Volume XXXVII
Number 2
January 18, 2002

Newspaper of the
American
Psychiatric
Association

PSYCHIATRIC NEWS

Photo: Philadelphia Convention and Visitors Bureau

The Liberty Bell, for more than two centuries an enduring symbol of America's fight for freedom, is just one of the many historic attractions that psychiatrists can visit while in Philadelphia for this year's APA annual meeting in May. A list of the CME courses offered at the meeting begins on page 23. Additional meeting information appears on page 20.

APA Proposes Adoption of New Medicare Payment Model

A new approach to federal payment for inpatient psychiatric care is now being developed. At stake is $3 billion annually in Medicare funds.

BY KATE MULLIGAN

APA met with staff of the Centers for Medicare and Medicaid Services (CMS) in December to review a per diem model for a prospective payment system (PPS) for inpatient psychiatric care of Medicare patients. APA's Committee on Psychiatric Reimbursement developed the model with The Health Economics and Outcomes Research Institute (THEORI).

APA President Richard Harding, M.D., described the meeting as "another important step in our efforts to make certain that APA has a place at the table when decisions are made that will have a profound and lasting effect on psychiatrists and their patients."

The Balanced Budget Act of 1999 (BBA) gave the Department of Health and Human Services (HHS) an October 2002 deadline to implement a new system to reimburse psychiatric hospitals and psychiatric units in general hospitals for treating Medicare beneficiaries.

Since 1983 medical and surgical Medicare services at general hospitals have been reimbursed through a PPS based on diagnosis-related groups (DRGs). Psychiatric hospitals and units have been exempt since 1985 because of work done by APA demonstrating that DRGs could not effectively distinguish variation in cost among hospitals and, therefore, would not be a

see ***Medicare*** *on page 22*

House GOP Vote Dashes Hopes For Parity Bill Passage

Mental health parity legislation failed to garner enough votes for passage before Congress adjourned last month. APA and its parity coalition vowed to continue the fight.

BY CHRISTINE LEHMANN

House Republicans dealt a severe blow to people with mental illness and those who treat them last month when they killed legislation that would have required health plans that cover mental illness to do so at the same level they cover other medical illnesses. Nonetheless, just after word of the defeat reached APA and its partner organizations in the Coalition for Fairness in Mental Illness Coverage, they vowed to renew their battle for parity in the new year.

The legislation, which was in the form of an amendment to the Labor–Health and Human Services appropriations bill for 2002, was voted down during deliberations of a House and Senate conference committee.

Conferees were able to agree only to a one-year extension of the 1996 Mental Health Parity Act, which expired last September. Congress passed the appropriations bill with the extension only days before its December recess.

The parity amendment, the Mental Health Equitable Treatment Act (S 543), was originally introduced by Sens. Pete Domenici (R-N.M.) and Paul Wellstone (D-Minn.) in March. In August it sailed through the Senate Health, Education, Labor, and Pensions Committee, chaired by parity supporter Sen. Edward Kennedy (D-Mass.) *(Psychiatric News*, September 7, 2001). The Senate then unanimously passed the legislation as an amendment to the appropriations bill, which conferees began debating last month *(Psychiatric News*, November 16, 2001).

The Coalition for Fairness in Mental Illness Coverage has urged Congress for years to pass a comprehensive mental health parity bill. It achieved some measure of success when President Bill Clinton signed the 1996 Mental Health Parity Act, but that law barred only discriminatory annual and lifetime dollar limits in health plans that cover both "physical" and mental illnesses.

By contrast, the Domenici-Wellstone

see ***Parity*** *on page 32*

Senate Approves Bill to Fund Post-Disaster MH Care

The full psychological impact of the events of September 11 may never be known. But the Senate has approved a bill to fund local efforts to provide long-term treatment and develop coordinated mental health responses to disasters.

BY CHRISTINE LEHMANN

"Every American is at risk, whether a loved one worked at the World Trade Center or the Pentagon, or whether the family simply watched the attack on television from a continent away," said Sen. Edward Kennedy (D-Mass.) in remarks to the Senate December 12.

The Senate unanimously passed the Post Terrorism Mental Health Improvement Act that same day, which was sent to the House for action later last month.

Sen. Edward Kennedy: "Congress has an obligation to ensure. . .we are better prepared to deal with the mental health consequences of future tragedies."

Kennedy, a cosponsor of the bill (S 1729), chairs the Senate Health, Education, Labor, and Pensions Committee, which held a hearing on the psychological impact of terrorism in September following the attacks on the World Trade Center and the Pentagon (*Psychiatric News*, October 19, 2001).

"The September 26 hearing made it clear that Congress has an obligation to ensure that these mental health needs are met and that we are better prepared to deal with the mental health consequences of future tragedies," Kennedy told the Senate last month.

Psychiatrists who testified at the hearing included Spencer Eth, M.D., medical director of behavioral health services at St. Vincent's Hospital in New York City. Eth and other mental health experts warned that untreated symptoms of trauma could lead to long-term mental illness.

Funds for Training

The bill passed by the Senate authorizes additional mental health funding to state and local governments to train psychiatrists and mental health professionals to treat victims of terrorism. The federal Substance Abuse and Mental Health Services Administration (SAMHSA) released roughly $27 million last year to several states to help meet the needs of people affected by the events of September 11 (*Psychiatric News*, October 5).

If the Senate bill becomes law, state and local governments or other public entities would be able to apply for grants established by the bill to respond to the long-term mental health needs of people in areas directly affected by the terrorist attacks, according to the legislation.

Funds for Treatment

The grantees would have the option of using the funds to locate and provide treatment, including medication, for individuals suffering from a mental illness as a result of the September 11 attacks, according to the legislation.

However, the grants can be used only to pay for treatment that is not covered under federal or private health insurance programs, the bill stipulates.

The bill will also fund the development of a local coordinated mental health response to future disasters and research on how state and local entities can better respond to the needs of disaster victims.

Lastly, the legislation reauthorizes a $40 million appropriation for the treatment of children who experience violence-related stress.

The summary, status, and text of the bill can be accessed on the Thomas legislative Web site at <thomas.loc.gov> by searching on the bill number, "S 1729." ■

Building Bridges to Global Psychiatry

BY RICHARD HARDING, M.D.

One of the duties and pleasures of being president of APA is meeting with APA members and professionals from other countries who share common goals for the mentally ill. Psychiatric colleagues from around the globe now work side by side with us in seeking improved access to quality psychiatric care for all those in need.

At the invitation of the Indian Psychiatric Society, I will travel to Calcutta (Kolkata), India, this month to attend its annual meeting and address the membership. I am most honored to do so and will report back to you about the proceedings.

Whenever an officer of APA makes an international trip, he or she is often criticized. For example, my wife questions my mental status for traveling 20 hours by plane in each direction over a six-day period. In addition, there are members who feel that a six-day trip to the other side of the world is of little substance, and my time and energy should be spent on "APA matters." Others feel that going to one country and not other competitive countries will lead only to hard feelings and problems in the future.

Understanding and accepting these criticisms, I chose to go to India. As a representative of American psychiatry, I want to take this opportunity to publicly recognize the contribution of all international medical graduates to the care of our patients and for the contribution they have made in clinical, academic, and research fields since World War II in this country. We have been most fortunate and honored to have them in America. International medical graduates have been some of the most innovative psychiatrists in our profession and continue that tradition today.

International medical graduates' presence in America has become a symbiotic relationship. They have benefited from our excellent psychiatric training, which has led to better psychiatric personpower for those among us in America with mental illnesses. In addition, they often returned to their country of origin with cutting-edge psychiatric knowledge that has led to the improvement of worldwide standards for our profession and for patient care.

It is a new world we live in. We have been jolted to the reality of the absolute need to work with our global colleagues. Few of us would doubt the importance of working together with global colleagues on research, education, and even nomenclature. Few of us would doubt that American-trained global psychiatrists will have the opportunity to lead academic and public health initiatives throughout the world. Few of us would doubt the need for close ties with the World Psychiatric Association and the World Health Organization.

A challenge for us will be to keep our own APA house of psychiatry in order while nurturing our relationships with global siblings. About half of the world's psychiatrists are in the U.S. We must decide if we will turn inward and reduce our investment in global psychiatric issues. We must decide whether we can develop new initiatives with others to improve the quality of psychiatric care throughout the world.

Close to 20 percent of APA members are international medical graduates. They have developed a cohort of rising leadership in our Association and other psychiatric organizations. "They are us." We have to learn from each other as we engage in this new 21st century. We can do that. ■

Cancer Group Therapy Adds To Well-Being, Not Longevity

A major study of a type of group psychotherapy in patients with metastatic breast cancer finds no advantage in terms of survival time, but some patients did experience marked improvement of psychological symptoms.

BY MARK MORAN

The mind matters when it comes to treating metastatic breast cancer. But better psychological health doesn't necessarily translate into longer life.

Those were the findings from a multicenter trial of group psychosocial support for women with metastatic breast cancer published in the December 13, 2001, *New England Journal of Medicine*.

The study found that breast cancer patients who participated in weekly supportive-expressive group therapy did not live longer than women who received no such intervention.

Yet women who received the weekly psychosocial support reported less pain and greater improvement in psychological symptoms.

"We were not able to demonstrate a survival benefit for these women," said psychiatrist and lead author Molyn Leszcz, M.D., in an interview with *Psychiatric News*. "But what we did show is a significant psychological benefit, such that women who participated were psychologically much better than those who did not receive the intervention. That finding was especially true for women who started the study at a higher baseline of psychological distress.

"What I think we are showing is that the mind does matter," he said. "I would say this treatment has life-altering but not life-prolonging effects."

Leszcz is an associate professor and head of group therapy in the department of psychiatry at the University of Toronto. The study was led by oncologist Pamela Goodwin, M.D., also of the University of Toronto.

In the study, 235 women with metastatic breast cancer in seven Canadian cities were randomly assigned to receive weekly supportive-expressive group therapy or standard medical and psychosocial care. The average survival among the two groups was nearly identical: 17.9 months for women receiving the intervention, and 17.6 months for those who did not.

The study is the 10th randomized, control trial seeking to replicate findings from a landmark 1989 study published in the *Lancet* showing that supportive group psychotherapy improved survival for women with metastatic breast cancer. The results are now evenly divided—five trials have shown a survival benefit from psychosocial support, and five have not.

David Spiegel, M.D., lead researcher in the 1989 study and author of an editorial accompanying the report of the new study, acknowledged that the most recent study is a disappointment for those hoping to demonstrate that psychotherapy can extend the lives of patients with a life-threatening illness. But he emphasized that the study does corroborate the value of psychological interventions in the treatment of severe disease and in medical conditions generally.

"I would like to see psychiatrists pay more attention to the interface between psychiatric disorders and medical conditions and to the subthreshold depression and anxiety that accompany them," said Spiegel, who is associate chair of psychiatry and behavioral sciences and director of the psychosocial treatment laboratory at Stanford University School of Medicine. "We have left a lot of the territory of consultation and therapeutic support for people with medical illness to other disciplines."

Leszcz said that clarifying the benefits and limitations of psychosocial support—and the specific subgroup of patients whom it is most likely to help—is a significant advance.

When Group Therapy Matters

"What this study teaches us is that if you are well-supported socially, and if you are coping well and don't have a high degree of psychological stress, you don't need to do this group," Leszcz said. "But if you are stressed, you can count on being significantly and meaningfully helped."

That's crucial, Leszcz pointed out, because in the wake of studies suggesting that psychosocial support groups could extend life, some patients may have felt compelled to participate. "What it does is give choice back to people," he noted. "It removes the potential that people might feel a desperate need to get into this. Not everyone is interested in support groups."

The value of choice for women with breast cancer was also stressed by patient groups responding to news about the study.

"We believe that these findings are not surprising, and we will continue to reinforce psychosocial support as an option for improving a patient's quality of life," said Rebecca Garcia, Ph.D., vice president of health sciences for the Susan G. Komen Breast Cancer Foundation, in response to the *NEJM* report. "The Komen Foundation feels that it is important for women to have a wide variety of support options when facing a breast cancer diagnosis and will continue to empower patients to make their own choices as to how to find the support they need during this time."

