patients:

• Conduct life reviews with dying persons to instill meaning and purpose in their lives. You can ask when they were naughty or did good deeds, who their enemies were, what their preferences or aversions were. You can ask them what it was like when they were at the apex of their lives. "I have done life reviews with patients who could not remember who I was, but they could remember their pasts," Byock said.

• Help dying individuals forgive themselves. You can tell them, "We are all going to come to the end of life imperfect, so get over it!" Smokers who are dying from lung cancer or emphysema especially need help to deal with their guilt. You might ask them in a jovial way, "Do you think that if you had not smoked, you never would have died?" Then tell them to repeat to themselves, "I am a good person."

• Help dying persons become reconciled to loved ones from whom they are estranged. You can write down on a three-by-five-inch card what they should say: "Please forgive me, I forgive you, thank you, I love you, goodbye." Byock wrote such a sentence down on a card for a cowboy who was dying and estranged from his wife and children. The cowboy read the sentence aloud to his wife and children and said that he felt a lot better afterward. So did his wife and children, Byock added.

• Help dying persons realize that it is normal to be dependent on others at this point in their lives and that they should accept such dependence.

• Help dying individuals respond to the mystery of life, to connect to something larger than themselves. For many people it means connecting with a god, and for those who believe in a god, it is indeed a strength. But dying persons who do not believe in a god can derive spiritual comfort in other ways—say, by deciding to be buried on a plot of land that is important to them or to have their ashes distributed in the wilderness.

• Perhaps most crucially, you can help the dying "surrender to the transcendent—to let go," as Byock put it.

Byock also touched upon how "baby boomers" such as himself can prepare for dying well, even in their middle years. First, accept that you are going to die at some point. Then ask yourself, If an earthquake struck me today, what important business would I leave unfinished?

"Your first thought would certainly not be your Palm Pilot," Byock chuckled. Then set about finishing that business before it is too late, he admonished his audience. ■

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Experts Explore Sadism, But Answers Remain Elusive

What type of people become sadists and what makes them tick? Some forensic authorities who have had firsthand experience with sadists provide some answers.

BY JOAN AREHART-TREICHEL

Michael Stone, M.D., a professor of clinical psychiatry at Columbia University, will freely admit that he has a "morbid hobby." He collects information about people who have committed atrocious deeds. Some of these are notorious killers who have had books written about them. Others are individuals whom Stone knows personally from his forensic work.

When *Psychiatric News* asked Stone what prompts him to collect material on people who have engaged in heinous acts, he said that he has become increasingly interested in such people over the years—in the dark side of human nature, so to speak. And a lot of them are sadists, Stone reported at in May at APA's 2002 annual meeting in Philadelphia in sessions on sadism and evil.

What is sadism? While it is related to evil, it is not quite the same, Stone explained. Whereas evil is intentionally hurting another person, sadism is not only the intentional imposition of suffering on another person, but enjoyment in seeing that person suffer.

Take, for instance, the case of a man who shot his daughter while he was on the phone with his ex-wife, Stone said. The act was evil in relation to the girl because she died immediately, and the man could not derive any enjoyment from watching her suffer. But the act was sadistic in relation to the ex-wife because she suffered anguish upon hearing her daughter shot and the man could derive pleasure from her pain.

Ann Burgess, D.N., who is a professor of nursing at the University of Pennsylvania and has helped rape victims, recounted one of those rape cases. "There was a lot of blood everywhere. It looked as if the victim had been pounded against a car window." Yet the rapist shrugged his actions off with this comment: "It was rough sex."

Yet sadism can take much less flagrant forms, Burgess pointed out—say, in verbal cruelty in which one person puts another down. Joseph Merlino, M.D., a professor of clinical psychiatry at New York University School of Medicine, agreed with Burgess. When one hears about evil or sadism, he said, it "conjures up creepy organ music." But evil and sadism, he said, can be "present in petty cruelties in everyday life."

Why are people sadistic? The major reason, it appears, is the desire to control one's victim, Stone and Welner reported. Stone cited a case that illustrates how the desire for control can drive sadism. A district attorney treated his mistress sadistically. When she tried to escape from him, he caught her, killed her, and packed her body in a trunk.

Revenge, however, can also prompt some people to commit sadism, Stone pointed out. He cited the case of a man in Japan who had a palm deformity and resented it to the point that he wanted to take revenge against society for his misfortune. So he killed children, chopped off their hands, and sent the hands to their parents.

What types of people engage in sadism? Serial killers and psychopaths, for starters, Stone reported. Of the some 100 serial killers he has studied, he said, more than 90 percent were psychopaths. And psychopaths in turn, he explained, are extremely narcissistic, impulsive, sensation seeking, and deceitful. They also lack goals, compassion, and remorse, and sponge off others. In Stone's opinion, the most depraved people who commit homicide are psychopathic murderers who enjoy torturing their victims.

continued on facing page

Clarification

The article in the April 19 issue describing actions taken by APA's Board of Trustees omitted citing the Committee on Confidentiality for its work in the development of two APA resource documents: "Documentation of Psychotherapy by Psychiatrists" and "Psychotherapy Notes Provision of HIPAA Privacy Rule." ■

Nonetheless, it is not just serial killers and psychopaths who engage in sadism, stressed Michael Welner, M.D., a forensic psychiatrist and chair of the Forensic Panel in New York City. People who function otherwise "normally" in society can be sadistic as well.

The people who engage in sadism, Stone indicated, may include that tyrannical, mildly abusing husband down the street or the bully in one's class. And while sadism is practiced more by men than by women, Stone said, Welner added this caveat: "If we think it is only men who are sadists, we are kidding ourselves."

People who commit crimes of passion, however, are rarely those who engage in sadism, Stone pointed out, and far more sadists can be found in prisons than in forensic psychiatry facilities. In short, sadists tend to be "bad, not mad," he said.

If sadism is one of the murkiest, most reprehensible of human behaviors, is there any chance of successful treatment? Sadistic persons rarely seek treatment and are generally untreatable, Stone said. However, "some do have the capacity for remorse and self-reflection," he acknowledged. For instance, he worked with one woman on becoming less brutal with her son, and after several years she managed to do so. Of course, she was not nearly as depraved as many sadistic people are, he admitted.

Welner proposed that antagonists against the neurotransmitter dopamine might help to counter sadistic behavior. Dopamine has been associated with mediating feelings of pleasure and reward. Blocking dopamine could curb sadistic behavior because sadism, he said, "is about satisfying compulsions."

And if sadism is one of the most loathsome of human behaviors, is there any chance of preventing it? Possibly, Welner indicated. For instance, he said, one of the best ways to identify youth at risk for sadism is by zeroing in on young people who torture animals. "I think that animal torture is a practicing instrument for later sadism against people, and such behavior in youths should be a big alarm bell," he said. Psychiatrists and mental health professionals might then try to awaken empathy in these young people, he added—say, by focusing on when they had been mistreated.

"Working with adolescents will certainly prove more beneficial than working with adult offenders who have already tasted blood, so to speak," Stone said.

Empathy training in schools might also help counter sadistic behaviors, Welner suggested. And placing more control over pornography might also make a dent in sadistic behaviors, he added, since pornography has been shown to be closely linked to sadism.

Since prostitutes are often victims of sadism, Welner suggested that the number of injuries caused by sadistic individuals could be reduced if the police were to engage in better communication and undertake educational efforts with prostitutes.

All in all, Stone concluded, sadistic behaviors are far from rare in American society. "So why should we psychiatrists turn a blind eye to the sadistic personality?" he asked. "I think we should put it back in the DSM."

It was provisionally in the appendix of *DSM-III-R*, he explained, but was subsequently omitted, in part because psychiatrists worried that its inclusion, its "medicalization," might be used by defense attorneys to get sadists exonerated from their criminal acts. Of course, if it *is* included in the *DSM*, he asserted, it should not be used for that purpose. ■

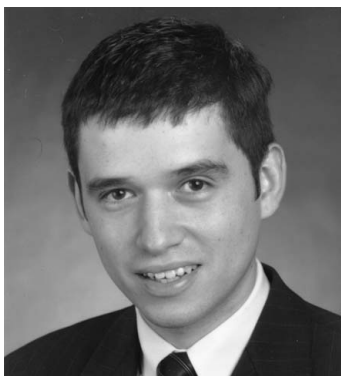
Former Ohio Congressman **Louis Stokes** is presented APA's ***Solomon Carter Fuller Award*** by **Michelle Clark, M.D.,** chair of APA's Committee of Black Psychiatrists. The award, established in 1969 and named for Solomon Carter Fuller, M.D., the first African-American psychiatrist, is given each year at APA's annual meeting in recognition of an individual who has pioneered in an area that has benefited significantly the quality of life for African Americans. Stokes retired from Congress after 30 years of service in which he had fought relentlessly for civil rights, equality, and social justice. He was the founder and chair of the Congressional Black Caucus Health Brain Trust and a member of the Pepper Commission on Comprehensive Health Care.

William B. Lawson, M.D., is presented the ***Jeanne Spurlock Minority Fellowship Achievement Award*** by **Irma Bland, M.D.,** the award's first recipient. This award is presented to an alumna/alumnus of the minority fellowships (APA/NIMH, APA/CMHS, or APA/AstraZeneca) who has made significant contributions to psychiatry and/or minority and underserved populations. Lawson is a former APA/NIMH fellow and chairs the department of psychiatry at Howard University School of Medicine. He is also the training director and chair of the Section of Psychiatry and Behavioral Sciences of the National Medical Association. He has written on severe mental illness and its relationship to psychopharmacology, substance abuse, and racial and ethnic issues and is a vocal advocate for severely mentally ill people and their access to treatment.

Nonphysician Prescribing: A Resident's Perspective

BY CARLOS E. GUZMAN, M.D.

The leadership of the American Psychological Association has been pursuing "prescriptive authority" for psychologists for a number of years, with the ultimate goal of obtaining unsupervised prescription privileges for psychologists in all 50 states. Many medical and nonmedical authorities, including prominent members within the American Psychological Association, have criticized such efforts as being driven purely by economic interests, with evolving strategies motivated by the likelihood of legislative success. Indeed, it is quite surprising to me that in an era when psychotherapeutic interventions are starting to reveal powerful efficacy rates in randomized controlled trials, the American Psychological Association leadership has virtually abandoned an effort to standardize their psychotherapeutic training in favor of pursuing prescriptive authority.



Dr. Guzman is a fellow in child and adolescent psychiatry at Columbia Presbyterian/New York State Psychiatric Institute in New York City.

The American Psychological Association cites the shortage of psychiatrists in rural and traditionally underserved communities and proposes that psychologists could address this disparity of care if granted the right to prescribe. Their efforts have paid off in New Mexico, where Governor Gary Johnson (R) has signed a bill granting what amounts to unsupervised prescription rights to psychologists (as it looks so far, after completion of an approximate 400-hour pharmacotherapy course and one year of supervised practice, although these requirements could still be changed) *(Psychiatric News*, April 5).

These efforts continue to gain popularity with state-level legislators who are trying to address the needs of their underserved populations in the most expeditious manner. However, there is insufficient evidence to support that psychologists would relocate to rural areas or that such a measure would improve mental health care in these communities. Statistics show that psychologists and psychiatrists tend to follow similar patterns of regional distribution, with the greatest density being in the Northeast and the lowest in the South and Midwest.

Many in our profession feel confident that our training as physicians will always give us the advantage vis-à-vis lesser-trained clinicians in managing side effects like weight gain, impotence, and visual, cardiac, immune, hematological, and hemodynamic compromise. Some even welcome prescriptive privileges as a "proverbial noose" of future litigation for nonphysicians. In contrast, there are those who suggest that if put through a standardized, rigorous training program, psychologists (and why not social workers, case managers, and schoolteachers?) could effectively prescribe a limited number of drugs with minimal, if any, need for supervision. The number of programs that claim to offer psychopharmacological training continues to grow throughout the United States.

In my opinion, there is a broader issue that policymakers and politicians will need to address eventually. There continues to be an increasing effort by organized allied health care providers to train more nonphysician clinicians (for example, nurse practitioners, nurse midwives, nurse anesthetists, chiropractors, naturopaths, and nurse specialists) and to expand their prescriptive and reimbursement authority to eventually practice as independent primary care providers. Many of their arguments are similar to those of the American Psychological Association, in that enhanced privileges will encourage these practitioners to relocate to underserved rural communities. Not only is there a lack of evidence that they will move to underserved areas, but they enjoy living in the same geographic areas that federal government statistics show are already "oversupplied" by physicians!

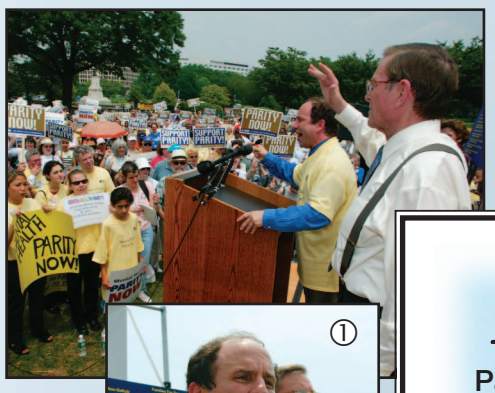
The traditional theory of supply and demand supports the notion that there would be a strong demand for practitioners up to the point that our health care system reaches a surplus of practitioners (which would be evidenced by their higher unemployment rates, lower workloads, and decreased growth in health care spending). While this generally holds true in efficient and competitive markets, in reality health care is not subject to these simple market forces. Many economists note that the demand for health care is inelastic, meaning that demand for health services remains stable despite increases in cost. Individual consumers (and practitioners) attain greater utility with increased utilization of health services; thus, demand is described as insatiable. Indeed, our record shows that health service utilization is likely only to be curbed by external constraints such as those imposed by HMOs or government regulation. It has also been recognized that unrestricted growth of allied health practitioners is contributing to the rapid rise in health care expenditures in the United States; as many economists note, when supply increases in

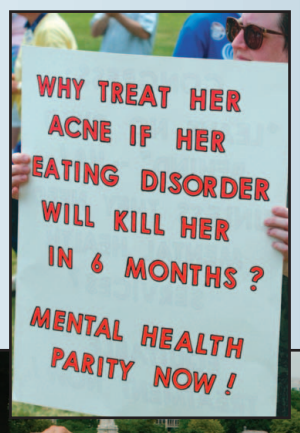
see ***Residents' Forum*** *on page 39*

A CAPITOL IDEA

Parity supporters rallied at the U.S. Capitol in June to push for passage of the Mental Health Equitable Treatment Act in Congress.

Among those who addressed the demonstrators were members of Congress who support the Mental Health Equitable Treatment Act: ① Sen. Paul Wellstone (D-Minn.); ② Pete Domenici (R-N.M.); ③ Rep. Patrick Kennedy (D-R.I.), with Nancy Domenici (wife of Sen.Domenici) looking on; and ④ Rep. Marge Roukema (R-N.J.). Other speakers included ⑤ Jim McNulty, president of the National Alliance for the Mentally Ill, and ⑥ Ron George of the National Association of Anorexia Nervosa and Associated Disorders. ⑦ Wayne Creelman, M.D., president of the Western Michigan Chapter of the Michigan Psychiatric Society, waves a sign among other parity supporters.





Photos: David Hathcox

Converging Forces About to Reshape Psychiatry Training

To graduate top-quality clinicians for the 21st century, educators will have to make significant alterations in the way they train residents, not all of them to their liking, experts maintain.

BY KEN HAUSMAN

In the 30 years since Richard Harding, M.D., was a psychiatry resident, he has had a distinguished career as a clinician, teacher, and administrator, and he just completed a year as APA president. But what he would really like is to be a resident all over again.

Residents training in psychiatry over the next few years "are going to see astounding things," he told a large gathering at the Presidential Symposium at APA's 2002 annual meeting in Philadelphia in May, and a few of those developments are likely to cause dramatic changes in the way psychiatry is practiced. But for residents to make the most use of what they learn, psychiatric educators will have to rethink the methods and goals that guided their training in the last century, Harding said.

In the past, "knowledge half-life was measured in decades instead of months," he stated. From here on, clinical competence for psychiatrists will have to be a continuing education process that will be measured "throughout the professional life cycle."

Psychiatrists in the 21st century "will need to be taught to manage constructive change and not resist change," Harding stressed. Educators and other leaders in psychiatry will need to ensure that they "foster professionalism in residency and medical school and throughout the life cycle and become advocates for quality care to government, public institutions, and, yes, insurance companies."

Carol Bernstein, M.D.: Programs that do an excellent job of training residents in both pharmacology and psychodynamics are "not the norm."

He called on psychiatric educators to teach psychiatrists to be "informed, scientifically grounded clinicians who use and advocate for effective treatment choices based on scientific data and clinical experience.

"Prepare us," he said, "to deal effectively with the forces that complicate providing that which is in the patient's best interest, such as the growing commercialism in medicine, the loss of doctor autonomy, and an outcomes movement that ignores the doctor-patient relationship in favor of nothing but objective data."

Changing the methods and philosophy that have formed the basis of psychiatry training will be no simple task, considering the array of forces lined up to impact the field, warned Carol Bernstein, M.D., assistant dean for graduate medical education and director of residency training in psychiatry at New York University.

The knowledge base in psychiatry is expanding so quickly that a major challenge for educators is "how to incorporate clinically relevant material" into residency curricula. Programs that do an excellent job of training residents in both pharmacology and psychodynamics are, unfortunately, "not the norm," and medical students gravitate to programs that stress one or the other, noted Bernstein, who is also APA's treasurer.

Residency programs may also need to find a strategy to incorporate training in psychiatric subspecialties. The Accreditation Council for Graduate Medical Education (ACGME) and the Residency Review Committee in Psychiatry are moving to require residents to have skills in areas such as geriatric and forensic psychiatry, but they have not made it clear how programs can incorporate such additional content into four-year residency programs, Bernstein said. In the future, "it may be almost impossible" to adhere to the traditional residency time frame, she added.

Psychiatry—like the rest of medicine—is also being forced to deal with the "competencies" movement, which is being driven in large part by the health care system, she noted. The conundrum for medical educators, however, is that while this prompts a need for "more real-time supervision," additional faculty time to accomplish this is rarely reimbursable under the existing system.

The goal of the "competency movement" is not to prepare doctors for a single event or exam, but to get them to view competency as "a habit," stated Donald Leach, director of the ACGME.

The push to require demonstrated competencies arose from several issues, Leach said, including public concerns about medical safety, variable patterns of care that aren't based on science, and complaints about "poor customer service." The competency-measurement system that the ACGME has put in place gives residency programs "the flexibility to adapt to a harsh educational environment" and evaluates "actual rather than potential education," he explained. "Whatever we measure, we tend to improve. . . . What we attend to and how we attend to it define who we are."

see ***Training*** *on page 20*

PFIZER ARICEPT
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Making Research Appealing

Psychiatry training will have to change if residents are going to graduate equipped to deal with the shifting demands of the health care system and the knowledge explosion about brain disorders and how to treat them, educators insist (see story on page 18). One intractable problem that defies easy solution, however, is how to make a research career appealing to future psychiatrists.

A critical strategy is to take "a longitudinal view of mentorship and skill building," said Charles Reynolds, M.D., a professor of psychiatry and neuroscience at the University of Pittsburgh and associate dean of its medical school. This can't happen in one training module or class.

The components to building a career in research are a complex blend of intellectual orientation, disciplined thinking, technical and managerial skills, and a commitment to the idea that "scholarly advances improve patient care," Reynolds said at APA's annual meeting in May.

Unfortunately, he noted, this mixture is becoming increasing difficult to find. The number of physicians who identify themselves as principal investigators or say that research is their major professional activity declined from 4.2 percent in 1984 to 1.8 percent in 1999. There has also been a 50 percent decline in the number of physicians applying for research fellowships at the National Institutes of Health/National Institute of Mental Health.

Reynolds attributed the steep decline to the amount of debt young physicians face and the time required to prepare for a research career.

He described a research-mentoring program instituted by Pittsburgh's Western Psychiatric Institute and Clinic that has established a research-career "developmental pathway" that begins at the undergraduate level and continues through medical school, residency, and fellowship and into junior and then senior faculty positions.

To make sure that there is adequate support for these promising researchers, the university set up the Junior Faculty Scholar program, which provides partial support for up to eight junior faculty members, Reynolds said. This backing comes in the form of salary support, research seed money, and statistical help on research projects.

"We've learned these students want a very focused didactic course. The students are active problem solvers; they don't like to just sit in a classroom," he pointed out. "What we haven't learned to do yet," he added, is find a way to foster greater faculty involvement with and mentoring of these researchers to be. Doing so "needs to be a value of the department chair, and if it is, it should then trickle down to the faculty."

Training

continued from page 18

And unavoidable, Bernstein stressed, is the influence of managed care on medical education and its continuing pressure on psychiatry training in particular.

The industry's reimbursement policies end up depriving residents of valuable clinical experience, because companies refuse to credential residents to treat insured patients and will pay for care only when a supervisor is present with the resident, she said.

Managed care also compromises training by its strategy of "using psychiatrists as medicators" and relying on psychologists and social workers to conduct psychotherapy, Bernstein said.

As residency directors devise ways to respond to all of these forces, they also will have to ensure that residents leave training with the expertise to treat a patient population that is growing more culturally and ethnically diverse, she emphasized.