Raising the Survival Ceiling

Spiegel told *Psychiatric News* that recent improvements in medical treatment of breast cancer may have raised the ceiling of survival, making it that much harder to demonstrate a survival benefit with psychotherapy. And some of those treatments, including new selective, estrogen-receptor modulators, appear also to affect the same stress-related hormone systems that psychosocial support may act on.

Spiegel stated that the entire arena of psychological treatment of breast cancer patients has improved markedly since his 1989 study. Then, it was difficult to recruit women to participate in psychosocial support groups; today, just the opposite is true, he said.

The "supportive-expressive" group therapy utilized in the new study is modeled on a protocol standardized by Spiegel for use with women having metastatic breast cancer—a disease with an average survival of two and a half years. Led by a professional therapist, the groups allow women to confront existential issues in a supportive atmosphere.

Spiegel said that the success of such groups at improving psychological health—if not always improving survival—has shattered the notion that life-threatening illness must be met with denial and a smile.

"When these groups were started in the 1970s, there was an assumption that we would make people worse by having them confront their own mortality," he observed. "It is extremely clear that that is not the case. Facing one's own death and the death of another can be a growth experience, not a demoralizing one."

Leszcz agreed that the model of psychosocial support championed by Spiegel has sprung open the "prison of positive thinking" many patients with life-threatening illness feel confined by.

"Rather than facilitate denial, we wanted to create an environment in which women would be able to meaningfully confront their concerns, support each other, and develop coping strategies," he said. ■

Bill Extends Benefits to Companies That Test Drugs in Children

Congress renews and strengthens a federal law that grants pharmaceutical companies six additional months of patent exclusivity for drugs they test in children.

BY CHRISTINE LEHMANN

A bill renewing a 1997 federal law giving pharmaceutical companies a financial incentive to test drugs in children was passed by Congress last month. The president is expected to sign the bill (S 178) this month.

The Best Pharmaceuticals for Children Act extends the pediatric testing provisions in the 1997 FDA Modernization Act for another five years and adds new provisions to strengthen the program.

The legislation requires pharmaceutical companies submitting new drug applications with the FDA to show that they conducted studies on children. The law also extends drug patents for six months if the drug is considered to be important to study in children, and the drug companies agree to conduct the studies.

The FDA has granted patent extensions to 53 drug companies for undertaking studies of their products in children.

The law was prompted by the fact that fewer than 20 percent of medications on the market in 1996 were studied or approved for use in children. Yet many medications were being prescribed without important information about safety, efficacy, and side effects in children.

Concerned about the lack of pediatric prescribing information led physician groups including APA, the AMA, and the American Academy of Child and Adolescent Psychiatry to advocate for the pediatric testing provisions in the 1997 law and its renewal last year.

Since 1997, drug companies have undertaken more than 400 pediatric studies on a wide range of drugs, of which 58 have been completed, according to the bill's sponsors. In addition, the FDA has granted patent extensions to 53 drug companies for undertaking studies of their products in children.

Pediatric patent extensions have been granted for three psychotropic drugs—fluoxetine (Prozac), buspirone (Buspar), and fluvoxamine (Luvox). Only fluvoxamine, however, was approved by the FDA for a label change for the treatment of obsessive-compulsive disorder in youth (*Psychiatric News*, July 6, 2001).

The results of a study of fluvoxamine by Solvay Pharmaceuticals showed that a dose increase may be necessary in adolescents and that girls from 8 to 11 years of age may require lower doses. By contrast, the results of a study of buspirone by Bristol-Myers Squibb did not support that the drug was safe or effective in treating general anxiety disorder in youth from 6 to 17 years of age at doses recommended for adults, according to the FDA.

Eli Lilly, the maker of fluoxetine, was granted a six-month extension to study its drug in children, but the results were not informative enough to warrant a label change, according to the FDA.

Because the FDA cannot mandate that drug companies with existing patents study their products in children, the 1997 law was amended in the 2001 bill to allow the National Institutes of Health Foundation to serve as a funding mechanism for studies of drugs in children that might not be done otherwise because their manufacturers declined to study them or because they have expired patents, according to the legislation.

In addition, drug companies will have to respond to the FDA's written requests to conduct studies and make label changes within specific timeframes set out in the legislation. The FDA has a priority list of approximately 25 psychotropic drugs for which it has issued about 12 written requests for studies.

For example, a drug company has 30 days to make a FDA-requested labeling change. Otherwise, the FDA can label a drug misbranded if it attempts to market it for an unapproved use, according to the legislation.

The bill also requires the secretary of Health and Human Services to establish an Office of Pediatric Therapeutics to coordinate all FDA pediatric activities and to contract with the Institute of Medicine to review federal regulations, reports, and support for research involving children, paying particular attention to issues of informed consent, payment, and benefit/risk assessments in research.

The text and a summary of the Best Pharmaceuticals for Children Act is available at the Thomas legislative Web site at <thomas.loc.gov> by searching on the bill number, "S 1789." ■

Psychosis Fails to Block Psychiatrist's Career Path

Through her own example, a psychiatrist shows her patients that they can accomplish their goals and dreams.

BY EVE KUPERSANIN

Elizabeth Baxter, M.D., has come a long way since the days when her life was clouded by psychosis, agitation, and confusion, and when psychiatrists desperately—and often unsuccessfully—sought treatments to stabilize her illness.

Now she is fighting this battle for others. A psychiatrist herself, Baxter advocates, writes, teaches, and treats patients who are in some ways very much like her.

Elizabeth Baxter, M.D.: "My experiences have helped me to understand my patients better."

Baxter was diagnosed with schizoaffective disorder shortly after medical school, but emerged triumphant.

Last October, Baxter won the Public Eye category of the 2001 Lilly Reintegration Award for her outstanding contributions as an advocate and health care professional in helping people with schizophrenia reintegrate into society.

"It means a great deal to me that I won this award," Baxter told *Psychiatric News*. "I support psychiatric rehabilitation and everything that means, including placing people with serious mental illness into new social and occupational roles."

Baxter's debilitating, year-long episodes of depression began in her sophomore year at Rhodes College in Memphis, Tenn. Despite the anguish these depressions caused her, Baxter led several campus organizations and was elected student-body president her senior year. "I was able to hide my illness because I was so prominent on campus," said Baxter.

In the fall of 1985, Baxter began medical school at Vanderbilt University in Nashville. The rigorous course load wasn't easy. "I spent so much time taking care of my illness that it was like holding down a full-time job aside from my medical training."

At Vanderbilt her illness became harder to mask, and during freshman-year final exams, Baxter said she sat staring at her exam for four hours, doing nothing. She then knew that she needed help, and she was able to see a psychiatric resident in the hospital that night. "The resident was very insistent that I get help for my illness," she recalled.

Baxter took a medical leave of absence halfway through her sophomore year to spend some downtime with her grandparents on their Texas ranch. Six weeks after arriving there, Baxter had her first psychotic break and ended up in the hospital.

She returned to medical school the next fall, and with medication, psychotherapy, and the support of friends, she was able to continue her studies. She told those around her that she had a mental illness. At that point, she noted, psychiatrists told her that she had bipolar disorder, but she would later be diagnosed more accurately with schizoaffective disorder.

"I decided to be honest and open [about my illness], and although it made things difficult sometimes, in the end that decision has helped me a great deal."

For her honesty, Baxter was often awarded with discrimination and stigma.

"I had trouble getting out of medical school," recalled Baxter, "because people weren't too excited about a person with mental illness graduating."

Baxter's honesty also became a liability when she applied to residency training programs in psychiatry. She said she fell through in the residency match, which meant that no program ranked her in the list of applicants they wanted. "Residency training directors told me that the training wouldn't be good for me and that I'd never be able to survive it."

Looking back at those years, Baxter said, "It is interesting to see how stigmatizing the field of psychiatry has been."

After an internship in internal medicine in Memphis, Tenn., Baxter began her residency training in psychiatry in Rochester, N.Y. She was receiving medications and psychotherapy during her training.

"At times, my colleagues treated me differently, but most saw how hard I was trying to take care of my illness—that I was being responsible about it," she said.

Baxter completed her residency training on schedule, but became ill afterward. She had become a staff psychiatrist at a state hospital in Rochester, but her days were filled with despair and feelings of self-doubt. She wondered how she could be a doctor when she couldn't help herself.

Learning to Function Again

In November 1994 Baxter decided to end her misery. "I was afraid that if I failed at my suicide attempt, I would never be able to practice medicine again," she said, explaining the seriousness of her attempt.

"I took a knife to my throat and tried to sever my carotid arteries. I had been at this a half hour or so, and it is very much a miracle that I didn't succeed."

It was a long recovery process.

"I was ill, very psychotic, and had to start from the beginning again," said Baxter. "Learning to get up, take a shower, eat three meals a day."

"I was in the hospital for six to eight months after the suicide attempt, in about four different hospitals," she said, as doctors searched for the right combination of medications to help her.

Once she was started on clozapine, her psychosis lessened each day. In addition, while she was recovering, Baxter had a spiritual awakening. "God brought me through the suicide attempt alive. . . . He wanted me to live, and I decided that I wanted to serve God in whatever I did."

Baxter said that each step of the way, she tried to use her life to help other people.

Soon she became a medical writer for the Bridges Program, run by the Tennessee Mental Health Consumers Association. Bridges is a psychoeducational program developed to educate mental health care consumers about mental illnesses and to help them cope with their emotions and circumstances.

Advocacy Efforts

Baxter also became an advocate. She has traveled the nation speaking about her life and experiences both with mental illness and recovery.

She emphasized that as an advocate she reinforces one point—that people with mental illness don't have to recover completely in order to get on with life. "Despite the fact that medicine and psychotherapy may not take away all of the symptoms of a person's mental illness, it is still important to set personal goals and try to meet those goals." Baxter also said that one crucial reason people with serious mental illnesses recover is because they find someone who believes in them and their recovery.

In 1998 Baxter began seeing patients and now works in Nashville with a continuous-treatment team. The team includes case managers who go out into the community to identify people with treatment-resistant mental illness. Many, said Baxter, have been in and out of hospitals and jails, and the program attempts to keep them from returning to those institutions.

Baxter said she has been able to integrate her experiences with mental illness and recovery into her work with patients in an objective way. "My experiences have helped me to understand my patients better," said Baxter. "My work is very meaningful." ■

Better Use of Treatment Knowledge Could Cut Youth Suicide Rate

The high suicide rate in youth is related to the onset of major mood disorders and schizophrenia, says researcher and clinician Kay Redfield Jamison, Ph.D. Early recognition and effective treatment are critical to reducing the death count.

BY CHRISTINE LEHMANN

Psychologist, researcher, and author Kay Redfield Jamison, Ph.D., is no stranger to suicidal thoughts, having struggled with the manic form of bipolar disorder since she was a teenager.

She first considered suicide at age 17, seeing it as the only solution to an unendurable level of mental pain, said Jamison at the Canadian Psychiatric Association (CPA) annual meeting in Montreal in November.

After a serious suicide attempt when she was 28, she began investigating bipolar disorder and suicide professionally as a faculty member in the department of psychiatry at the University of California at Los Angeles.

She made some startling discoveries. Twice as many young American men died from suicide during the Vietnam War as young men who died in combat.

Suicide is the third-leading cause of death among adolescents who are between 15 and 19 years old in the United States, according to Jamison, who gave the R.O. Jones, M.D., memorial lecture at the CPA meeting. Jones was the first CPA president.

Kay Redfield Jamison, Ph.D., noted author, researcher, and teacher, receives the Presidential Commendation Award from Canadian Psychiatric Association President Michael Myers, M.D.

"There is the societal illusion that suicide is rare. It is not rare, and certainly the mental illnesses that are tied to suicide are not rare. Unlike cancer and heart disease, they disproportionately kill the young," said Jamison.

Bipolar and other major mood disorders, severe anxiety disorders, schizophrenia, and addictive disorders account for most suicides, according to Jamison. Personality disorders also are associated with a high suicide risk. Having a major psychiatric illness and comorbid drug or alcohol abuse increases the suicide rate significantly, she noted. In bipolar patients, substance abuse increases the suicide rate 60 percent, said Jamison.

> **"Every 17 minutes, someone in America commits suicide. Where is the public concern and outrage?"**

Youngsters at Highest Risk

The onset of bipolar disorder, schizophrenia, and major depression in late adolescence and early adulthood signals a sharply increased suicide risk, said Jamison.