Adapting to a changed training environment depends, however, on finding and training considerably more clinical faculty, she said. Yet unless academic and professional requirements are altered to reward teachers, success will be elusive.

"We have done a poor job of mentoring and faculty development," she said, and of "teaching teachers to teach." ■

*see **Minority Students** on page 39*

Community Psychiatry Major Focus Of APA's Fall Institute

As Chicago eases into autumn, APA is sponsoring a continuing medical education gem whose emphasis is on public psychiatry.

BY ELIZABETH GALTON, M.D.

"What a wonderful meeting!," "I am happy I could participate in this meeting," and "Thank you" are typical evaluation comments that APA's Institute on Psychiatric Services gets from participants.

Smaller than APA's annual meeting, APA's fall institute—which is being held October 9 to 13 in Chicago—gives participants a more intimate setting in which to learn and share their experiences. Since sessions are smaller, there will be many occasions for personal interaction with faculty and other attendees.

The focus of the institute is on community psychiatry, and this year's theme, "Community Counts: Creating and Supporting Systems of Care," gives presenters an enhanced opportunity to discuss their innovative approaches to dealing with all the obstacles psychiatrists commonly encounter in providing patient care. We know them well: funding shortages, managed care, difficult patients, and so on. Institute attendees will hear from colleagues about how their ideas, usually worked out in collaborative groups, made a difference. Their insights will stimulate thinking and give a fresh perspective. Many of the presentations give practical, down-to-earth descriptions of what was done and what worked.

The CME courses being offered this year are mostly repeats of previous years, included in the program again because of the enthusiastic evaluations they received. Dr. Kenneth Minkoff is presenting "Integrated Model for Treatment of Co-occurring Psychiatric and Substance Disorders." The goal of this course is to help practitioners develop a framework that facilitates treatment planning and treatment matching, and permits the design of a comprehensive, continuous, and integrated system of care.

How about "Help! I've Been Promoted: Introduction to Administration and Management" by Drs. Mark Russakoff and Philip Veenhuis. This course will cover the basic concepts central to understanding organizations, organizational processes, and the management of personnel for those who are interested in clinical administrative positions or have recently been promoted to such positions.

"Personnel Management for Clinicians Managers," led by Dr. Stephen Soltys, is a new, highly interactive course in which three psychiatrists with extensive senior management experience will help participants develop the skills to deal with a range of personnel issues that commonly occur in private and public mental health settings. Techniques for effective recruitment, supervision, negotiating, discipline, motivation, and termination will be described.

"Correctional Psychiatry," led by Dr. Henry Weinstein, is a presentation of the APA Caucus of Psychiatrists Practicing in Criminal Justice Settings. Basic topics will include careers in correctional psychiatry, the legal context of correctional psychiatry, psychopharmacology in correctional settings, and basic ethics issues, as well as the "rules of engagement," that is, the rules and routines of a correctional environment and how psychiatrists can work within such constraints. Advanced topics will include integrating medical and mental health services, cross-training with security personnel, and dealing with special populations.

Other courses include "Build Your Own Relational Database Electronic Medical Record (EMR)" by Dr. Daniel Deutschman; "Limit Setting With Psychiatric Patients" by Dr. Donald Misch; and "Engaging Resistant and Hostile Patients Into Participatory Treatment" by Dr. David Mee-Lee.

Can you afford to miss out? See you in Chicago!

The institute's preliminary program and a detailed description of all the CME courses can be obtained by calling (888) 357-7924 or visiting APA's Web site at <www.psych.org/sched_events/ips02/index.cfm>. ■

Dr. Galton is a member of the Scientific Program Committee of the Institute on Psychiatric Services.

Photo: Todd Rosenberg

Lake Michigan is one of Chicago's most dazzling attractions, luring millions to its beaches and lakefront parks every year. Swimming, sailing, and boating are favorite activities against a backdrop of one of the world's most recognizable skylines.

Register Now!

There are two easy ways to register for APA's Institute on Psychiatric Services, which is being held in Chicago, October 9 to 13:

- Register online on APA'S Web site at <www.psych.org/sched_events/ips02/index.cfm>
- Request a preliminary program from the APA Answer Center at (888) 357-7924. The program contains hotel information and registration forms.

More information on the institute begins on page 29. Save on fees by registering before September 9.

Are Atypicals Missing Link In Bipolar Treatment?

A series of recent studies agrees with APA's newly revised practice guideline for treating bipolar disorder: adding an atypical antipsychotic could be just what the doctor ordered.

BY JIM ROSACK

A substantial volume of current reports, including a number of presentations at APA's 2002 annual meeting in May, support the use of atypical antipsychotic drugs in the medication management of bipolar disorder and treatment-resistant depression. Indeed, a seemingly burning question during the annual meeting centered on what moniker the drugs in the class should really carry, given their expanding use beyond psychosis.

New research presented during annual meeting seminars, symposia, and new research poster presentations demonstrated the effectiveness of olanzapine (Eli Lilly's Zyprexa), risperidone (Janssen Pharmaceutica's Risperdal), and aripiprazole (Bristol-Myers Squibb's new "atypical-atypical," currently under review by the FDA; *Psychiatric News*, June 21) as adjunctive therapy (and in the case of olanzapine, as effective monotherapy) in the treatment of bipolar disorder. The annual meeting reports coincided with journal reports on the same topic and support the newly revised recommendation of APA's Practice Guideline for the Treatment of Bipolar Disorder, which was released earlier this year *(Psychiatric News*, January 4).

Augmenting Efficacy

"The goal of therapy in patients with bipolar disorder is to control symptoms to prevent relapse and manage complications such as mixed episodes," said Paul Keck, M.D., a professor and vice chair of research at the University of Cincinnati College of Medicine. Keck was a member of the work group on bipolar disorder helping to revise APA's practice guideline.

"Often, a mood stabilizer is not enough to adequately control all phases of the illness and maintain remission, so doctors may need to consider appropriate additional medication to stabilize mood," Keck explained in a prepared statement accompanying the annual meeting release of data on olanzapine's effectiveness in the disorder.

Annual meeting sessions detailed reports of clinical trials funded by Lilly in which olanzapine was found to be effective as an adjunct to either lithium or valproate, extending the time to relapse and prolonging remission in patients with bipolar disorder. One study found specifically that those patients taking olanzapine and either lithium or valproate remained free of symptoms of mania for an average of 362 days, versus 63 days for those patients taking only lithium or valproate. Rates of relapse for patients with a mood stabilizer plus olanzapine were 15.2 percent, versus 35.4 percent for those taking only a mood stabilizer.

A second Lilly-funded report detailed a comparison of olanzapine with the company's combined olanzapine and fluoxetine formulation (OFC). The company has been looking at OFC as a treatment for bipolar disorder as well as treatment-resistant depression and psychotic depression and hopes to file a new drug application with the FDA for the combined product later this year.

The comparison study found that olanzapine alone not only controlled the mania phase of bipolar disorder, but also improved depressive symptoms as well. The efficacy and rapid onset of the actions of OFC, however, were significantly greater than olanzapine alone.

In these studies the most frequently reported adverse events for olanzapine alone were weight gain, increased appetite, headache, and dry mouth. For patients treated with OFC, the most common adverse event reported was somnolence, followed by less-frequent reports of diarrhea, weight gain, dry mouth, headache, and increased appetite.

New research presented at the annual meeting, supported by Janssen Pharmaceutica, looked at the efficacy of adding risperidone to either lithium or valproate in patients with rapid-cycling bipolar disorder. The small study—only 25 patients—indicated that patients receiving risperidone in addition to a mood stabilizer experienced statistically greater improvement in scores on the Beck Depression Inventory and the Global Assessment of Functioning. However, scores on the Hamilton Depression Rating Scale and the Young Mania Rating Scale did not statistically differ from placebo.

A second new research report detailed a 15-month head-to-head comparison of adding either risperidone or olanzapine to a primary mood stabilizer (again lithium or valproate). In this study, funded by Janssen's sister company, Johnson and Johnson Pharmaceutical Research and Development, both drugs were found to be equally effective at improving outcomes over monotherapy with only the mood stabilizer. Side-effect profiles for both the atypicals did not differ statistically except for a very significant increase in the number of patients gaining a "clinically significant amount" of weight on olanzapine versus those on risperidone (four times as many).

Stand-Alone Efficacy

The June *American Journal of Psychiatry* contains the results of a Lilly-sponsored, three-week, double-blind, head-to-head comparison of olanzapine and divalproex (Depakote, marketed by Abbott Laboratories) for the treatment of acute mania.

The report comes from Mauricio Tohen, M.D., D.P.H., a Lilly clinical research fellow and associate clinical professor of psychiatry at Harvard and McLean, and his extensive list of colleagues at Lilly Research, Harvard Medical School and McLean Hospital, the University of California at Los Angeles Neuropsychiatric Institute, and the National Institute of Mental Health.

Zyprexa, incidentally, is only the third brand-name drug to gain approval from the Food and Drug Administration—in March 2000—for the treatment of acute mania. Lithium has been approved since 1972; it was more than 20 years before the second brand-name drug, Depakote, was approved.

Tohen's team followed just under 250 patients hospitalized for acute bipolar manic or mixed episodes. Patients were randomly assigned to receive either olanzapine or divalproex at starting doses consistent with the approved labeling of both medications. The researchers were free to adjust the dosing of either drug, based on clinical outcome and adverse events, as well as blood levels for patients randomized to divalproex. Patients randomized to olanzapine also had blood drawn, although no analysis was performed because no standard blood levels have been shown to be clinically valuable for olanzapine. Olanzapine dosing ranged from 5 mg to 20 mg per day, and divalproex dosing ranged from 500 mg to 2500 mg per day.

The patients taking olanzapine at the end of the three-week protocol showed a mean improvement in the Young Mania Rating Scale (YMRS) total score of 13.4 points, while the group taking divalproex showed an average improvement of 10.4 points. The three-point difference was statistically significant. Indeed, observations over the three weeks showed olanzapine to be statistically significantly better at improving mania on days 2, 14, and 21 of the study.

However, the mean improvement seen in the olanzapine group was statistically significant in only three YMRS items: increased motor activity, sleep, and language-thought disorder.

The percentage of each group achieving a "clinical response," defined as a greater than or equal to 50-percent improvement in the YMRS total score, was not significantly different. The olanzapine group, however, responded more quickly than the patients taking divalproex.

Similarly, the difference in the percentage of each medication group achieving remission (with a YMRS total score at the end of the study equal to or below 12) did not reach statistical significance either. But again, the olanzapine group achieved remission more quickly—in three days, compared with six days for the subjects taking divalproex.

Tohen's team got a surprising result when it compared the response of subjects with and without psychosis. The patients without psychotic features experienced statistically greater improvement while taking olanzapine as compared with divalproex. In the group of patients who did exhibit psychotic features, no statistically significant difference was found between the two drugs. The finding was contrary to what would have been assumed, knowing olanzapine's well-documented efficacy in treating symptoms of psychosis, the authors wrote.

"Often," Keck said, "patients with bipolar disorder require complex treatment regimens to manage all phases of their illness, creating a compliance challenge for patients and a management challenge for clinicians. These studies suggest that physicians may be able to use olanzapine as a foundation to simplify patients' treatment regimens, and the combination of olanzapine and fluoxetine could be an effective treatment choice." ■

Studies Close In on Diabetes, Psychiatric Illness Link

Researchers are striving to shed light on the puzzling link between severe and persistent psychiatric illness, psychotropic medications, and diabetes.

BY JIM ROSACK

A significant volume of recent data, including several reports of new research presented at APA's annual meeting in May, is helping some researchers begin to form what they believe is a solid hypothesis explaining the persistent link between psychiatric illness and problems with glucose regulation.

Many researchers suspect that psychotropic medications, antidepressants and antipsychotics in particular, may be aggravating an underlying predisposition or risk for developing diabetes. Although some researchers suspect the drugs' actions on 5HT1A receptors play a role in the interaction, no one believes the mystery is close to being solved.

"In psychiatry, we prescribe a host of medications that are known to carry a liability of weight gain," said John Newcomer, M.D., an associate professor of psychiatry at Washington University School of Medicine in St. Louis. "This weight gain is almost surely predominantly an increase in adiposity—the degree of body composition made up of fat, or adipose, tissue. We've known for years now, since the 1970s, that an increase in adiposity can be associated with an increase in insulin resistance," Newcomer, who has studied the question extensively, told *Psychiatric News*.

The first report of a suspected link between psychiatric illness and diabetes was published in 1926, well before the advent of psychotropic medications. A significant number of reports have followed, especially after the explosive development of psychotropic medications in the last few decades. This has led both clinicians and researchers to ponder what part of the link is inherent to the disease process and what part is played by medications.

Newcomer explained that if a patient has baseline insulin resistance, the amount of fat the patient deposits into adipose tissue from energy taken in from a meal tends to increase. Adipose tissue itself secretes two hormones, leptin and resistin (characterized for the first time about a year ago), both of which can contribute to increased insulin resistance.

"The drugs that cause the most weight gain, then, would cause the largest shift in insulin resistance, bringing out an overexpression of diabetes," Newcomer explained.

Yet it's not that simple, he warned. There are many reports of patients developing diabetes when taking psychotropic drugs, even when they don't show significant weight gain. And in many cases, the onset of diabetes is within months of starting the drug, rather than the years that diabetes experts would predict in a nondiabetic and otherwise healthy individual.

Add to that the numerous reports of diabetes in patients with schizophrenia that were published before the development of modern psychotropic medications, and a confounding question emerges: Which came first, an inherent risk to develop diabetes along with psychiatric illness (possibly because of a baseline elevated insulin resistance) or the known contribution of psychotropic medications to the development of diabetes?

Data Don't Explain Differences

The data are indeed conflicting, but there is a perception in the field, Newcomer said, to think that the highest risk of developing diabetes while on a psychotropic medication occurs with the antipsychotics, particularly clozapine or olanzapine. But that perception may not actually be on target, he noted.

"I think all this rank-order stuff is still really up in the air," he said.

"When I look at the preponderance of data," agreed John Buse, M.D., Ph.D., "there simply doesn't seem to be any major difference between antipsychotic therapies and the incidence of diabetes."

Buse is an associate professor of medicine and chief of the Division of General Medicine and Clinical Epidemiology at the University of North Carolina. "My advice to psychiatrists," Buse, a diabetes expert and director of the UNC Diabetes Care Center, told *Psychiatric News*, "is to recognize that with people who have severe and persistent disease—particularly schizophrenia, but also severe psychotic depression and bipolar disorder—there may be simply a higher risk of those people developing diabetes than the general population, regardless of their medication profile."

Recent Reports

Several recent reports have examined the issue. In May both Britain's Medicines Control Agency and the Japan's Health and Welfare Ministry issued diabetes-related alerts regarding olanzapine. The British agency cited 40 "reports of hyperglycemia, diabetes mellitus, or exacerbation of diabetes" including four that resulted in ketoacidosis and/or coma, and one resulting in a patient's death. Japan reported two deaths of patients with existing diabetes who were prescribed olanzapine and seven other patients who had "loss of consciousness or coma" while taking the drug.

Reports have recently been published that review the FDA's MedWatch system for reporting adverse events in the U.S. involving several antipsychotics and diabetes.

see ***Diabetes*** *on facing page*

Weight Management Cuts Risk Of Antipsychotic-Related Diabetes

New research suggests that comprehensive weight management can help alleviate the risk of developing diabetes while taking antipsychotic medications.

BY JIM ROSACK

In response to recent critical reports linking its $2.5 billion a year antipsychotic olanzapine (Zyprexa) to diabetes and diabetic complications resulting in some deaths (see story on facing page), Eli Lilly and Company has been busy researching ways to break the link or at least to alleviate its severity.

A report of research funded by Lilly and presented at APA's 2002 annual meeting in May suggests that patients who take antipsychotics may be able to reduce their risk of glucose-regulation problems by controlling weight gain through dietary changes and exercise.

Recent warnings from British and Japanese regulators about the link between olanzapine and severe diabetes prompted Lilly in May to strongly defend its drug's safety history, saying that any "report suggesting a causal relationship between Zyprexa and blood-sugar problems was not an accurate reflection of the European Union or Japanese labeling or even current scientific evidence."

Researchers have long thought that olanzapine causes weight gain in roughly one-third of patients who take it, with some of those patients gaining in excess of 25 pounds. That weight gain may increase the risk of developing type 2 diabetes.

"Managing weight gain is a challenge for many Americans, especially those with severe and persistent mental illness," said Franca Centorrino, M.D., director of the Bipolar and Psychotic Disorders Outpatient Program at McLean Hospital and Harvard Medical School.

Centorrino presented data at the APA annual meeting indicating that patients who took olanzapine, risperidone, clozapine, or ziprasidone and participated in a weight-management program were able to decrease their body mass index (BMI) and their weight.

At baseline, patients' average BMI was 36.6, with a corresponding average weight of 231.4 pounds. Each patient had gained at least 10 pounds while on antipsychotic therapy. The patients participated in weekly dietary counseling and twice-weekly group exercise including treadmill, step machine, biking, and rowing and were followed for 24 weeks.

Over 90 percent of the patients, Centorrino reported, experienced an average decrease in BMI of 2.1 points, on average losing 13.1 pounds. Patients taking olanzapine saw the largest reduction, followed by patients taking clozapine or risperidone (about half the reduction seen with olanzapine). Patients taking ziprasidone saw the smallest reduction in both BMI and weight, as would be expected since patients taking ziprasidone on average do not gain a significant amount of weight.

"Dependably managing schizophrenia with appropriate medication should be the first priority for physicians and their patients. Once their symptoms and lives are under control, patients can then implement simple lifestyle changes to help manage weight gain, and stay on the treatment that works best for them," said Centorrino in a press briefing.

"Dependably managing schizophrenia with appropriate medication should be the first priority for physicians and their patients."

A second study looked at the long-term benefits of the weight-management program. In a six-month follow-up study, Betty Vreeland, M.S.N., an advanced practice nurse at the University of Medicine and Dentistry of New Jersey, also found that nutritional counseling and regular exercise resulted in weight loss for patients on antipsychotic therapy.

"Our program was successful," Vreeland said in a press release, "because patients were very satisfied with the program and found it easy to follow. Ninety-eight percent of patients said they felt better in general, now eat healthier, exercise more, and have found better ways to cope with stress."

In addition, patients in both studies were able to lower their resting heart rates, blood pressure, cholesterol, and triglycerides by the end of the studies.

Managing weight not only reduces risk of diabetes, it also helps patients remain compliant with their medication, according to a Pfizer-sponsored study released at the annual meeting.

In a survey of 300 U.S. psychiatrists, completed for Pfizer (which makes the Geodon brand of ziprasidone) by Roper Starch Worldwide, 90 percent of those responding said they believe that weight gain is the most likely side effect to cause patients to stop taking their medication. The survey indicated that not only does weight gain affect compliance, but psychiatrists believe it affects patients' self-esteem as well and adversely impacts patients' quality of life. ■

Diabetes in Brief

Diabetes, a disease in which the body either does not produce enough insulin or is not able to use the insulin it does produce, occurs in two major types. Type 2 diabetes, associated with psychiatric illness and taking psychoactive medications, is easily distinguishable from the more severe form, type 1.

According to the American Diabetes Association, type 2, the most common form of diabetes, has a later onset (type 2 is often referred to as "adult onset"), and results from the body's inability to produce adequate amounts of insulin or the inability of cells to use the insulin to transport glucose out of the blood and into the cells for fuel. When glucose builds up in the blood, two things occur: cells begin to starve for energy, and over time cellular damage occurs, commonly in the heart, kidneys, eyes, and peripheral nervous system.

Type 2 diabetes often responds to changes in diet, a program of regular exercise, and weight loss. In addition, medications that boost insulin production as well as decrease insulin resistance are available. Rarely, in more progressive type-2 disease, insulin injections may become necessary.

Type 1 diabetes is usually diagnosed in children and adolescents and has been commonly referred to as "juvenile-onset diabetes." Type 1 results from a failure of the pancreas to secrete insulin. Current consensus regards Type 1 as an autoimmune disorder in which the person's immune system attacks and obliterates the beta cells within the pancreas that produce insulin. Patients with type 1 must rely on strict meal planning, exercise, and regular insulin injections to keep blood glucose levels from fluctuating wildly.

Diabetes

continued from facing page

These reports note that from 1990 to 2001, there were 242 accounts of new-onset diabetes and 54 reports of worsening of existing diabetes for patients taking clozapine. Most of the cases developed within six months of starting the drug, and 25 patients died as a result of diabetic complications.

A new report on MedWatch data presented at last month's Endocrine Society meeting in San Francisco reviewed risperidone. It identified 83 newly diagnosed cases and 40 patients with pre-existing diabetes that worsened after being started on the drug between 1993 and 2001. There were five deaths of patients taking risperidone tied to diabetic complications.

Elizabeth Koller, M.D., a medical officer in the Division of Metabolic and Endocrine Drug Products at the FDA, cowrote the MedWatch reports as an individual researcher rather than as an FDA official. Koller wrote in the risperidone report that "these data, along with similar reports of hyperglycemia with olanzapine, clozapine, and quietiapine, suggest that antipsychotic use may unmask or precipitate diabetes in psychotic patients. Causality cannot be ascertained because of the nature of these data and absence of control groups. While the number of such cases in the literature and in MedWatch attributed to clozapine or olanzapine are greater than those with risperidone, no conclusions can be made until direct prospective studies of causality and relative risk are done."