Researchers in Sweden found that hospitalized bipolar patients were 15 to 22 times more likely to commit suicide than were control subjects. But bipolar patients under age 30 were 70 to 80 times more likely to commit suicide than controls in the same age group, said Jamison. The authors of the study, reported in the September 2001 *Archives of General Psychiatry*, noted that the mortality rate from suicide was especially high for younger patients during the first years after diagnosis.

Several factors converge in the early stage of the illness. "A person knows little

see ***Suicide*** *on page 33*

Psychiatrists Create Web Site for Psychopharmacology Algorithms

Two psychiatrists have won an award for their Web site, which is devoted to getting physicians to use psychopharmacology algorithms.

BY JOAN AREHART-TREICHEL

There is a Web site devoted to Harvard Medical School's Psychopharmacology Algorithm Project. Although the site is essentially focused on getting psychiatrists to use psychopharmacology algorithms—in other words, make psychiatric-medication decisions on the basis of the strongest scientific evidence possible—the introduction to the site, "What Is the Psychopharmacology Algorithm Project at the Harvard South Shore Department of Psychiatry?," gives psychiatrists and other visitors a good overview of what the site is about.

As a result, the general editor and director of technology for the site have received a $1,000 journalism award from the Kanter Family Foundation for "telling the important story that. . .clinicians are increasingly using scientific, evidence-based information to guide their medical-treatment decisions."

The site's general editor is David Osser, M.D., an associate professor of psychiatry at Harvard Medical School and president of the Massachusetts Psychiatric Society. The director of technology is Robert Patterson, M.D., a lecturer in psychiatry at Harvard Medical School.

Robert Patterson, M.D. (left), and David Osser, M.D. (right), chat with Joseph Kanter, president of the Kanter Family Foundation, shortly before receiving the foundation's $1,000 journalism award for their Web site.

Osser and Patterson entered their Web site into the Kanter journalism awards competition last June. As Osser wrote the Kanter Family Foundation at that time: "The Web site of our project appears to qualify for consideration on the basis of its. . .potential for stimulating greater public knowledge and understanding of the benefits of collecting and standardizing data on health outcomes so patients and clinicians can use scientific, evidence-based information to guide their treatment decisions."

Osser and Patterson received their award in October in Washington, D.C., during the "Health Legacy Partnership Conference on a National Health Outcomes Database," which was sponsored by the Kanter Family Foundation and the Agency for Healthcare Research and Quality, which is part of the U.S. Department

see ***Web Site*** *on page 33*

China Interested in Web Site

After David Osser, M.D., and Robert Patterson, M.D., won an award for their psychopharmacology algorithm Web site (see article at right), Osser agreed to a *Psychiatric News* request to provide more details about China's interest in the Web site.

First, Osser said, China's Ministry of Health is sponsoring the development of psychopharmacology algorithms for use throughout China. The ministry has commissioned China's leading mental health institution, the Institute of Mental Health at Peking Medical University, to lead the process of consulting with colleagues and developing the algorithms. A four-person international steering committee has been established to provide international consultants in this process. One of those persons is Osser.

Second, Osser said, China's Ministry of Health would like to use the software from his and Patterson's psychopharmacology algorithm Web site to house and disseminate those psychopharmacology algorithms that are developed for China. True, "the Internet is not as extensively available in China as in the United States," Osser pointed out, "but its use there is growing very rapidly."

What remains to be determined at this point, Osser conceded, is exactly how the ministry will use the software.

One possibility is that the ministry will take the algorithms on Osser and Patterson's Web site, which have already been translated into Chinese by members and staff of the Chinese Psychiatric Association and use them as a template for its own algorithms. "They don't want to use our algorithms because they don't have some of the drugs we have," Osser explained, "and there are special issues where the Chinese experts might do things differently."

Another possibility is that the ministry will create its own algorithms from scratch. "Either way, Patterson and I will be closely involved," Osser said.

Scully to Head Psychiatric Delegation to AMA

Psychiatry gains a seasoned veteran as chair of its delegation to the American Medical Association, with the appointment of James Scully, M.D., to replace Joseph T. English, M.D.

BY JIM ROSACK

APA's delegation to the policy-making body of the American Medical Association, the House of Delegates, gained a seasoned veteran as its new leader when APA President Richard K. Harding, M.D., nominated James H. (Jay) Scully Jr., M.D., to succeed Joseph T. English, M.D., as chair of the delegation.

"I am honored to assume these duties," Scully told *Psychiatric News*. Scully is the Alexander G. Donald Professor and chair of the department of neuropsychiatry and behavioral science at the University of South Carolina School of Medicine. In addition to his current duties with the AMA delegation, Scully holds several component appointments within the APA Council on Medical Education and Career Development and is a former director of APA's Office of Education.

"We have an extraordinary team representing our APA at the House of Delegates of the AMA," Scully told *Psychiatric News*, "and I want to indicate my personal and the delegation's great appreciation for the outstanding service and leadership provided by Dr. English. His successful efforts to significantly improve our specialty and Association's linkages with the AMA and the House of Delegates should be recognized by all."

Jay Scully, M.D.: "When the AMA supports parity for mental illness, that means something to legislators."

The current team includes both rising stars and seasoned veterans of APA, Scully said, including former APA presidents English, John McIntyre, M.D., and Rodrigo Muñoz, M.D., as well as former APA Deputy Medical Director Carolyn Robinowitz, M.D.

The AMA's Section Council on Psychiatry, composed of the APA and American Academy of Child and Adolescent Psychiatry delegations as well as invited representatives of allied psychiatric organizations, is in the process of focusing its mission, Scully said, which continues to be advocating both for the psychiatric profession and for psychiatric patients within the house of medicine.

Indeed, Scully chaired an APA task force last fall that prepared recommendations for APA's Board of Trustees on maximizing the functioning and effectiveness of the section council. In a report to the APA Board, the task force addressed both the role of the APA delegation within the section council in particular and the AMA on the whole. The task force also proposed to the Board clarifications of APA procedures with regard to the APA delegation.

One clear goal in Scully's future is to continue English's successful efforts to expand communication links with clinicians in other specialties.

"We are much more effective when we get support from our fellow physicians," Scully emphasized.

When dealing with difficult issues such as psychologists' pursuit of prescribing privileges, Scully said, it is extremely helpful to have the support of other physicians facing erosion of their scope of practice. In the last year, the House of Delegates heard testimony from orthopedic foot and ankle surgeons facing encroachment from podiatrists and from anesthesiologists being marginalized by some facilities across the country in favor of nurse anesthetists.

Cardiologists, gastroenterologists, and other specialists have recently testified in support of APA's efforts in battling discriminatory carveouts, as their specialty practices have been carved into "disease management groups."

In addition, to carry forward the priorities of APA within the AMA, Scully said, "Our plan will include new outreach efforts with psychiatrists of the 'psychiatric caucus' as well as members of the 'neuroscience caucus.' " The two caucuses are made up of all psychiatrists and neuroscience physicians serving in the House of Delegates, in addition to those in the APA/AACAP delegations.

That kind of networking and effective collaboration on issues can yield significant results, namely in swaying an AMA policy position in favor of psychiatry and our patients, Scully indicated.

"When the AMA supports parity for mental illness," Scully stated, a position the AMA has strongly backed over the last two years, "that means something to legislators."

The delegation's work is a significant part of the advocacy efforts of APA, Scully told *Psychiatric News*, and being mindful of current APA budgetary concerns, "we will continue to build on our successes and strengthen our efforts." ■

Employers Losing Faith in Managed Care Strategies

The good news is that health care researchers have found decreasing use of the most restrictive tools of managed care. The bad news is that they collected their data when the economy was thriving.

BY KATE MULLIGAN

Managed care's "tool box" is nearly empty, according to a group of health care analysts, and employers are considering new approaches to the rising cost of insuring health care. Those conclusions emerged as a central theme of presentations at "Emerging Health Care Market Trends," a conference sponsored by the Center for Health System Change (HSC) last month in Washington, D.C.

Every two years, the HSC, which is funded by the Robert Wood Johnson Foundation, sends teams of researchers to interview 40 to 60 health care leaders about trends in 12 nationally representative sites. Those interviews are supplemented with physician and employer surveys. HSC presents its findings at a one-day conference, through issue briefs, and in a book (see story on page 12).

"We [saw] a clear trend among health plans to decrease their reliance on the most restrictive tools of managed care."

Glen Mays, health researcher at Mathematica Policy Institute Inc., told the audience, "We [saw] a clear trend among health plans to decrease their reliance on the most restrictive tools of managed care."

He believes that the guiding philosophy of managed care is "tight management of a generous benefit package." The key tools for implementation, he noted, are selective contracting, capitation, gatekeeping and utilization reviews, and comprehensive benefits. All four tools have lost clout, according to Mays.

Greater Clinician Choice Demanded

Consumers and employers have demanded greater selection of health care clinicians, which has diminished opportunities for selective contracting. In Seattle, for example, Regents Blue Shield had developed a network of physicians whom they determined by cost analysis to be particularly efficient. But demands from consumers and employers forced the insurance company to expand its network.

Capitation, which transfers cost risk to clinicians, has eroded because those clinicians are no longer willing to absorb the financial losses that resulted from the risk contracts.

"Providers just decided they'd had enough, . . .and they said 'we won't do it anymore,' " said Brian Ancell, executive vice president of Health Care Services and Strategic Development at Premera Blue Cross, in a response to Mays's presentation.

Mays cited administrative costs, consumer and physician dissatisfaction, and liability concerns as reasons that some managed care companies are abandoning the use of gatekeepers and other strategies to restrict access to care. The goal of using savings from managed care to provide comprehensive benefits was not met. In fact, benefit packages are becoming less generous because employers are instituting more copays and deductibles, he said.

Jon Christianson, the James A. Hamilton Chair in Health Policy and Management at the University of Minnesota, noted that employers view health benefits as a part of a total compensation package that enables them to attract and keep good employees. Employers responded to employee complaints about managed care during a time of extremely low unemployment, but the same employers might become more willing to accept employee dissatisfaction now because of the weakening economy and an easier time finding qualified workers.

Emerging Trends

Speakers identified several emerging trends that result from the changed economy and the perceived failure of managed care to contain costs. Joe Reilly, senior vice president at Aon Consulting, who advises companies on health benefits in New Jersey, said, "During the previous 18 months, I got blank stares when I mentioned defined contributions. Now employers are paying attention."

Under a defined-contribution program, employees receive a fixed amount of money, which they use to purchase insurance. Participants agreed that the publicity given defined contribution plans makes them appear more important than they currently are in the marketplace, but the strategy is "gaining a toehold" (*Psychiatric News*, December 21, 2001).

In general, employers have been reluctant to pass on to workers the full increase of health care costs in terms of higher premiums. Instead, they have increased copays and deductibles, because the higher costs are not so readily apparent to employees, and the changes do not affect everyone at the same time.

Employers are moving toward tiered insurance offerings in which employees can choose a lower-cost tier with a limited selection of clinicians, or a more expensive tier with higher premiums and higher out-of-pocket costs.

A new trend for psychiatrists and others concerned with mental health care is an increased focus on disease management and its link to productivity. Employers want to see concrete results from disease-management activities. So, rather than relying on standard programs developed by insurance companies, they are becoming more willing to develop their own programs and to judge them on their impact on employee productivity.

A transcript of the conference is posted at the Web site of the Center for Studying Health System Change at <www.hschange.org>. ■

New York Program Benefits Mentally Impaired Patients

An innovative program in New York state finds a way to get needed medical treatment for patients whose mental illness deprives them of the capacity to make crucial decisions about whether they should proceed with that care.

BY LIZ LIPTON

Psychiatrist Michael Dempsey, M.D., faced an urgent problem—a patient with schizophrenia who was experiencing delusions had developed a massive hernia.

The patient denied having the hernia and refused an operation to repair it. "He would not consent to what he did not have," said Dempsey, medical director of the Columbia County Clinic in Hudson, N.Y., and a clinical psychiatrist at the Capital District Psychiatric Center in Schenectady, N.Y.

Thus, considering that the patient lacked the capacity to make a decision about a needed medical procedure and did not have anyone authorized to provide consent, Dempsey had to decide how to obtain authorization for the patient's medical treatment to proceed.