"Patients, and even physicians, hear these kinds of reports," Buse commented, "and they just freak out." He reiterated that the topic is actually very complex, and only solid research will help answer the questions.

In the March *Archives of General Psychiatry*, Newcomer reported the results of a study looking at glucose regulation in 48 patients with schizophrenia. The study was funded primarily through grants from NIH and NARSAD, using no industry funding.

Newcomer's study was a blinded look at modified oral glucose tolerance tests to compare glucose regulation in patients receiving placebo, a "typical antipsychotic," or risperidone, clozapine, or olanzapine.

All patients in the study were nondiabetic and had already been receiving antipsychotic medications, avoiding what Newcomer described as the "tendency to flip into diabetes in the first few months of taking the drugs."

The study concluded that subjects taking olanzapine and clozapine had significant increases in blood glucose after receiving a dose of the drug compared with those receiving a typical antipsychotic or placebo. Risperidone-treated patients showed glucose elevations that were significant compared with placebo, but not significantly different from the typical antipsychotic group.

A second recent analysis, independent of industry funding, was presented at the APA annual meeting. The data are from a study published in the February *American Journal of Psychiatry*, by Jan Volovka, M.D., Ph.D., chief of the clinical research division at the Nathan S. Kline Institute for Psychiatric Research in New York, and his colleagues.

That report detailed a double-blind, head-to-head efficacy trial of clozapine, olanzapine, risperidone, and haloperidol. The new research presentation at the annual meeting described changes in glucose and cholesterol in patients taking the four medications. The trial studied patients who had failed on previous treatments.

"One of the take-home messages was that there were only 14 outliers [of 101 patients studied] who had elevations of glucose levels above 125 mg/dl," Leslie Citrome, M.D., M.P.H., told *Psychiatric News*. Citrome, a co-author on both the *AJP* report and the annual meeting presentation, is director of the Clinical Research and Evaluation Facility at Nathan Kline and clinical professor of psychiatry at New York University.

"Of those 14, six were taking clozapine, four were taking olanzapine, three were taking risperidone, and one received haloperidol," Citrome said.

"Whenever I initiate treatment for patients with schizophrenia," Citrome said, "I always want to do a comprehensive medical workup." He often finds, he said, that this patient population has received little if any comprehensive medical care. "These patients do have a higher risk of a number of medical conditions, including diabetes." He regularly orders lab tests including baseline liver enzymes as well as fasting glucose, cholesterol, and lipid levels.

By screening for diabetes at the outset, Buse noted, psychiatrists can catch it early and avoid the troubling scenarios in the case reports, regardless of which antipsychotic drug the patient may need.

"If there is a difference between these drugs, I at this point couldn't tell you which of the drugs has the greatest diabetes risk—other than clozapine," Buse concluded. "But the difference between the one with the greatest risk and the one with the least risk is small in comparison to the absolute risk of developing diabetes that is associated simply with having a severe psychiatric illness."

Newcomer added, "The patient may well be at risk. But then we [as psychiatrists] have the responsibility to ask whether or not there is an iatrogenic contribution—a modifiable degree of risk that we add. When we cause an increase in weight or adiposity, we're going to see some very predictable changes in glucose regulation." ■

Bipolar Disorder Often Misdiagnosed In Children, Expert Says

Key factors help distinguish the diagnosis of child-onset bipolar disorder from disorders for which it is sometimes mistaken, such as schizophrenia, ADHD, and conduct disorder.

BY JIM ROSACK

Nearly 30 years of experience tells Elizabeth Weller, M.D., that the controversial diagnosis of childhood bipolar disorder is real, but the way it presents in children is significantly different from the way it presents in adults.

"In 1975, when I was a resident, no one believed bipolar disorder existed in children, despite the fact that Kraepelin, as early as 1921, identified it, saying though that it was rare," Weller told a standing-room-only audience at her Distinguished Psychiatrist Lecture at APA's annual meeting in May.

Elizabeth Weller, M.D.: "All patients with bipolar disorder must be on a mood stabilizer as the medication of first choice."

Weller is a professor of psychiatry and pediatrics and vice chair of psychiatry at the University of Pennsylvania School of Medicine.

Through the early 20th century, no one diagnosed bipolar disorder in children, Weller said, because it was thought that "normal childhood behavior was sort of hypomanic."

Today, nearly 100 years later, there is still resistance to diagnosing the disorder, which Weller believes not only does occur in children, but also is very often either misdiagnosed or not diagnosed at all.

"In one of our studies, back in 1986," Weller said, "we went back through 157 case reports of 'disturbed children' in the literature. We blinded them, rediagnosed them, and found that 73 cases met criteria for bipolar disorder. Then looking back at the cases, we saw that only 12 of those had carried a diagnosis of bipolar disorder."

Other research, she noted, has found that the average time elapsed between the onset of symptoms in children with bipolar disorder and actual diagnosis is around eight years.

Mania in Children

Mania in children is very different from the classical presentation found in adults, according to Weller. According to adult criteria, she said, "mania in children is 100 percent atypical."

"Rather than grandiosity or euphoria in children and adolescents, the mood is most often irritable," she said. "They often have a decreased need for sleep—not insomnia, but an actual ability to function well on much less sleep than normal. Psychotic symptoms are also extremely common in children and adolescents with mania, which is why they are often misdiagnosed with schizophrenia," she told *Psychiatric News.*

Symptoms may also vary depending on the age of the child at onset of the illness, she indicated. In one of her studies, she and colleagues found that for children aged 1 to 8, the predominant symptoms were irritability and psychomotor agitation, while those aged 6 to 12 were almost evenly split between an elevated mood and irritability.

With most of the patients over age 9, symptoms began to look more like those of an adult, with elation, grandiosity, emotional instability, paranoia, and a general heightened state of sensory arousal.

She reiterated that full manic episodes, according to *DSM-IV* criteria, are almost never seen in children. Episodes in children are not nearly as clear cut, and duration is often not long enough to satisfy the criteria. Most children would most closely match criteria for mixed episodes or cyclothymia, she said.

"Several studies now, including our own," Weller told *Psychiatric News*, "have documented that children who have mixed episodes or are cyclothymic, overwhelmingly—nearly 40 percent to 50 percent—grow up to be adults with full mania."

Differential Diagnosis

"Comorbidity is the reason we have so much trouble making this diagnosis, because mania occurring alone is actually extremely rare in children," Weller said.

The most common comorbid conditions with child-onset bipolar disorder, according to several studies, are attention deficit/hyperactivity disorder (ADHD) and conduct disorder (CD). Anxiety disorders, substance abuse, and personality disorders can also occur comorbidly, Weller noted.

Studies have indicated between 40 percent and 90 percent of children with bipolar disorder also have ADHD, and around 50 percent have comorbid CD.

In a study of 320 hospitalized children with bipolar disorder, Weller found that 28 percent had only bipolar disorder, while 37 percent had two diagnoses, and 27 percent had three or more diagnoses.

ADHD more commonly occurs alone (about 20 percent of children with a primary diagnosis of ADHD have bipolar disorder as well), but the two share several characteristics—hyperactivity, distractibility, irritability, decreased need for sleep, and temper tantrums. But, Weller said, there are also characteristic differences in the presentation of the two.

"In children with ADHD, from the time they start walking, they are wearing the soles right off of their tennis shoes," she said. "With bipolar, the hyperactivity is much more episodic."

One key to differentiating bipolar illness from ADHD is the child's response to medications. Children with ADHD do not respond to a mood stabilizer, according to Weller, but for children with true bipolar disorder, mood stabilizers are usually "wonder drugs." Conversely, a stimulant, which helps patients with ADHD,

see ***Bipolar Disorder*** *on page 39*

Once Down for the Count, Lithium Lives to Fight Again

After 50 years, new research is modifying the love-hate relationship between psychiatrists and lithium.

BY JIM ROSACK

The importance of the topic was underscored by the overflow crowd attending a workshop on the last day of APA's 2002 annual meeting in May. The psychiatrists simply wanted to know about the latest information on a very old "friend"—lithium.

Eric Smith, M.D., a PGY-2 psychiatry resident at Boston University Medical Center chaired the workshop, titled "Lithium Revisited." He was joined by bipolar experts Frederick Goodwin, M.D., research professor of psychiatry and behavioral sciences at the George Washington University School of Medicine, and James W. Jefferson, M.D., distinguished senior scientist at the Madison Institute of Medicine and director of the Lithium Information Center, who served as discussants.

Both Goodwin and Jefferson praised Smith for an excellent overview of a drug that Goodwin characterized as "born well before the chair of this workshop!"

Indeed, Smith reviewed 50 years of experience in using lithium in bipolar states, noting that by far, it is the one drug in all of psychopharmacology with a "fully documented history of efficacy." There are, Smith noted, over a dozen placebo-controlled clinical trials documenting the drug's effects in reducing the frequency of manic episodes as well as stabilizing cycling between mania and depression, on average producing a fourfold reduction of episodes of mania or depression.

Frederick Goodwin, M.D. (right), discusses combining lithium with another mood stabilizer, while Eric Smith, M.D., looks on.

Not only is the drug a well-established mood stabilizer, Smith said, but "recent research has documented that lithium has some neuroprotective effects, and it is by far the most effective treatment for reducing—by as much as 50 percent—the overwhelming mortality associated with bipolar disorder." Lithium is the only drug that has been documented to decrease significantly both suicidal gestures and decrease the number of completed suicides among patients with bipolar disorder.

"But," Smith hedged, "it has a huge side-effect profile and correspondingly huge problems with patient compliance. Simply put, patients feel so much better taking it, but they stop taking it to avoid the side effects."

Chronic lithium therapy is commonly associated with nausea, diarrhea, dizziness, and blurry vision. In more severe cases, it is often referred to as "lithium intoxication," which can be associated with headache, excessive sweating, electrolyte disturbances, ataxia, tremor, seizure, and in severe toxicity, coma leading to death.

"Clinicians are always warned to check serum lithium levels," Smith noted, "but you have to remember that the serum level must be correlated with the clinical response. In some people, toxicity can and does occur at what would on average be considered a therapeutic level."

Lithium "is the most effective medication we have and, when appropriately managed, is quite safe."

The accepted therapeutic level, he noted, is being rethought, based on recent research. "A therapeutic level now seems to be in the range of 0.6 to 1.0 milliequivalents per liter rather than what older references said, which was to keep your patients between 0.8 and 1.2." Keeping the serum levels lower achieves equal efficacy, Smith said, but can drastically reduce side effects. In addition, using long-acting lithium, given daily at bedtime, also has been shown recently to reduce side effects.

Goodwin and Jefferson agreed that lithium is by far the most effective mood stabilizer. They disagreed somewhat on its side-effect profile, especially in the long-term effects of lithium therapy. Goodwin actively champions combination therapy, using lower doses of lithium along with another mood stabilizer—he often adds low doses of divalproex—and has done studies that indicate that patients on combination therapy do just as well symptomatically, while experiencing fewer side effects.

Smith noted that a good number of current bipolar experts do believe in lithium and use it frequently, in spite of recent research suggesting that it has fallen out of favor.

"As long as you get a good history, talk openly and candidly about the side effects of lithium with your patients, and monitor those side effects over time," Smith concluded, "lithium is still the drug of choice in bipolar disorder. It is the most effective medication we have and, when appropriately managed, is quite safe."

The Web site for the Lithium Information Center is <www.miminc.org/aboutlithinfoctr.html>. ■

AMERICAN PROFESSIONAL AGENCY P4C

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Thomas William Salmon: Psychiatry in Time of War

BY LUCY OZARIN, M.D.

Thomas William Salmon, M.D. (1876-1927), was in charge of psychiatry for the American Army overseas during World War I. He became medical director of the National Committee for Mental Hygiene (now the National Mental Health Association) in 1915. With World War I under way in Europe, the organization had begun to collect information about psychiatric casualties and their management. Also, an earlier survey of American Army troops had found a higher number of psychiatric cases than in the civilian population.

In early 1917 Salmon, with Dr. Pearce Bailey, a New York neurologist who later worked in the Army surgeon general's office, and Dr. Stewart Paton of Princeton, N.J., headed the preparation of a neuropsychiatric service plan for the Army. Salmon also went to Great Britain to study how that country was managing psychiatric casualties. When the United States entered the war, Salmon was named senior psychiatrist for the Army overseas. The plan had included the screening of inductees and establishment of base hospitals and 30-bed units in general hospitals for psychiatric patients. Most important was the designation of division consultants who were senior psychiatrists.

The term "shell shock" had come into popular use by this time but was rejected by Army personnel in favor of the term "war neurosis." Dr. Edward Strecker, a division consultant, wrote that the condition resulted from operation of defensive mechanisms based on the instinct of self-preservation.

The proposed plan, put into operation by Salmon, worked as intended. Soldiers evacuated because of psychiatric symptoms were treated as close to the front as possible with rest, nutrition, occupational therapy, and recreation. The staff and therapeutic atmosphere reinforced the expectation that these soldiers would return to their units for further duty. Psychotic patients were sent home to the United States. (Unfortunately, the success of the World War I plan was forgotten and had to be rediscovered during World War II.)

After the war ended in 1918, Salmon returned to the United States with much concern for the continuous care of veterans with psychiatric conditions. The Bureau of War Risk Insurance and the Public Health Service (PHS) were the responsible agencies. Existing PHS hospitals were first used, with the addition of new facilities, and the overflow was directed to public and private mental hospitals. Salmon found these arrangements unsatisfactory because of conflicting policies and staff limitations among Army and Navy agencies.

In 1919 the surgeon general of the PHS invited Salmon and four other outstanding neuropsychiatrists to develop a plan for hospitalized veterans who were diagnosed as mental and neurosis cases. The final report recommended special veterans hospitals.

The Harding administration, which came into office in 1921, rejected the report, claiming that no additional beds were needed. Salmon tackled the rejection head on, enlisting the aid of the American Legion and other organizations. Spokespersons for the American Legion later declared that Salmon was the greatest single factor in getting medical help for disabled veterans.

That same year, Congress established the Veterans Bureau to consolidate agency efforts, but a corrupt director, Dr. C. R. Forbes, ignored the psychiatrists' recommendations (he later went to federal prison for misusing federal funds). It was some years before the Veterans Bureau was able to become an efficient organization.

Salmon left his imprint on the practice of military psychiatry, and his memory lives on through the annual Salmon Lecture and Medal sponsored by the New York Academy of Medicine. ■

Grieving

continued from page 4

whose firefighter husband had also disappeared and who, on the day after the attacks, held an open house for sympathetic visitors.

There are normal grief, pathological grief, and ambiguous grief, Bellotti continued. Normal grief lasts one to two years. In pathological grief, healing does not occur, and the bereaved cannot move ahead with his or her life. Ambiguous grief is where one is not sure whether a person is dead or not. "The swings between hope and grief are tumultuous," she said. It has been reported that the survivors of missing victims are at high risk for anxiety, depression, and psychosomatic symptoms, and the longer the possibility that a loved one is still alive, the greater the risk for psychopathology. But tolerance for such uncertainty varies, she said.

Today, Bellotti indicated, Stella and Jeff are experiencing a mixture of pathological and ambiguous grief. They are still angry, they still refuse to accept that their daughter is dead, and "emotionally they are spent and seem to have aged rapidly."

Grief, Bellotti concluded, cannot be resolved unless there is an acceptance of death and unless one finds "a new ray of optimism in life." Yet such acceptance and optimism are indeed possible, O'Brien indicated. In the two weeks after September 11, he said, he "learned about courage and bravery in some wonderful people." ■

letters to the editor

More on Psychologists

The May 17 issue includes an article discussing the appointment of a psychologist to head the Yale Child Study Center. I do not have information on all the factors that led to this discussion but can comment on the broader implication of this action, which was not addressed in the article.

Currently we are experiencing a crisis in recruiting and retaining psychiatric researchers. This crisis is most profound in child psychiatry. To address this crisis, we need to first focus on enhancing research training in general and child and adolescent psychiatry residency training.

Then it is essential that the route into child psychiatry training be shortened and streamlined without interference with the quality of training. This will increase the number of child psychiatry practitioners and researchers. We now experience a severe shortage of both.

SIDNEY WEISSMAN, M.D.
Evanston, Ill.

Our organizational struggle with psychologists on prescribing authority has gone over the edge. We claim that allowing psychologists to prescribe is bad for patients, but are we willing to consider any outcome design that might lead to objective conclusions?

The New Mexico experiment seems very cautious and demands a great deal of study and supervised practice. Its graduates would have a good biological immersion that might make them equal to our nonpsychiatric physician colleagues in combination with their clinical psychological skills. They might even be as good as some of us.

The antipsychology frenzy is seen again in our opposition to the appointment of Alan Kazdin, Ph.D., to head the Yale Child Study Center. This protest echoes complaints voiced years ago—in *Psychiatric News*—about social workers supervising psychiatry residents in psychotherapy. Some of us believe that an M.D. should not look up to a non-M.D. for supervision—it might hurt the identity of the future leaders of the mental health team. This excess credentialism does not help us as team leaders or team players, and for our Board of Trustees to tell Yale who is best for its distinguished program is errant foolishness—especially when we have to say that, of course, we mean no criticism of Dr. Kazdin.

Again, as in psychologist prescribing, the guild or "turf" issue lurks right out there in the open. An objective observer might think we're afraid the innovation might work too well.

E. JAMES LIEBERMAN, M.D.
Washington, D.C.

Meeting Hang Up

Much of the use of cellular phones at APA's 2002 annual meeting in Philadelphia was clearly unacceptable. I do not recall a single event I attended where an audible cellular phone did not ring. And in several of these situations, the people called actually had the audacity to answer their phones in earshot of others in the room. Some people left the room to take their calls, but the volume of their voices ensured that they were still heard from the lobbies where they continued their conversations.

Quite simply, we must create and enforce appropriate social norms for cellular phones. While psychiatry supports empathy, the behavior that I endured at the meeting due to phones was anything but.

Cellular phones must be silenced in public forums. Please understand that I write this as a person who rarely goes without his phone, but I put it in vibrating mode when I am in public. If it buzzes, I decide whether I am in a position to answer and hold a conversation while not intruding on others. My caller ID generally identifies callers, and any unanswered calls go to voicemail for later response.

There should be zero tolerance at meetings for audible phone use in lecture halls, in much the same manner as we treat tobacco. Meeting registrants should be forewarned, in writing, about the standards for public behavior, which will lead to group norms being created and enforced by others via peer pressure. Those who believe that their immediate availability is critical might consider staying home.

As a microcosm of society, we are trying to figure out acceptable cellular phone use in much the same way as theaters and concert halls are struggling to address the issue. Apparently common sense and courtesy are not prevailing, so a bit of guidance and help is in order.

BRIAN L. GRANT, M.D.
Seattle, Wash.

More on Fromm-Reichmann

When I was a resident in the mid-1950s, my supervisor was in a training analysis with Dr. Frieda Fromm-Reichmann, and I heard some interesting anecdotes that Dr. Fromm-Reichmann had told about herself. On her immigration voyage to the United States, she practiced her English with a young American man on the ship. Near the end of the voyage she asked him, in her heavily accented English, "Now I want that you should teach me the dirty little four-letter words that you use to say how your really FEEL."

I once attended a meeting where she reviewed the analysis of a schizophrenic patient with the patient. They were sitting in two chairs facing the audience at an angle to each other. Dr. Fromm-Reichmann asked the patient whether there was any one moment that had made a crucial difference in her recovery. The answer has guided me ever since:

"Oh, yes. It was Christmas Eve in 19__. You had been sitting with me for an hour a day for a year, and I had refused to say anything to you. When you left on Christmas Eve, you said you would be back tomorrow, and I knew I had you [in a broken promise, like all the other people]. No one was going to come to see me on Christmas Day—but you came!"

I have always remembered that lesson in the possible importance of seemingly insignificant acts in therapy.

C. BROOKS HENDERSON, M.D.
Dunnellon, Fla.

Early Detection in Autism

This is in response to the article on autism in the June 7 issue. Some readers may be interested in the following development.

There is evidence suggesting that some cases of autism may be related to malformation of the brain stem. This can occur as early as 20 to 24 days after conception, before a woman may know she is pregnant. It is also possible that in some cases this abnormality may be detected at birth by electrophysiological means. It may not be necessary to wait about three years to confirm the presence of autism.

The benefit of early detection would mean that help to ameliorate the condition could be started much earlier than now, to the benefit of child and family.

MAURICE RAPPAPORT, M.D.
San Jose, Calif.

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.

Opinions expressed in letters do not necessarily reflect the views of APA or the editors. Clinical opinions are not peer reviewed and thus should be independently verified.

residents' forum

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the health sector, so does demand. This could explain why there might be an oversupply of practitioners yet health care training programs can continue to grow and still provide very high job placement rates in already saturated markets for their graduates.

Many opponents also propose that there would be a detrimental effect on quality of care. As the number of less-trained health practitioners with ever-increasing privilege authority continues to grow, so too would the use of unnecessary medications and diagnostic tests and subsequent need for management of side effects and false-positive results (remember sensitivity and specificity?). Furthermore, as the methods employed by one coalition of providers proves successful at obtaining more privileges, other coalitions will seek to obtain those same privileges to gain competitive advantage.