If this scenario had occurred in New York state before 1986, Dempsey would have had no choice but to go through the court system, a process that could have taken weeks. In fact, in public hearings conducted in 1984 by the New York State Commission on Quality of Care for the Mentally Disabled, some witnesses reported that they routinely waited several months to obtain court authorization for surgical procedures, and others reported waiting as long as 57 days to obtain authorization for other major medical procedures.

Due in part to these delays, the commission created the first program in the nation to serve as an alternative to such court proceedings: the Surrogate Decision-Making Committee (SDMC) program, in which a panel of four specially trained volunteers conducts a quasi-judicial hearing and then authorizes or refuses consent for the patient's nonemergency major medical treatment.

From its statewide listing of more than 950 volunteers, the commission convenes such a panel in the region where the patient resides. The panel consists of a health care professional such as a psychiatrist or a nurse; an attorney; a former consumer of mental health care or development disability services or a family member of, or advocate for, individuals with mental illness or developmental disabilities; and an individual with expertise or interest in services for individuals with mental illness and/or developmental disabilities.

During the hearing, panelists evaluate documents and listen to testimony. They render up to three decisions.

First, they decide if the patient has the capacity to make his or her own medical decision. Second, if the patient is determined not to have that capacity, the panel determines if he or she has a surrogate authorized to make such a decision. Finally, if no such surrogate exists, the panel determines if the treatment is in the best interest of the patient. Its overall goal is threefold: to protect the patient's autonomy, ensure due process, and consider the patient's best interests.

Unless the case is complicated, the panel issues its decision immediately after the hearing, and the paperwork in support of the decision is available that day, Tom Fisher, director of the SDMC program, told *Psychiatric News*.

The program serves individuals diagnosed with mental illness or developmental disabilities who receive services from facilities licensed, operated, or funded by the New York State Office of Mental Health or the Office of Mental Retardation and Developmental Disabilities (OMRDD). It also serves individuals from facilities to which those offices have distributed federal funding. About 90 percent of these individuals are from the OMRDD facilities.

Not All Treatments Covered

Only certain medical treatments are covered by the program—for example, the use of general anesthesia, procedures involving significant risk or significant invasion of bodily integrity, the administration of chemotherapy, and HIV testing.

Among the excluded treatments are electroconvulsive therapy, termination of pregnancy, and the administration of routine medications, including psychiatric ones.

As of last August, panels had rendered decisions on 5,432 cases and had authorized 5,723 procedures. (Some patients had more than one procedure authorized.) In fact, one such panel ruled that Dempsey's patient should have surgery, which he underwent without any difficulties.

There are several benefits to this statewide program. For patients requiring urgent but nonemergency medical care, an expedited review can be requested through which a hearing takes place in seven days or fewer.

Another benefit is that facilities using this program do not incur court or lawyer fees, although they may incur expenses for travel or consultants.

Also, instead of the decision being made by a judge, it is made by four individuals. "The diverse make-up of the panel covers a lot—the legal rights of the patient, the advocacy of the patient, and medical aspects. The committee consists of people looking at the case from different angles," said Dempsey, a volunteer panelist since 1986.

"[Overall] this program is an exceptionally humane way to provide care for individuals who are incapacitated. It expedites treatment. . . . The people who are [at the hearing] are genuinely interested in the patient's medical well-being and looking out for them legally and making sure that this procedure really needs to be done," said Dempsey.

In light of these benefits of the program, it is not surprising that it has been profiled in medical journals and that another large state, Texas, enacted a similar program in 1993.

How It Works

The first step in the review process is that an interested person, often a nurse or social worker from the facility where the person resides, completes a "user-friendly," 14-page application with line-by-line instructions. The individual making the application also attaches medical records, X-rays, lab tests, and other pertinent information. For patients not requiring an expedited review, this process takes from several days to several weeks, depending on the facility's protocols and the urgency of the case, said Fisher.

After receiving this information, the regional SDMC coordinator schedules the hearing, which takes place in an average of about 14 days. Before the hearing, the commission's staff performs such tasks as processing the application, gathering additional information, setting up a panel, notifying New York State Mental Hygiene Legal Services about the case so they can represent the individual during the hearing, and arranging for concerned individuals (including the patient's caregiver) and the patient to speak at the hearing.

"The patient always comes before the panel unless there is a medical reason that the person cannot attend," said Fisher.

Panel members review all the requisite information prior to the hearing. If, during the hearing, more information is needed, a conference call is arranged between the panel and any other party whose input is needed.

Because they are familiar with the case prior to the hearing, the panel members can usually issue their decision in about 25 minutes. ■

Decision-Making Committee in Action

Mary Ellen Labra, R.N., who has been a nurse for 25 years, described examples of two patients whose care she has overseen for whom medical-treatment decisions were made by New York's Surrogate Decision-Making Committee (SDMC) program.

One patient was an elderly woman diagnosed with PTSD, OCD, an anxiety disorder, and moderate-to-severe mental retardation. A few months after undergoing a bilateral mastectomy in the late 1990s, she received an ultrasound examination, which revealed something suspicious on an ovary.

"This woman, who had limited [mental] ability, made it clear that she didn't want any more doctors, needles, or hospitals. . . .She had been institutionalized much of her life and found comfort in her routine. Being in the hospital did not allow her to complete her rituals and created greater anxiety," said Labra, who has worked at Greystone Programs Inc., in Dutchess County, N.Y., since last January. Greystone provides residences for individuals diagnosed with developmental disabilities.

Some medical professionals involved with the case thought the woman should have additional diagnostic procedures; others, including Labra, agreed with the patient.

"The SDMC panel listened to everyone including the woman and decided she should not have any further invasive procedures. For her remaining years, she was able to live with dignity and control over her life," said Labra.

In another case she described, an ADMC panel ruled that a 45-year-old man diagnosed with moderate mental retardation should have dental surgery, which required general anesthesia. The earliest appointment his caregivers could obtain for him was in a Connecticut hospital, but when the hospital's administrators found out that consent had been granted via the SDMC program, which they had not heard of previously, they cancelled the appointment.

The commission sped into action. It arranged a teleconference among the panel members, who granted a time extension for the consent. They also explained the program to the hospital's administrators, who changed their minds about allowing the surgery.

"Without [the commission's] support, his surgery probably would have been delayed for months," said Labra.

APA, AADPRT Develop Model For Psychotherapy Competence

Sample standards issued by AADPRT and APA will go a long way toward ensuring that residents become excellent psychotherapists.

BY EVE KUPERSANIN

Psychiatrists in training now have new standards to meet when they practice psychotherapy.

A collaborative effort between members of the American Association of Directors of Psychiatric Residency Training (AADPRT) Task Force on Core Competency and APA's Commission on Psychotherapy by Psychiatrists (COPP) have produced sample standards for residency training programs across the country.

The standards, or competencies, include the knowledge, skills, and attitudes that residents should have to practice the following types of psychotherapy: cognitive-behavioral, psychodynamic, brief, supportive, and psychotherapy combined with psychopharmacology.

> "This is a project that will continue over the next decade."

Residency programs across the country received the sample competencies at the end of last year. The standards describe the knowledge, skills, and attitudes that psychiatry residents must demonstrate when practicing each type of psychotherapy.

Two years ago, the Residency Review Committee for Psychiatry asked residency programs to implement new training requirements by January 2001, including a requirement that residents demonstrate competency in the five types of psychotherapy listed above (*Psychiatric News*, January 7, 2000).

The responsibility for developing the standards for psychotherapy practice by residents fell to AADPRT and its Task Force on Core Competency, in particular. However, the group consulted with members of APA's COPP during the development process.

Lisa Mellman, M.D., co-chair of the AADPRT task force, told *Psychiatric News*, "Members of the COPP who were experts in the specific psychotherapies provided enormous help in writing the initial samples of the competencies."

Mellman said that, in addition, members of APA's Task Force on Competency in Graduate Education, of which she is vice chair, and residency training directors in AADPRT helped to edit the sample standards.

'Sample' Competencies

The new standards are not written in stone, explained Mellman, but instead provide a template for psychotherapy training. The standards are referred to as samples because it is expected that training programs will modify the standards to meet their individual needs. "Since the RRC is now requiring that residents demonstrate competence for each of the five psychotherapies, it falls upon each of the residency programs to teach and supervise residents so that they gain the needed competence," she said. "By further defining the competencies, I think it sets the standards for what residents can expect from their training programs."

When writing the sample competencies, Mellman said, task force members deliberated about how comprehensively the key components of each psychotherapy should be defined and the level of expertise that should be demonstrated by residents in terms of knowledge, skills, and attitudes for each type of psychotherapy.

The group decided that residents practicing cognitive-behavioral therapy should be able to understand the relationship of thoughts to emotions, the concepts of automatic thoughts and cognitive distortions, and the common cognitive errors, for example.

When practicing psychodynamic psychotherapy, residents must be able to recognize, utilize, and manage aspects of transference and countertransference, defense, and resistance in the course of treatment.

Residents treating patients with a combination of psychotherapy and psychotropic medications should be able to understand the conscious and unconscious aspects of the doctor-patient relationship, placebo effects, and the signs of comorbid medical conditions.

Common to all the competencies are the requirement that residents be sensitive to sociocultural and socioeconomic issues that arise in the therapeutic relationship.

Next Step

Now that the sample competencies have been issued to training programs, Mellman said, the next step is measuring the competence demonstrated by residents. This will involve determining how to assess and measure the competencies, developing the tools to measure the competencies, and ensuring that the competencies being measured are valid.

"The field of psychiatry is in an early stage in terms of assessment and measurement," said Mellman. "This is a project that will continue over the next decade." ■

Experts Describe Health System In Search of New Direction

It's déjà vu all over again as policy analysts and political leaders call for reform of the health care system.

BY KATE MULLIGAN

Health care costs are rising, and the economy is staggering. Consumers are complaining and health care professionals are rebelling. Very few people any longer express confidence in the capability of managed care to solve cost or quality problems.

That complicated picture of a health care system in flux emerged from panel presentations at "Emerging Health Care Market Trends," a conference sponsored by the Center for Studying Health System Change (HSC) in December (see story on page 9).

In the conference's keynote speech, Janet Corrigan, director of the Board on Health Care Services at the Institute of Medicine, said, "We see a lack of real clear direction for health system change." All we see is "knee-jerk policy making. . .that responds to the emergency of the day or the need to contain costs rapidly."

Problems are exacerbated by conflict and mistrust between key stakeholders in the health care system and the failure of the "whole national experiment with managed care" to live up to expectations, Corrigan stated. Managed care strategies relied more on a stick than a carrot approach and were viewed by clinicians and patients as attempts to control cost, rather than to improve quality.

Corrigan found two key lessons in the experience of the last 10 years. "[To] achieve real widespread change in the health care sector, the metric must include quality, in addition to cost." Without information on quality of care, consumers and others will always assume that the steps being taken to control costs are detrimental to quality.

But, Corrigan noted, "[T]here is a sizable body of literature that substantiates [the idea] that for some types of quality shortcomings, we can decrease costs and improve quality." Improvements of quality that target medical errors and overuse of services would lead to slower increases in health care expenditures, she said.

System Overhaul Needed

The second lesson is that "the change strategy must address fundamental overhaul of the delivery system."

The efforts to redesign the system during the last 10 years did not include building an information infrastructure to support health care delivery or encouraging clinicians to form multidisciplinary teams.

Corrigan noted that in the mid-1960s about 100 articles were published annually that reported results of randomized clinical trials. Today, that number is more than 10,000 and continues to grow. An infrastructure that would enable clinicians to sift through that information is lacking.

Corrigan expressed hope for a future with "innovative delivery system models, much more extensive use of e-health delivery options, and an information-rich environment that would provide active support to patients, their families, and clinicians when they make treatment decisions and to legislators and regulators when they make decisions about policy."

New Organizations Forming

Discontent about the problems with the health care system is resulting in the formation of several new organizations that address the problems identified by Corrigan and other health care analysts.

A front-page story in the *Wall Street Journal* on December 17, 2001, reported that these new organizations are "intent on rekindling serious discussions over the future of the health care system and on coming up with workable solutions to its refractory problems."