The estimated supply of nonphysician clinicians in training continues to grow at multiple times the rate of physician trainees, and soon their supply will overshadow that of all M.D.s and D.O.s. As health care expenditures continue to rise as a percentage of GDP, and business leaders continue to put pressure on politicians to decrease the rate of growth, the limitations in access to basic care continue. For example, the tepid mental health parity bill that allowed insurance companies to opt out if they could demonstrate a 1 percent increase in health expenditures was defeated late last year for fears of further uncontrolled increases in health care costs.

As the leadership of the American Psychological Association attempts to convince legislators of the need to obtain prescriptive privileges to provide adequate care, that association only diminishes the work and accomplishments of its own members and the legitimacy of its current scope of practice throughout the United States. More important, the proposed changes ultimately fail to address the disparities in access to care. I propose that all mental health care practitioners increase organized efforts toward more common interests. Our lack of unity has kept us from achieving legislative successes in more pertinent areas such as mental health parity and improving access to care. With solidarity we could propose the best strategy for legislators to ensure an optimal and more equitable system. ■

education & training

Minority Students

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Mental illness does not discriminate; it strikes both rich and poor and cuts across all ethnic and cultural backgrounds. Thus, the effective treatment of people suffering from mental illness requires a culturally competent psychiatric workforce. Equally important, however, is a workforce that understands and relates to patients of various backgrounds because they themselves are members of that particular group. Because of this need and the shortage of minority psychiatrists, the recruitment of minority students into psychiatry has become a high priority for the psychiatric profession and for APA.

The American Psychiatric Foundation and APA have teamed up with AstraZeneca to address this challenge by creating the American Psychiatric Foundation/AstraZeneca Fund for Minority Recruitment, with an educational grant of $25,000 from AstraZeneca. This fund will be administered by the foundation's Board of Di-

clinical & research news

Bipolar Disorder

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pushes a bipolar child into increased symptoms of mania.

CD is distinguished from bipolar by a characteristic lack of guilt—children with CD will do something wrong, but have no remorse, Weller said, whereas bipolar children often feel guilty, even for no reason. Children with conduct disorder also often feel paranoid, as do children with bipolar illness, "but paranoia in kids with conduct disorder is not evidence of psychosis," Weller emphasized, "it's justified—they did something wrong, and now someone is out to get them!"

Schizophrenia, she pointed out, the most common misdiagnosis for these children, is distinguished by having a more insidious onset, with no rush of speech or flight of ideas.

Getting the diagnosis correct, Weller stressed, leads to the correct treatment pathway.

"All patients with bipolar disorder must be on a mood stabilizer as the medication of first choice," Weller said. "I personally like lithium—in smaller doses than we used to use—however, there are several [mood stabilizers] now that are promising." (See story on page 27.) ■

Parity

continued from page 1

once and for all we will no longer accept stigma, we want to end discriminatory insurance practices, and we want full mental health coverage for men, women, and children!

"The only people we don't have support from is the health insurance industry, and if they think they can stop parity, they can't."

Kennedy praised the grass-roots advocacy effort for "putting the pressure on Congress to pass parity last year, although the legislation was ultimately defeated by special interest groups."

Patient Advocates' Perspective

Kennedy also thanked Ron George, who addressed the crowd immediately before Kennedy spoke, for his willingness to talk about a painful subject. His daughter, Lisa, died at age 19 from medical complications of anorexia nervosa, a condition she was diagnosed with a few years earlier. Eating disorders affect 7 million women and 1 million men, according to the National Association of Anorexia Nervosa and Associated Disorders (ANAD).

"When my daughter was hospitalized, she did regain the weight she had lost, but the underlying problem wasn't addressed. Even when we paid out of pocket for daily counseling, it wasn't enough to save her. What she needed was long-term intensive treatment, but that wasn't covered," said George.

Speaking on behalf of ANAD, George implored members of Congress to ensure that eating disorders are covered in any parity bill that is enacted.

"Early intervention in anorexia and bulimia is more effective and ultimately less costly than heroic treatment. ANAD estimates that the inpatient cost of treating eating disorders can run as high as $30,000 a month. But our insurance company paid $138,000 for 22 hours of extraordinary effort to save our daughter, and our daughter is dead. Nobody won."

George was one of three patient advocates who described the personal costs of inadequate mental health insurance coverage.

Lisa Cohen, M.S.W., was diagnosed as a young adult with bipolar disorder and a rare blood disorder (idiopathic thrombocythemia). "Although both these disorders are life threatening, my insurance company chooses to view these illnesses with an unequal eye. The coverage for mental illness has been much harder to obtain. The benefits I have received have been discriminatory and incomplete," said Cohen.

Her insurance plan has a 30-day limit on hospitalization for psychiatric disorders. "During a severe episode of bipolar disorder, the hospital planned to discharge me when my stay was 31 days instead of 30. I continued to be hospitalized only because my family intervened and paid the hospital for the additional days," said Cohen.

"Meanwhile, my insurance company had no trouble paying for any and all care for my blood disorder, including more tests than I care to count. No questions asked, no limits on doctor's visits or hospital stays."

Jim McNulty, president of the National Alliance for the Mentally Ill, said that when he was diagnosed with bipolar disorder in 1987, his insurance plan provided no coverage for treatment of mental illness. "I was forced to seek treatment from a primary care physician who knew nothing about treating manic depression. I lost my job, my home, and my family."

McNulty's situation improved in 1994, when, as a resident of Rhode Island, he benefited from the state's first parity law.

"Finally I was able to afford to see a psychiatrist who prescribed medication and regularly monitored my condition. The results of good treatment were rapid. I recovered from the depths of despair, started a business, and began helping others with similar problems," said McNulty.

Cost Issues

Wayne Creelman, M.D., president of the Western Michigan Chapter of the Michigan Psychiatric Society, attended the rally on behalf of APA. Creelman told *Psychiatric News*, "I am impressed by the incredible support of members of Congress, the Mental Health Liaison Group, and the folks here who know that passing parity legislation is the right and timely thing to do."

Creelman and several patient advocates attending the rally visited their Congressional representatives on Capitol Hill after the rally. Creelman is a Republican candidate for the Michigan legislature for the 9th District. "I am embarrassed to say that Michigan is one of the 15 states that have not enacted parity legislation. If elected, I will move passage forward."

Creelman added that opponents in business and the insurance industry have unfairly labeled parity legislation before Congress as an unfunded mandated benefit. "We know that the costs to employers are pennies compared with the long-term cost savings. Parity is not a mandated benefit. The legislation applies only to employers who already offer mental health benefits and requires them to be covered at the same level as medical benefits."

Creelman's comments were supported by a May 22 memorandum from the Congressional Budget Office to "interested parties." The CBO reaffirmed its August 2001 projection that enacting the Mental Health Equitable Treatment Act would, on average, increase insurance premiums by less than 1 percent *(Psychiatric News*, June 7). The CBO also concluded that the parity bill now before Congress doesn't require health plans to cover services that are not medically necessary or new services they did not previously cover.

"Under the bill, plans would retain the ability to use exclusions of specific services, as well as medically necessity and other cost-management techniques," according to the memo.

A memorandum to APA members on Congressional support of the parity legislation from Jay Cutler, J.D., director of the Division of Government Relations, is posted on the Web at <www.psych.org/pub_pol_adv/parity52802.cfm>. ■

Medicare

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tion of Retired Persons, is worried that seniors will pay the price for increases to health care providers. David Certner, director of federal affairs at AARP, said that the proposal would mean "less money for drug benefits in a pot that was already insufficient," according to the *Times*.

Goldreich told www.kaisernetwork.org that Thomas and Tauzin "swear it isn't [coming from the prescription drug benefit]."

The committee chairs claim that their proposal for a prescription drug benefit would produce a cut in the cost of prescription drugs for seniors of 30 percent. The savings would be the result of promoting competition among private health insurance companies that would offer policies to cover drugs only and by encouraging them to negotiate discounts with the drug companies.

"Medicare Physician Payment Update Background and Talking Points" is posted on the Web at <www.ama-assn.org/ama/pub/article/6930>.

Numerous reports on Medicare are posted at <www.kaisernetwork.org/daily_reports/rep_index.cfm>. ■

from the president

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also been able to encourage the symposia organizers to include a wider diversity of presenters. An APA committee representative sits in on every ISS session to monitor for bias in the presentations (for example, overtly promoting the sponsor's product), and subcommittee members listen to tapes of the sessions after the fact. Evidence of bias can lead to exclusion from subsequent APA annual meeting presentations.

What about those elaborate pavilions on the exhibit floor, where pharmaceutical companies give away all sorts of trinkets? My problem is not with the companies—marketing being the quintessential capitalist exercise—but with the behavior of some of our colleagues. Are there any psychiatrists in America who can't afford to buy their own pens, notepads, and frisbees or to call home from the annual meeting on their own dime? What other than a feeding frenzy can explain the shopping bags crammed with giveaways that some attendees can be seen lugging from the convention center? (Do they really send their kids to the park to play with frisbees emblazoned with the name of a popular SSRI?) I don't blame the companies for trying to foist this stuff on us; I blame us for taking it.

Imagine what would happen if we—all of us—suddenly stopped clamoring for logoed paperweights and calendars. Picture the consequences of our approaching the pharmaceutical displays and asking for reprints of controlled studies from peer-reviewed journals demonstrating the efficacy of the product being hawked and comparing it with alternatives (especially less expensive ones) on the market. Within a year, the nature of the handouts would change from squeezable tension relievers shaped like the human brain to compilations of published studies and other educational information. And it's all in our hands.

Are there risks attendant to the pharmaceutical presence at our meetings? Without question. Moreover, the risks mutate over time. Last year, the Scientific Program Committee noticed that some poster presentations were being made by pharmaceutical company representatives rather than the researchers and that reps were present to distribute marketing information. In response, this year reps were barred from the poster areas. Should we simply toss the industry out of our meetings? I think we would lose more than we would gain by doing so. Rather, I think the AAN Board of Directors got it right when it said:

"We value the relationship the AAN has had with industry, but the corporate role needs to be continually defined and monitored. When violations occur, they must be dealt with promptly and decisively with imposed penalties that are proportional to the infractions. Appropriate guidelines are an essential component of managing this relationship, if we are to maintain our integrity as an organization and the confidence of the public in the medical profession." ■

professional news

Migraines

continued from page 5

said Silberstein. For example, patients with bipolar disorder may overmedicate themselves with a caffeine-barbiturate combination to treat their mood disturbance.