Among them are the Center for Practical Health Reform (CPHR), which states that one of its goals is to "restabilize and improve health care delivery and finance through increased access, establishment of standards, introduction of accountability, and upgrading of well-understood mechanisms for all stakeholders."

The CPHR's advisory panel includes Harris Berman, M.D., CEO of Tufts Health Plan; John Burns, M.D., former chair of the Washington Business Group on Health; George Lundberg, M.D., former editor in chief of the *Journal of the American Medical Association;* and other leaders in the health care field.

Former senators Bill Bradley and David Durenberger have signed on as spokespersons for America's HealthTogether. That organization will promote a national dialogue that will seek consensus and "real-life solutions" to the problem of providing access to quality health care.

Another new organization, the American Health Initiative, plans to "involve the nation in a strategic conversation intended to provide the direction and the political will necessary for establishing a quality health care system that assures every American equitable, affordable access." Lundberg is its honorary chair.

The Web site for the Center for Studying Health System Change is <www.hschange.org>; the Web site for the Center for Practical Health Reform is <www.practicalhealthreform.org>; the Web site for America's HealthTogether is <www.healthtogether.org>; and the Web site for American Health Initiative is <www.americanhealthinitiative.org>. ■

Michigan to Start Restrictive Medicaid Drug Formulary

Rising costs of prescription drugs are fueling a new push for formularies in state Medicaid programs. The Michigan Psychiatric Society is fighting back.

BY KATE MULLIGAN

Michigan has joined the ranks of state governments that are developing new tools in their efforts to contain the fiscal burden from the rising cost of drugs prescribed for patients receiving Medicaid.

The Urban Institute estimates that Medicaid spending for outpatient prescribed drugs increased by an average of 18.1 percent per year from 1997 to 2000, compared with 7.7 percent for all Medicaid expenditures. The increase reflects both higher prices for drugs and an increase in the number of prescriptions used by beneficiaries.

The amount of money spent on these drugs and the rate of increase in cost is "unsustainable," said Ray Hanley, Arkansas's Medicaid director and chair of the Pharmacy Committee for the National Association of Medicaid Directors.

In an interview with *Psychiatric News* he estimated that states collectively will spend about $27 billion on prescription drugs for Medicaid patients this year. Approximately 25 percent of that total, Hanley said, will be spent on drugs related to mental illness.

Linda Elam, senior policy analyst at the Kaiser Commission on Medicaid and the Uninsured, said, "Almost every state government is trying something to rein in costs. Michigan, Oregon, and Louisiana are using a formulary approach in which only drugs on a list developed under state auspices can be ordered without prior authorization."

Michigan has garnered the most attention by taking on the entire pharmaceutical industry. In fact, on December 7, 2001, a front-page story in the *Wall Street Journal* claimed, "Michigan's experiment. . .takes dead aim at drug companies' freedom to set prices. Instead of taking as a starting point the prices offered to companies' most-favored customers, the Michigan experiment seeks to drive all prices down to a low common denominator."

Committee Chose Drugs

A committee of physicians and pharmacists chose so-called best-in-class drugs in 40 categories covering a range of illnesses across all of medicine. If a physician wants to prescribe a drug not on the list, he or she must "call a state technician and get approval," which will be granted only if the drug is considered "medically necessary."

The reasoning behind the state's action is somewhat murky. Faced with a statewide $1 billion shortfall, the Michigan legislature budgeted for $42 million in pharmacy savings. James Haveman Jr., director of the state's Department of Community Health (DCH), wrote to the leaders of the state legislature that two key policy changes would be necessary to capture those savings: "expansion of prior authorization for single-source drugs and obtaining additional rebates on drugs provided through the Medicaid program, as well as on state-funded pharmacy programs."

The Pharmaceutical Research and Manufacturers of America (PhRMA) claims that the state's Department of Community Health (DCH) "will no longer routinely pay for drugs in the Medicaid or other state-funded programs unless the manufacturer agrees to pay the state steep rebates over and above what the state already receives." It has filed suit to halt implementation of the pharmacy program.

Policy Defended

In a position paper, however, DCH defends prior authorization for psychiatric drugs by saying that general practitioners with no specialized training in psychiatry are prescribing atypical antipsychotic drugs. DCH's second justification is that beneficiaries in the state's Medicaid managed care program are subject to drug formularies, while the 350,000 beneficiaries in the state's Medicaid fee-for-service program are not. DCH states that "it is unfair to have dramatic differences" in the drug-coverage programs.

The Michigan Psychiatric Society (MPS), assisted by APA and other advocacy groups, opposes DCH's recent actions on formularies. Jonathan G.A. Henry, M.D., medical director of the Clinton-Eaton-Ingham Community Mental Health Board, testified last December 11 on behalf of MPS before the state Senate's Subcommittee on Appropriations for Community Mental Health.

Henry noted the lack of data about the capability of the new drug policies to generate savings. He testified that new drugs with proven value such as nefazodone and venlafaxine would require preauthorization. Preauthorization requirements also result in a decrease in physician productivity, he noted.

"To authorize a state bureaucrat to overrule a physician's medical judgment is simply wrong public policy in both human and economic terms," commented Jay Cutler, J.D., director of the APA Division of Government Relations. "This policy seems to have lacked both serious legislative and public review of its impact on the most vulnerable patients, namely, the seriously mentally ill." ■

The APA Library: Past, Present, and Future

BY LUCY OZARIN, M.D.

The APA Library mirrors the growth of the Association since 1948. Prior to that time, APA's central office, under the administration of Austin Daires (1932-49), was housed with the National Association for Mental Health in New York. When Daniel Blain, M.D., became APA's first medical director in 1948, the office was moved to two rented rooms in downtown Washington, D.C. At the time, APA had 4,500 members (now it has approximately 38,000).

By 1951 APA required more staff and space to handle the growing workload associated with the increase in membership numbers and rented a large mansion near Dupont Circle. In 1958 APA bought a property at 18th and R streets in Northwest Washington, D.C., and acquired an adjoining building to house a museum and offices, which opened in 1966. That building had space for a library in the basement. APA's last move, which occurred in 1982, was to a new building at 14th and K streets, N.W.

The APA Library began in 1949 when Blain asked authors to send APA copies of their autographed books. Within a year, 115 books were received and housed in his office. During the next 10 years the monthly APA newsletter (later *Psychiatric News*) listed the authors and book titles received. With the move to 18th Street, the books were housed in the stately Century Room.

The first APA librarian, Jeremiah O'Meara, M.L.S., was hired in 1961 from the Chicago Psychoanalytic Institute. He was succeeded by Jean Jones, M.A. (1963-1981) of his staff. In 1981 Zing Jung, M.L.S. (1981-1989), came from the American Psychological Association. William Baxter, M.A. (1989-1995), the archivist, followed as director, and then Susan Heffner, who resigned in 1998.

In 1998 the Library staff numbered five, but by 1999 there were no full-time staff. In 2000 Gary McMillan, M.L.S., came from Howard University to head the APA Library and is now its sole staff member.

The autographed book collection formed the backbone of the APA Library until 1961, when the personal library of Adolf Meyer, M.D., was willed to APA. The Meyer collection of 3,000 books in English, French, and German includes first editions by Isaac Ray, M.D., as well as Bleuler, Freud, and Jung. Prominent psychiatrists have since donated their papers and books to the Library, including Blain, John Whitehorn, M.D., and Walter Barton, M.D. The papers of Albert Deutsch, M.D., are also in the archives.

At present, the APA Library, named in honor of Melvin Sabshin, M.D. (who was medical director from 1974 to 1997), occupies space on the third floor of the 1400 K Street building. The Logan and Daniel Blain Reading Room houses the periodicals collection. Funds have been donated for the Drs. Irving and Dorothy Bernstein Reference Collection. A well-furnished rare books room is dedicated to Garfield Tourney, M.D., the donor of many valuable books on psychiatric history. The large adjacent storage for archives contains APA records, personal collections, videos, oral histories, photographs, and works of art. A complete list of the contents of the archives and rare book room is available.

The rare books room has 1,000 volumes, some printed as early as 1580. A large 16th-to-18th century collection on witchcraft was donated by Marion Kenworthy, M.D. The most valuable book, appraised at $6,000, is *Studies of Hysteria* by Breuer and Freud. Almost all books have psychiatric significance, but there are other significant books by Jonathan Swift, John Locke, and Daniel DeFoe.

Organizationally, the Library is now part of APA's Information Systems operation. The APA Operations Manual notes that the Library and Archives provides reference and research services, preserves and stores APA records and publications, delivers materials to members and staff, and cooperates with other libraries and networks.

Through its unique collections, the APA Library preserves the history of psychiatry and its practitioners. Its future will depend on the resources that are available to maintain it in terms of space, staff, and funds. ■

High Court Won't Hear Appeal Of Forced Medication Case

Capitol Hill shooter Russell Weston's last chance to avoid being involuntarily medicated ends at the Supreme Court.

BY EVE KUPERSANIN

The U.S. Supreme Court denied an appeal by Russell Weston in early December that would have kept him from being medicated against his will. Now, as federal prosecutors have wanted, he can be tried for murder if his mental illness improves enough on the medication for him to meet the court's standard for competency to stand trial.

Weston, a 44-year-old man diagnosed with paranoid schizophrenia, stands charged with the 1998 murder of two police officers in the U.S. Capitol.

At the time of the shootings, Weston maintained that government agents were after him, that a computer chip in one of his teeth provided him with a direct line to Russia's ambassador, and that he had the ability to reverse time.

In April of last year, a federal judge in Washington, D.C., ordered that Weston, who had been medication noncompliant for much of his 20-year struggle with mental illness, be forced to take antipsychotic medications so that he would be competent enough to stand trial for the murders (*Psychiatric News*, April 6, 2001).

Weston appealed this decision, and in July the U.S. Court of Appeals for the D.C. circuit upheld a ruling by U.S. District Court Judge Emmet Sullivan that Weston could be given medication against his will to treat the symptoms of his schizophrenia (*Psychiatric News*, September 7, 2001). The lower court's decision rested, in part, on a 1992 Supreme Court decision in *Riggins v. Nevada* that said defendants can be forced to take medicine only if it is "medically appropriate." In this case, according to the D.C. court, it was medically appropriate to force Weston to take medications, and a court-appointed psychiatrist testified to that effect.

Weston's attorney appealed that decision claiming that Weston's Fifth Amendment rights to a fair trial would be violated by the involuntary medical treatment.

Medications could remove much of the evidence of the psychosis that was present when he allegedly killed officers Jacob Chestnut and John Gibson. Weston later claimed he shot the men to save the world from cannibals and deadly disease.

Although prior to the shootings Weston's family had urged him to continue taking the medications he had been prescribed, Weston grew frustrated at the side effects and stopped taking them.

see ***Weston*** *on page 32*

Bipolar Plus Panic May Be Distinct Disorder, Study Finds

When bipolar disorder is accompanied by panic disorder, which is often the case, it appears to be genetically distinct from bipolar disorder alone, Italian scientists report.

BY JOAN AREHART-TREICHEL

In a sense, life for bipolar patients can be an emotional roller-coaster ride, with exhilarating, but potentially dangerous highs, and devastating, potentially dangerous lows. And if that ride weren't taxing enough, a third of bipolar patients are also estimated to suffer from panic attacks.

This double disorder, so to speak, may be genetically distinct from bipolar disorder alone.

So suggest the results of a study conducted by Alessandro Rotondo, M.D., a molecular geneticist and assistant professor of psychiatry at the University of Pisa in Italy, and his colleagues. They report their results in the January *American Journal of Psychiatry*.

There is a gene located on chromosome 22 called the COMT (catechol O-methyltransferase) gene that makes an enzyme that breaks down the nerve transmitters dopamine, norepinephrine, and epinephrine. What's more, a particular variant of this gene has been linked with bipolar disorder. So Rotondo and his team decided to use this gene variant to see whether they could show that bipolar disorder without panic is genetically distinct from bipolar with panic.

They took DNA samples from 127 subjects without psychiatric illness, 49 bipolar subjects with panic disorder, and 62 bipolar subjects without panic disorder. They then examined each DNA sample to see whether it contained one copy of the gene variant of interest—that is, whether a particular subject had inherited one copy of the variant from one parent. They then calculated the percentage of subjects in each of the three groups who possessed one copy of the gene variant.

Only 39 percent of the control subjects had one copy of the variant, the researchers found. In contrast, 48 percent of bipolar subjects with panic disorder had it. This 48 percent was somewhat more than the 39 percent of controls, but not significantly different from it. However, 56 percent of bipolar subjects without panic possessed a copy of the variant. The 56 percent was a highly significant difference from the 39 percent of controls.

The researchers then examined DNA samples from their subjects to see whether any samples contained two copies of the gene variant—in other words, evidence that subjects had inherited a copy of the variant from each parent.They then calculated what percentage of subjects in each of the three groups possessed two copies of the gene variant.

Whereas only 15 percent of controls had two copies of the gene variant, 22 percent of bipolar subjects with panic had it, the researchers found. This 22 percent was somewhat more than the 15 percent of controls, but not significantly different from it. However, 40 percent of bipolar subjects without panic had two copies of the gene variant, the researchers discovered. This 40 percent was a highly significant difference from the 15 percent of controls who had it.

Evidence Builds

These findings thus support previous evidence that the COMT gene variant plays a role in bipolar disorder. But they also suggest that the variant is only a culprit in bipolar disorder per se, not in bipolar plus panic disorder. This points to the likelihood that bipolar disorder without panic is genetically distinct from bipolar with it, as Rotondo and his colleagues suspected.

But the researchers did not stop there. They decided to see whether they could bolster their case that bipolar without panic is not genetically identical to bipolar with panic. To evaluate this they decided to use another rogue gene variant that had previously been associated with bipolar disorder as their exploratory tool. It came from a gene called the 5-HTT gene. This gene is located on chromosome 17 and is involved in the transport of the nerve transmitter serotonin.

Rotondo and his colleagues examined DNA samples from each of their subjects to see whether any contained one copy of the maverick gene. They then determined what percentage of healthy subjects, what percentage of bipolar-with-panic subjects, and what percentage of bipolar-without-panic subjects had one copy of the gene variant and compared the percentages for the three groups.

Highly Significant Difference

Compared with the 43 percent of controls who had at least one copy of the gene variant, 49 percent of bipolar-with-panic subjects did, the researchers found, a percentage that was not significantly different from the percentage found for controls. However, 58 percent of bipolar-without-panic subjects had at least one copy of the gene variant, they discovered. This 58 percent was a highly significant difference from the 43 percent of controls.

Finally, the investigators examined DNA samples from each of their subjects to see whether any contained two copies of the

*see **Bipolar** on page 33*

Studies Show How Speed Exacts Toll on Brain

A series of recent studies sheds light on the interaction of methamphetamine and dopaminergic neurons in the human brain and reveals specific damage caused by this commonly abused drug.

BY JIM ROSACK

A team at Brookhaven National Laboratory has published two reports in which they detail the actions of methamphetamine in the brain, showing how it leads to damage of dopaminergic neurons.

A similar study by researchers at the University of California at San Diego reports specific cognitive dysfunction tied to that damage. However, the second Brookhaven report offers some hope that the damage may not be entirely permanent.

Nora Volkow, M.D., Linda Chang, M.D., and their colleagues at Brookhaven report in the December 2001 *American Journal of Psychiatry (AJP)* that methamphetamine acts on some of the same brain mechanisms as cocaine and alcohol.

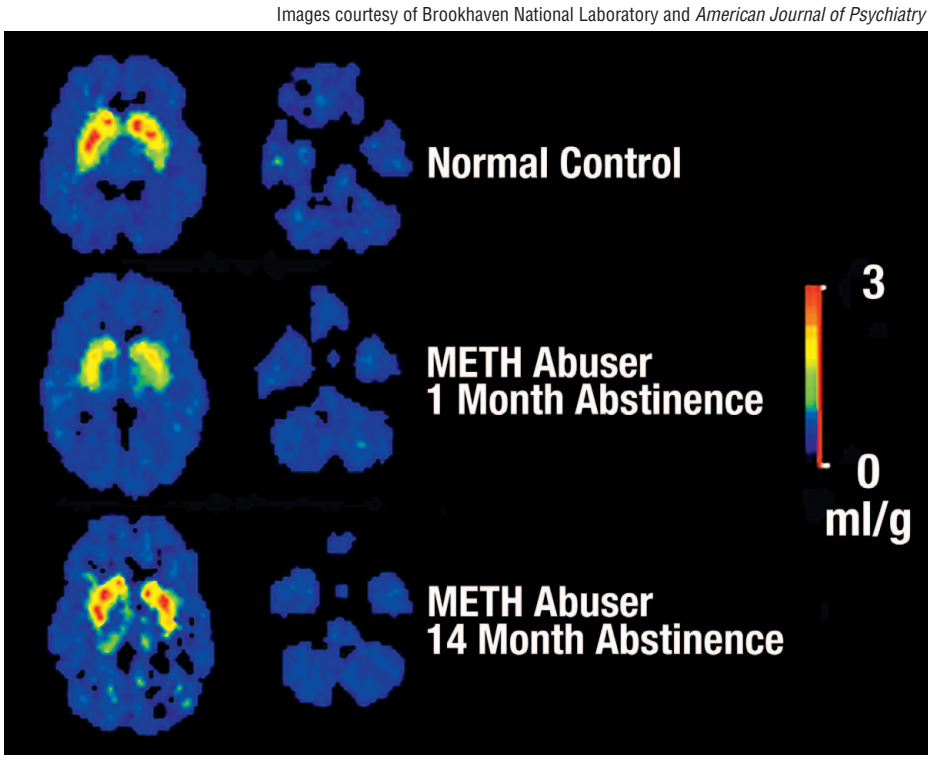
The team used positron emission tomography (PET) scans to measure the level of dopamine D2 receptors and to assess the rate of glucose metabolism in the brains of 15 methamphetamine abusers. They compared those results with the same scans and measurements from 20 people who were not drug abusers.

Those using methamphetamine were found to have lower levels of dopamine receptors and lowered rates of glucose metabolism in the orbitofrontal cortex, a region of the brain linked to compulsive behaviors.

The researchers postulate that disruption of the metabolism of the orbitofrontal cortex may contribute to compulsive drug intake in individuals with addiction.

The association between decreased dopamine receptors and lowered metabolism of glucose in the orbitofrontal cortex has previously been reported in individuals addicted to cocaine and alcohol. This is the first association, according to Volkow, of the effects with methamphetamine use. The work was funded by the National Institute on Drug Abuse.

Images courtesy of Brookhaven National Laboratory and *American Journal of Psychiatry*



PET scans show levels of dopamine transporters in cortical (left column) and subcortical (right column) regions of the brains of individuals abusing methamphetamine. After 14 months of abstinence, transporter levels are recovering to near normal levels (red indicates high levels; yellow, moderate levels; and blue, low levels).

Cognitive Deficits

In a report in the January issue of *Neuropsychopharmacology (NPP)*, Marc A. Shuckit, M.D., and his colleagues at UCSD and the San Diego Veterans Administration Medical Center, used functional magnetic resonance imaging (fMRI) to determine the relationship between decision-making dysfunction and neural activity in different brain regions of individuals addicted to methamphetamine.

The team hypothesized that decision-making difficulties in those addicted to methamphetamine and other stimulants might be due to differences in task-related activation of neurons in the prefrontal cortex.

They studied 10 addicted subjects and 10 control subjects, matched for age and level of education. Each performed a two-choice prediction task and a two-choice response task during an fMRI scan. The researchers assessed subjects' bias toward one of the two choices, delay in completing the task, and used mutual information measures to evaluate the underlying strategies the subjects used to complete the tasks.

The team reported that subjects addicted to methamphetamine were more influenced in completing the current task by the outcome of the immediately preceding two-choice task. They also saw less activation of the specific areas of both the orbitofrontal cortex and prefrontal cortex on the fMRI scans.

These results, the authors concluded, support the basic hypothesis that stimulant-dependent subjects develop fundamental cognitive deficits during decision-making tasks that are consistent with both orbitofrontal and prefrontal damage caused by the drug of abuse.

This study was funded through the Department of Veterans Affairs.

Possible Recovery

The neuronal damage from methamphetamine use may not be permanent, however. The Brookhaven team led by Volkow reported in the December 1, 2001, issue of the *Journal of Neuroscience (JN)* that methamphetamine-damaged brain cells may recover after prolonged abstinence from the drug. However, the team cautioned, the extent of recovery may not be enough to regain lost cognitive function associated with the damage.

The team again used PET scans, this time to measure levels of dopamine transporters, of which the dopamine D2 receptor is one part. The team studied addicted individuals enrolled in a rehabilitation program monitored by a California state drug court.

Dopamine transporter levels were studied in five methamphetamine abusers who were able to stay free of drug use throughout the study. The first scan was taken within six months of the last use of methamphetamine, with a second evaluation occurring at least nine months later.

Levels of dopamine transporters measured during the second PET scan increased significantly, between 16 percent and 19 percent, compared with the baseline scan. The longer the period between the first and second scans, the greater the percentage of recovery. In addition, those who had used methamphetamine for a shorter period or in smaller quantities also recovered more dopamine transporters than did long-term, heavy users of the drug.

"This indicates," Volkow said in a NIDA press release announcing the results, "that the length and severity of use may ultimately limit the amount and speed of recovery of dopamine transporters."

In addition to scanning dopamine levels, the subjects in the second Brookhaven study were given a battery of tests to evaluate skills known to be associated with dopamine transporters, including evaluations for gross motor function, fine motor coordination, and memory function. Slight improvement in some motor and memory skills was noted, but the improvements were not statistically significant.

"One explanation," Volkow said, "could be that neuropsychological function requires other brain systems that may have been affected by methamphetamine use for which recovery may be slower or not present."

The second Brookhaven study was funded by both NIDA and the National Institutes of Health.

***An abstract of the* AJP *article is posted on the Web at <http://ajp.psychiatryonline.org/cgi/content/abstract/158/12/2015>; an abstract of the* NPP *article can be accessed at <www.elsevier.com/gej-ng/10/33/33/show/> by searching on "Shuckit"; and an abstract of the* JN *article is posted at <www.jneurosci.org/>.** ■

Smoking When Pregnant Tied to Risk That Offspring Will Be Criminals

A dose-response relationship is found between the arrests of young men and women for a variety of crimes and how many cigarettes their mothers smoked during the last three months of pregnancy.

BY JOAN AREHART-TREICHEL

Can young men and woman who commit murder, robbery, rape, assault, theft, fraud, forgery, blackmail, embezzlement, vandalism, prostitution, narcotics offenses, or other crimes blame it on how many cigarettes their mothers smoked during pregnancy?

Maybe.

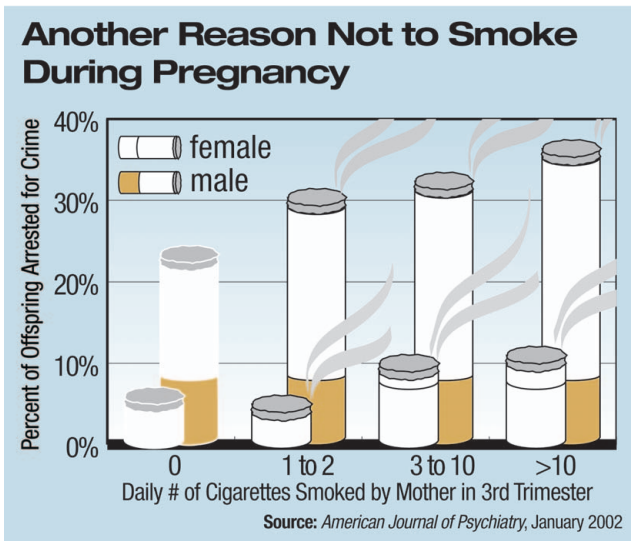
A dose-response relationship has been found between the arrests of young men and women for such crimes and how many cigarettes their mothers smoked during the last trimester of pregnancy.

The finding comes from a study conducted by Patricia Brennan, Ph.D., an assistant professor of psychology at Emory University in Atlanta, and reported in the January *American Journal of Psychiatry*.

The persons Brennan and her colleagues decided to use as subjects for their study were some 8,000 individuals who had been born in Copenhagen, Denmark, between 1959 and 1961. Extensive demographic and medical information was gathered for each of these individuals before, during, and after their births. And it was this extensive data bank that Brennan and her coworkers wanted to tap for their study.