Once the comorbid disorder is correctly diagnosed, one medication can often be used to prevent recurrent migraines and treat the psychiatric disorder, said Silberstein. For example, divalproex can be used to treat mania, anxiety disorders, and migraines. The tricyclic antidepressants amitriptyline and nortriptyline are effective in treating migraines and depression, anxiety disorders, and insomnia. Selective serotonin reuptake inhibitors (SSRIs) are used to treat depression and migraines, although there is less research on their efficacy for migraines.

Beta-blockers should not be used to treat migraines in people with depression, and SSRIs are contraindicated in people with mania, said Silberstein.

Patients who experience migraines can also benefit from psychotherapy, such as cognitive-behavioral therapy and relaxation techniques, including biofeedback, he noted.

The "Evidence-Based Practice Guidelines for Migraine Headache" is posted on the Web site of the American Academy of Neurology at <www.aan.com/public/practiceguidelines/headache_gl.htm>. Additional information is posted on the Web site of the National Headache Foundation at <www.headaches.org>. ■

Nursing Homes

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ices are provided to residents with mental disorders conform with strict federal regulations enacted as part of the Omnibus Budget Reconciliation Act (OBRA).

OBRA's goal was to protect nursing home patients from abuse and neglect and to ensure that they receive quality medical care, explained workshop chair Marc Rothman, M.D. It mandates that residents receive comprehensive mental health assessments, for example, and are free from "unnecessary" medications. This was a response to a volume of complaints to Congress about nursing home patients being overmedicated, often into a stupor, and then ignored.

OBRA also requires that residents on antipsychotic drugs receive gradual dosage reductions and are provided with "behavioral interventions" as well. In patients for whom a dosage reduction would not be appropriate, psychiatrists must document their reasoning, Rothman noted. For residents who have not been on an antipsychotic, psychiatrists must show that such a drug is necessary to treat a specific condition.

OBRA appears to have succeeded in its goal of significantly decreasing use of antipsychotics and restraints, said Rothman. ■

Moffic Award

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to the cultural concerns of both clinicians and patients.

As chair of the department of psychiatry and behavioral sciences at Eastern Tennessee State University in Johnson City, Tenn., Pumariega spent some time researching and writing about the general lack of cultural sensitivity in managed behavioral health care systems.

"The managed behavioral health care industry was developed and is run mainly by Caucasian males," Moffic said. "With the prominence of poor ethnic minority patients in the public sector, the lack of cultural competence in managed care has become even more of a concern."

Pumariega led the development of a 1996 document, titled "Best Principles for Managed Care Medicaid RFPs: How Decision Makers Can Select and Monitor High Quality Programs," which included recommendations for states setting up managed care systems that included culturally competent assessments and certain ethical standards in contracts between managed care vendors and providers.

That same year, as chair of the National Latino Behavioral Health Workgroup, Pumariega oversaw the production of cultural competence guidelines, titled "Cultural Competence Guidelines in Managed Care Mental Health Services for Latino Populations."

In the guidelines, Pumariega advised that "a culturally competent individual at the executive level should be appointed to take responsibility for and have authority to monitor implementation of the cultural competence plan."

Moffic said that the National Committee for Quality Assurance, the accrediting body for managed care companies, now requires that managed care companies implement cultural competence standards, largely due to Pumariega's influence.

The following year saw another strong advocate for culturally competent care receive a Moffic Award. Michael Hoge, Ph.D., chief operating officer of Yale Behavioral Health, helped to design the program that serves diverse Medicaid populations and addresses not only patients' psychiatric needs, but social needs as well.

Moffic explained that because many people with severe or chronic mental illnesses have unstable living situations, they must receive social or residential services to be able to find adequate housing, learn work skills, and acquire social supports. Often, the systems that provide psychiatric care and social care are different, and the two don't necessarily communicate well with one another.

Staff at Yale Behavioral Health helps patients find housing and build social support systems while they are in treatment. "There have been few systems that take care of psychiatric and social needs under one funding source, and this system has been successful," said Moffic.

According to Ezra Griffith, M.D., who nominated Hoge for the Moffic Award, the Yale system "was able to maintain a primary emphasis on client need, placing cost as a secondary consideration."

As associate professor of psychology in the Yale University department of psychiatry, Hoge has also used education as a tool to improve managed behavioral health care systems. He developed a successful curriculum for psychiatry residents at Yale that extends beyond the practice of managed care to the principles that underlie it. Residents learn how to develop relevant treatment plans, employ evidence-based treatments, and analyze the cost of those treatments, for instance.

"Hoge teaches how managed care has driven improvements within the field of medicine," said Moffic. He has also taught these principles to mental health professionals from other disciplines, administrators, politicians, and consumers. Hoge envisioned an "integrated system that would provide high-quality, cost-effective mental health care," Moffic continued.

Nominations are now being invited for the Moffic Award. Moffic can be reached by phone at (414) 456-8950 or by e-mail at bpernitz@mail.mcw.edu. ■

Moffic Award Winners

The Moffic Award for Ethical Practice in Public Sector Managed Behavioral Health Care, established in 1998, recognizes individuals and organizations that set new standards for ethical practice in public managed care systems to improve patient services in public managed care systems. The awardees are listed below:

1998-99

Cliff Tennison, M.D., and the Helen Ross McNabb Center, for advocating for patients' rights and creating new services.

1999-2000

Noel Drury, M.D., for leading a successful challenge to Magellan Behavioral Health in Montana while continuing to work on behalf of patients in the public sector.

The Greater Oregon Behavioral Health Inc. and Peter Davidson, M.D., for finding new ways to combine ethics and cost-effectiveness, including forming a cooperative relationship among agencies that incorporate prevention and outreach efforts to those at risk.

David A. Pollack, M.D., who, as a Robert Wood Johnson Health Policy Fellow, worked on managed care reform and helped to draft the federal Patients' Bill of Rights.

Andres Pumariega, M.D., who led a national effort to incorporate cultural competence into public sector managed behavioral health care systems.

Roy C. Wilson, M.D., who, as director of the State of Missouri Department of Mental health, resisted pressures to enter immediately into managed care contracts or preserve the status quo and led a slow and successful transition into managed care.

2001-02

Michael A. Hoge, Ph.D., who created a managed care behavioral health organization, Yale Behavioral Health, which successfully demonstrated how patient care could be managed ethically and still succeed financially.

2002-03

Christine Cline, M.D., M.B.A., medical director of the Behavioral Health Services Division of the New Mexico Department of Health, for leading a smooth transition into a managed care system and ensuring that quality accountability is built into managed care objectives.

James Sabin, M.D., who helped develop the Harvard Community Health Plan in 1975 and is currently codirector of the Center of Ethics in Managed Care of Harvard Pilgrim Health Care.

Most Honorable Mention

1998: David E. Dangerfield, D.S.W., Ryan Finkenbine, M.D., Paulette Gillig, Ph.D., David A. Pollack, M.D.
2001: Joel S. Feiner, M.D.
2002: Barbara J. Burns, M.D., Leighton Huey, M.D.

Film

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beling children with different diagnoses instead of relating to them as human beings or trying to understand where they are coming from," she said.

Panelist Ivan Walks, M.D., a psychiatrist who is chief health officer and director of the Department of Health in Washington, D.C., said he too takes issue with the way traumatized children are treated in this country. "It bothers me that we keep diagnosing children instead of environments," he said.

Children with serious and persistent mental health problems should have to go no further than their own backyards to find help, he stated. "We need to stop pretending that the way to fix a child is to send him or her to the place where they 'fix' children. In D.C., if your child is a fire setter or a sexual offender, the place he or she is sent to get 'fixed' is far away."

Panelist and family therapist Emily Brown, L.C.S.W., agreed that a fragmented mental health system doesn't work for children. A past president of the Greater Washington D.C. Coalition for Mental Health Professionals and Consumers, she said she watched as the Montgomery County, Md., mental health system became privatized and put up for bids. "No private group will bid on treating families with adolescents," she said. "Schools are being used to treat children with mental health problems."

Brown said that, ideally, children should have a continuum of mental health programs at their disposal.

How can quality mental health programs for children become a reality? Former APA President Harold Eist, M.D., said that people who care about children should back politicians who care about children.

"One politician, with the stroke of a pen, can do more good work than all of us, working all our lives, can do for the children of America," he emphasized, "and one politician, with the stroke of a pen, can do more harm than all of us can repair to the children of America."

Marasco agreed. "I know many parents who have the same problems that I have had [with the mental health system], and I tell them, 'You can't just sit around and complain; you have to do something about it. Become an active voter.'

"I won't stop," said Marasco tearfully. "James isn't the only one in this situation, and everybody deserves a chance."

More information about "If I Could" is available on the Web at <www.ificould movie.com>. ■

Drug Industry

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are "legitimate" and defined in advance and who have been selected using criteria directly related to the identified services. It stipulates that the number of consultants not be greater than the "number reasonably necessary to achieve the identified purpose," and specifies that "it is not appropriate to pay honoraria or travel or lodging expenses to nonfaculty and nonconsultant attendees at company-sponsored meetings."

The same guidelines apply to physicians who are recruited and trained at company meetings to participate in the company's speaker bureau, as long as the participating physicians receive "extensive training on the company's drug products and on compliance with FDA regulatory requirements for communications about such products."

Scholarship and educational funding to students, residents, fellows, and other health care professionals to attend "carefully selected educational conferences"—a major educational, scientific or medical association conference—is permissible, "so long as the selection of the individuals is made by the academic or training institution."

As far as those pens, notepads, and other "reminder" items of minimal value that carry company or product logos, they are permitted "if they are primarily associated with a health care professional's practice." Items that are "not of substantial value ($100 or less)" may be provided to physicians if they are primarily for the benefit of patients, and should be offered only on an "occasional basis." The code indicates that a stethoscope or anatomical model would be acceptable; however, a VCR or CD player, music CDs, artwork or floral arrangements for the office, and those tickets to concerts and sporting events are out of the question.

Unless a physician is a contracted speaker or consultant to a company, the code declares that "cash or equivalent payments of any kind [such as a gift certificate] create a potential appearance of impropriety or conflict of interest" and therefore should not be offered.

The code concludes that "nothing should be offered or provided in a manner or on conditions that would interfere with the independence of a health care professional's prescribing practices."

Yet, that is exactly what marketing is all about, Appelbaum noted.

"I haven't yet met a psychiatrist," he concluded, "who couldn't afford to buy his or her own pens, rather than carrying around a subtle reminder of whose medication should be prescribed."

It is not yet apparent which pharmaceutical companies will adopt the new code; however, spokespersons for companies contacted by *Psychiatric News* indicated their companies already have in place internal policies that are at least as stringent, if not more so, than the PhRMA guidelines.

The "PhRMA Code on Interactions with Healthcare Professionals" is posted on the Web at <www.phrma.org/press/newsreleases//2002-04-19.390.phtml>. ■