For instance, whether the fathers of the individuals had a criminal history had been determined from the Danish criminal register. Whether the fathers or

see ***Smoking*** *on page 33*



Researchers found that the more cigarettes a woman smoked during her third trimester of pregnancy, the greater the likelihood that her child would later engage in criminal activity.

annual meeting

Philadelphia: A Lot More Than Brotherly Love

APA is holding its 2002 annual meeting in Philadelphia May 18 to 23. The city's numerous historic and cultural attractions will keep APA members busy after scientific sessions end each day.

BY MARVIN KANEFIELD, M.D.

Philadelphia and its surrounding counties provide an abundance of historic sites, museums, theaters, cultural events, architectural delights, and neighborhoods that exemplify the spirit of our country.

Dr. Kanefield is chair of the APA Task Force on Local Arrangements.

Let's begin the tour with history. Philadelphia is an historic town in a big, modern city. The roots of American democracy are found here. Major historic sites are within a short walk of the Pennsylvania Convention Center, where registration and most of the annual meeting's scientific sessions will be held.

A good place to start is Independence National Park. Most people are familiar with Independence Hall (where the Lights of Liberty sound-and-light show is held nightly) and the Liberty Bell, which are must-sees.

In the same area you will find the visitors center, Betsy Ross House, Carpenters' Hall, Congress Hall, Christ Church, Franklin Court, Elfreth's Alley, the U.S. Mint, and many small museums and other historic sites. The area is a walker's delight, but for those who prefer riding, narrated carriage tours are available.

Venturing away from the city, you can explore Washington's Crossing State Park and Valley Forge.

A new tour visits a more recent period in history with the opening of the U.S.S. New Jersey, which is located in Camden, N.J., right across the Delaware River.

Philadelphia is resplendent with art. We have incredible museums, outdoor art, wonderful architecture, and cultural attractions galore.

Art Museums

Let's start with the Philadelphia Museum of Art. Located on the Benjamin Franklin Parkway, the museum is magnificent inside and out. It is our "Parthenon on the Parkway." If you are feeling energetic, climb—or run—up the steps immortalized in the film "Rocky." Its permanent collection showcases many of the world's most famous paintings and sculptures. (Don't miss the three generations of Calder mobiles in one unbroken line of sight.) The museum also houses collections of decorative arts, weapons and armor, textiles, and Indian and Himalayan art.

Across the parkway is the Rodin Museum, which houses the largest collection of Rodin sculptures outside of Paris.

A world of ancient artifacts can be found in another great museum—the University of Pennsylvania Museum of Archaeology and Anthropology.

If new appeals to you, Philadelphia boasts the Institute of Contemporary Art.

For an architectural treat that should not be missed, be sure to stop by Philadelphia City Hall, located in the middle of Center City. While its purpose is to house city government offices, it is a visual treat with a beautiful courtyard.

A new addition to the city is the National Liberty Museum, dedicated to liberty and honoring heroes of freedom with its glass sculpture "The Flame of Liberty" by Dale Chihouly.

Also unique is the Barnes Foundation, which houses the magnificent impressionist collection of Dr. Albert C. Barnes (advance reservations are required).

For the scientific minded there are the Franklin Institute Science Museum and the Mutter Museum. If it's marine life you enjoy, visit the New Jersey State Aquarium just across the river. There are also many heritage museums including the National Museum of American Jewish History, the African-American Museum, and the Balch Institute for Ethnic Studies.

Performing Arts

Let's now get in step with the lively arts. Philadelphia offers fun for everyone. Performances of music, theater, and dance abound. Visitors in May will have the opportunity to see the Kimmel Center for the Performing Arts, which opened its doors in December. It is home to the famous and fabulous Philadelphia Orchestra. Due to an extended season there will be an orchestra performance Saturday evening, May 18, with Maestro Wolfgang Sawallisch conducting. The Kimmel Center is located on the Avenue of the Arts, where you will find many theaters and restaurants and the venerable Academy of Music.

There will be many venues in Center City to enjoy. Broadway musicals and dramas fill stages large and small. Performances range from classical, opera, rock and roll, and dance, to blues and jazz. There is indeed something for everyone.

For musicians and fans of blues and jazz, there are many clubs and jam sessions. Open jam sessions are held every Tuesday night for blues musicians at Warmdaddy's and for jazz at Chris' Jazz Cafe, Ortlieb's Jazzhaus, and the 23rd St. Café.

Whatever your interests or tastes, day or night, Philly has it all. ■

World Psychiatric Association Prepares for 21st Century

The WPA's programs and activities are fostering new collaborations between individual psychiatrists and international psychiatric organizations.

BY EVE KUPERSANIN

For half a century the World Psychiatric Association (WPA) has been uniting psychiatrists from all points on the globe to promote good mental health.

The WPA brings together 118 psychiatric societies from across the world, representing a combined total of 180,000 psychiatrists.

Recently psychiatric societies from Bangladesh, Sudan, Uganda, and Kenya have joined the WPA, according to Secretary General Juan Mezzich, M.D., Ph.D.

The WPA has its roots in the Association to Organize World Congresses of Psychiatry, which held its first world congress in 1950 in Paris, and was followed by world congresses in Zurich, Montreal, Madrid, Mexico City, Hawaii, Vienna, Athens, Rio de Janeiro, and Hamburg.

The Association to Organize World Congresses of Psychiatry was renamed the World Psychiatric Association in 1960. The WPA's mission is to connect national psychiatric societies to advance the field of psychiatry and improve mental health across the world.

WPA President Juan López-Ibor Jr., M.D., Ph.D., said in the 2000 celebration of the WPA's 50th anniversary, "The WPA has been extending and diversifying its membership to all corners of the planet, adapting to global changes, modernizing itself, and responding to the expectations its founders trusted the WPA would fulfill."

The WPA has 54 scientific sections dedicated to various area of clinical psychiatry and mental health, such as women's mental health, affective disorders, transcultural psychiatry, and urban mental health.

Many of these sections are active internationally and accomplish a number of goals such as organizing symposia, publishing books and journals, and developing educational programs.

Many of the WPA's activities are devoted to promoting the highest ethical standards for psychiatric practice across the world, according to Mezzich, who said that the WPA has developed ethical guidelines, which are assembled in the Madrid Declaration. "Endorsement and observance of these guidelines are a requirement for the admission and continuing membership of national psychiatric societies," he said. The Standing Committee to Review Abuse of Psychiatry considers cases of alleged abuse and recommends a course of action to the Executive Committee and the General Assembly. The following are examples of other WPA programs and activities:

- The WPA is developing a core curriculum for postgraduate training in psychiatry. According to Ahmed Okasha, M.D., president-elect of the WPA, the curriculum is aimed at improving the level of training to ensure that it is not only scientifically sound but also culturally sensitive. This curriculum involves basic recommendations that will be distributed widely to inform the development and refinement of psychiatric residency programs across the world.
- The WPA's institutional program to promote the professional development of young psychiatrists is designed to foster the future of the field across the world and particularly in developing countries. It accomplishes this through organizing fellowships at WPA congresses and meetings, preparing courses for career development, and establishing awards for scientific contributions.
- The WPA has established the Global Program Against Stigma and Discrimination Because of Schizophrenia, with the participation of various medical and behavioral science disciplines, patient and family associations, and intergovernmental organizations. "At stake are therapeutic effectiveness, as well as human rights and the highest ethical aspirations of our profession," said Mezzich.
- To better identify, assess, and treat people with mental illness, the WPA is working with the World Health Organization, APA, and other psychiatric associations to decide how to best use and develop further international systems of classification and diagnosis. Interest has been expressed in the development of a more coordinated international standard attentive to the diversity of clinical realities and needs across the world, according to Mezzich.
- The WPA is promoting the advancement of psychiatry and mental health in Sub-Saharan Africa and Central Asia. It is holding several meetings in those areas with local psychiatric organizations. Since there are few psychiatrists in those areas, the meetings should expand mental health services for underserved populations by helping psychiatrists network with other health professionals. The WPA is encouraging participation from its large member societies such as APA.

Juan Mezzich, M.D., Ph.D., is the secretary general of the World Psychiatric Association.

Okasha, who chairs this program, has organized meetings in Egypt and other locations in Africa and is organizing a federation of African psychiatric societies to coordinate the work of psychiatrists and mental health professionals there. In addition, former APA President Harold Eist, M.D., chair of APA's Commission on Global Psychiatry, is working to connect American psychiatrists of African ancestry with colleagues working in Africa.

Another WPA initiative is the development of educational programs. It has, for example, developed the International Guidelines for Diagnostic Assessment and is establishing a program of continuing medical education credits.

On the publishing front, the WPA is coming out with a new journal, *World Psychiatry*, which will be distributed free to 20,000 psychiatrists beginning in February, through a distribution system arranged in consultation with WPA member societies and sections. The contents will include original scientific articles, review papers, and statements of general interest for clinical practice and public health and will highlight activities of the WPA and its scientific sections.

More information about the World Psychiatric Association is posted on the Web at <www.wpanet.org>. ■

WPA Congress to Be Held in Asia

Many nations will unite to find new ways to improve mental health at the next World Congress of Psychiatry.

The first world congress of the World Psychiatric Association (WPA) in Asia will take place next August in Yokohama, Japan, and will serve as an international forum for the discussion of key issues in psychiatry.

The XII World Congress of Psychiatry also celebrates the 100th anniversary of the Japanese Society of Psychiatry and Neurology. The WPA congress takes place every three years in a different city.

The theme of the 2002 congress, "Partnerships for Mental Health," is aimed at building collaborations between nations, people with mental illness and their families, and mental health professionals of many disciplines.

"During the past decade, world congresses of psychiatry have been milestones for the development of our discipline and for the enrichment of our knowledge as professionals," said WPA President Juan López-Ibor, M.D., Ph.D., in a statement last year. "Each world congress is also an opportunity to contact colleagues from other parts of the world and confront different approaches to psychiatry."

Juan López-Ibor, M.D., Ph.D., is president of the World Psychiatric Association.

The meeting will take place August 24 to 29 and offers English translation throughout the program, which will include plenary lectures, forums, symposia, workshops, courses, and posters. The deadline for scientific submissions is January 31.

Congress organizers expect 250 symposia will be offered, with topics ranging from recent results of investigations of the biological correlates on mental illness to ethical issues in psychiatric education. WPA sections (many of which are led by American psychiatrists) play a major role in the preparation of symposia and other aspects of the scientific program.

According to WPA past president and chair of WPA's Scientific Committee Norman Sartorius, M.D., there will be special emphasis at this year's congress on symposia that discuss the notion of partnerships. "The differences between countries and the experiences of psychiatrists working in them could be a rich source of inspiration for research and service development," he said in a written statement.

Sartorius said that finding ways to develop quality mental health programs in developing countries would be useful models for psychiatry in more wealthy countries currently facing economic difficulties.

Among those who attend WPA congresses are psychiatrists, mental health professionals, people with mental illness and their families, politicians, attorneys, and policymakers.

In addition to a scientific program, there will be a rich cultural program, and attendees can explore the traditional music, art, and culture of Yokohama through courses and visits to a variety of monuments in Yokohama and vicinity.

The richness of the Congress's scientific and cultural program shall be particularly attractive to American psychiatrists, given the growing multiculturality of the APA membership and the U.S. population.

The WPA is offering a fellowship for 200 young psychiatrists with promising scientific skills. The fellowship will fund all aspects of their attendance at the 2002 congress and is intended to help them improve their academic and leadership abilities so that they can work with various national psychiatric societies.

The WPA is offering discount packages with national societies to cover both travel and accommodation expenses. Further information about this and other aspects of the congress can be obtained by e-mail at wpa_sec@c-linkage.co.jp or wpa@dci.net; on the Web at <www.wpa2002yokohama.org>; or by telephone at (718) 334-5094. ■

Medicare

continued from page 1

fair method of distributing Medicare resources.

APA's Committee on Psychiatric Reimbursement, chaired by Joseph T. English, M.D., and co-chaired by Steven Sharfstein, M.D., has as its primary mission to protect the critical care provided on inpatient psychiatric units. The committee's work is supported by staff members Lloyd Sederer, M.D., director of clinical services, and Irvin (Sam) Muszynski, J.D., director of the APA Office of Healthcare Systems and Financing.

The committee commissioned a policy paper, "Prospective Payment for Inpatient Psychiatric Services: A Review of the Evidence and Key Issues," from the Department of Health Care Policy at Harvard Medical School.

The paper confirmed the findings reported in the article "Diagnosis-Related Groups and General Hospital Psychiatry: The APA Study" by English, Sharfstein, Muszynski, Donald Scherl, M.D., and Boris Astrachan, M.D., in the February 1986 *American Journal of Psychiatry*. That study found that existing classification systems (including the DRG system) did not adequately reflect the tremendous variation in resource use and cost involved in treating psychiatric patients. In fact, those classification systems could put facilities at financial risk for treating high-cost patients and thereby create incentives to curb care and avoid offering care to some patients.

The committee used the new paper as the basis for its opening statement to CMS, the federal agency that administers the Medicare program, to begin to build its case to protect an already imperiled system of inpatient psychiatric care.

Sederer said, "Hospitals might try to avoid admitting older patients and others who typically cost more to treat, such as those who need restraint, seclusion, or who require many medical services. They might be financially motivated to discharge patients too early if the payment system does not fairly support costs."

The current psychiatric bed shortage adds urgency to the problem. The November/December 2001 issue of the APA publication *Psychiatric Practice & Managed Care* contains reports from 16 states acknowledging psychiatric bed shortages. The combined number of private and public psychiatric hospitals increased until 1992, after which the number of psychiatric hospitals began to decline.

Sederer said, "The risk is that a change in the payment system could produce winners and losers. The losers could experience tremendous pressure to close beds to limit their financial bleeding, but it is unlikely that any winners would add beds." He added, "We are talking about $3 billion annually for psychiatric inpatient care under Medicare."

The model APA presented to CMS suggests a transition plan for facilities that will suffer financial loss, mitigates their losses, and thus reduces incentives for abrupt changes in availability and quality of care.

APA was able to enlist the services of THEORI, a division of the Greater New York Hospital Association, where English has been an association leader since 1973. THEORI has worked extensively on patient classification and financial-risk models.

"The risk is that a change in the payment system could produce winners and losers."

Building on existing THEORI analyses and modeling, THEORI's staff worked with APA committee members and staff to develop a new approach to a psychiatric PPS. The approach was to develop a model that would include patient characteristics and other factors that reflect differences in cost. The model could be implemented using existing administrative data and would not require any clinical staff time.

Sederer added, "We were concerned about initial results from a University of Michigan study that CMS had commissioned to develop a PPS. Their payment system would require facilities to use a new patient-assessment instrument that would add to staff's burden." The University of Michigan study also relies on data that are not subject to independent analysis, because they are not replicable.

The APA committee joined with the American Hospital Association and the National Association of Psychiatric Health Systems, thus increasing its influence with CMS. Those two organizations also helped refine the model.

Sederer explained that the Committee on Psychiatric Reimbursement (formerly the Committee on Prospective Payment) "has been a component of APA since 1983. The committee was appointed to advise government on behalf of the most vulnerable of psychiatric patients and the psychiatrists who care for them."

Further reports on this effort will appear in future issues of *Psychiatric News*. ■

APA 2002 ANNUAL MEETING • The 21st Century Psychiatrist • PHILADELPHIA, PA • MAY 18–23, 2002

Philadelphia

The 21st-Century Psychiatrist

MAY 18-23

APA'S 155TH ANNUAL MEETING

Course Guide

next 6 pages...

More than a hundred Category 1 continuing medical education courses will be offered at the 155th Annual Meeting of the American Psychiatric Association in May. The courses are in keeping with the goal of presenting a well-planned, highly structured, educational experience for participants.

Admission to all courses, which will be offered in half-day and full-day formats, requires an annual meeting badge and course ticket. Advance enrollment for the CME courses is open to all annual meeting registrants.

You are encouraged to enroll early during the advance enrollment period to avoid the potential disappointment of discovering that your selected courses have been fully subscribed. Please note that requests will be processed on a first-come, first-served basis. Complete course descriptions appear in this section of *Psychiatric News* and in the CME course brochure, which is included in the Advance Registration Information Packet. The packet was mailed earlier this month; if you do not receive your packet by February 1, refer to the box below.

Please use the Advance Registration and Course Enrollment Form combined with the course brochure when making your selections.

The fees for the courses are as follows: half day (four credit hours): advance, $95, and on site, $125; full day (six credit hours): advance, $150, and on site $175; full day (eight credit hours): advance, $190, and on site, $250.

The maximum number of participants for each course is listed in this section, as are the date, time, and fee. If the appropriate fees are not received with your advance registration for both the meeting and selected courses, course spaces will not be reserved for you. Fees must be paid in U.S. dollars.

Advance enrollment closes April 13 for U.S. registrants, and April 6 for all others. Tickets for CME courses not sold by April 13 will go on sale to all registrants at 10 a.m. on Saturday, May 18, at the Course Enrollment Area in the Pennsylvania Convention Center. **No one will be able to purchase course tickets until after registering for the annual meeting.** The registration area will be located in Halls A-C, Exhibit Hall Level.

After the advance enrollment deadline, absolutely no refunds will be granted or changes in course selections permitted. Written notices of cancellation or changes received postmarked by the deadline will be honored, less a $10 processing fee. These written notifications should be addressed to CME Course Coordinator, APA, 1400 K Street, N.W., Washington, D.C., 20005.

MORE INFORMATION

More information on the annual meeting is available in these ways:

- Go to APA's Web site at www.psych.org and click on the annual meeting logo.
- Call the APA Answer Center at (888) 35-PSYCH; from outside the U.S. and Canada, call (202) 682-6000.

Photos courtesy of the Philadelphia Convention and Visitors Bureau

APA's Philadelphia: The 21st-Century Ps

SATURDAY, MAY 18, 2002

COURSE 1: ***COMPUTER-ASSISTED DIAGNOSTIC INTERVIEW.*** **Co-Directors:** Paul R. Miller, M.D., Charles Chiu, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) summarize research showing that CADI's diagnostic precision is reliable, valid, and complete, equal to gold standards (SCID, Consensus), and significantly better than traditional diagnostic interviews; (2) explain how to use CADI with the computer and/or Palm Pilot; and (3) identify when and how to use CADI in clinical practice and research. **Course Level:** This is an intermediate course. Participants should have familiarity with PC, Windows, and the DSM-IV. **Sat., May 18, 8-12; Convention Center; Fee: Advance $95, On-Site $125; Spaces Available: 25.**

COURSE 2: ***ANTIPSYCHOTIC-INDUCED MOVEMENT DISORDERS: ASSESSMENT AND TREATMENT.*** **Director:** Leonardo Cortese, M.D. **Faculty:** Richard Williams, M.D., Michael Caligiuri, Ph.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) classify the types of movement disorders; (2) list clinical features, differential diagnosis, and risk factors of all four types of antipsychotic-induced movement disorders; (3) understand treatment modalities of all four types of extrapyramidal syndromes (EPS); (4) examine a patient for movement disorders; (5) identify EPS through video clips of patients with a vast array of movement disorders; and (6) understand the benefit of using instrumentation in the assessment of EPS. **Course Level:** This is an intermediate course. Participants should have a basic understanding of antipsychotic medication, but no specific or comprehensive background knowledge is required to learn the material of this course. **This is a repeat of a course given last year. Sat., May 18, 8-12; Convention Center; Fee: Advance $95, On-Site $125; Spaces Available: 50.**

COURSE 3: ***ADD IN CHILDREN AND ADOLESCENTS.*** **Director:** Thomas E. Brown, Ph.D. **Faculty:** Jefferson B. Prince, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) recognize types of child and adolescent attention-deficit disorders (ADDs), (2) assess and diagnose ADDs using updated instruments and methods, (3) select appropriate medications for ADDs with comorbid conditions, and (4) design multimodal treatment programs for ADD children and adolescents. **Course Level:** This is a basic course. No previous experience or knowledge is required. **This is a revision of a course given last year. Sat., May 18, 8-12; Convention Center; Fee: Advance $95, On-Site $125; Spaces Available: 75.**

COURSE 4: ***WRITING ABOUT CLINICAL EXPERIENCES.*** **Director:** John S. Strauss, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) appreciate the details, depth, and richness of a clinical experience, and (2) describe these experiences in writing. **Course Level:** This is a basic course. The only background requirement of participants (of any discipline or orientation) is that they have experience as clinicians and be willing to try. **Sat., May 18, 8-12; Convention Center; Fee: Advance $95, On-Site $125; Spaces Available: 25.**

COURSE 5: ***ECT IN NEUROLOGICAL DISORDERS.*** **Co-Directors:** Georgios Petrides, M.D., Charles H. Kellner, M.D. **Faculty:** C. Edward Coffey, M.D., Raymond A. Faber, M.D., Max Fink, M.D., Chitra Malur, M.D. **Educational Objective:** At the conclusion of the course, the practitioner will be able to: (1) identify and select those patients with neurological disorders for whom ECT may be useful, and (2) manage the technical requirements for safe ECT. **Course Level:** This is an intermediate course for practitioners who have an interest in broadened application of ECT to such neurological disorders as delirium, dementia, intractable seizures, catatonia, NMS, Parkinson's disease, and the mentally ill with brain lesions. **This is a revision of a course given last year. Sat., May 18, 8-12; Convention Center; Fee: Advance $95, On-Site $125; Spaces Available: 50.**

COURSE 6: ***BASIC CONCEPTS IN ADMINISTRATIVE PSYCHIATRY: THEORY, HUMAN RESOURCES, AND FISCAL MANAGEMENT.*** *APA Committee on Psychiatry in the Workplace and Academy of Organizational and Occupational Psychiatry.* **Co-Directors:** Christopher G. Fichtner, M.D., Thomas A. Simpatico, M.D. **Faculty:** L. Mark Russakoff, M.D., Stuart B. Silver, M.D., S. Atezaz Saeed, M.D., Shivkumar Hatti, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to demonstrate familiarity with theories, principles, concepts, and developments relevant to administrative psychiatry and their applications in psychiatric service systems. **Course Level:** This is a basic course. No previous experience or knowledge is required. Participants are not required to take the two-course series. **The two-course series is suggested for those seeking certification. Sat., May 18, 9-4; Convention Center; Fee: Advance $150, On-Site $175; Spaces Available: 50. A companion course on this topic will be offered on Sun., May 19, 9-4. See Course 23 for details.**

COURSE 7: ***INTERPERSONAL PSYCHOTHERAPY.*** **Director:** Scott P. Stuart, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) conduct interpersonal psychotherapy treatment (IPT), (2) demonstrate a knowledge of the research regarding IPT, and (3) deal effectively with difficult and resistant patients using IPT. **Course Level:** This is a basic course. No previous experience or knowledge is required. **This is a revision of a course given last year. Sat., May 18, 9-4; Convention Center; Fee: Advance $150, On-Site $175; Spaces Available: 25. An intermediate course on this topic will be offered on Wed., May 22, 8-12. See Course 81 for details.**

COURSE 8: ***PERSONALITY AND POLITICAL BEHAVIOR.*** **Director:** Jerrold M. Post, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to demonstrate an enhanced understanding of the manner in which psychological processes affect political processes, including the psychology of leadership and leader-follower relationships, with particular emphasis on charismatic movements and of the psychological foundations of political terrorism, ethnic/nationalist hatred, and genocidal violence. **Course Level:** This is a basic course. No previous experience or knowledge is required. **This is a revision of a course given last year. Sat., May 18, 9-4; Convention Center; Fee: Advance $150, On-Site $175; Spaces Available: 25.**

COURSE 9: ***PSYCHIATRY UPDATE FOR THE INTERNATIONAL SPANISH-SPEAKING COLLEAGUE (IN SPANISH).*** **Director:** Gabriel Kaplan, M.D. **Faculty:** Javier I. Escobar, M.D., Jorge R. Petit, M.D., Eduardo Dunayevich, M.D., Rodrigo A. Pizarro, M.D., Dario F. Mirski, M.D., Ana Kaplan, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to summarize recent advances in the treatment of major psychiatric diagnoses for all ages. **Course Level:** This is an intermediate course. **Participants must be Spanish speaking. Sat., May 18, 9-4; Convention Center; Fee: Advance $150, On-Site $175; Spaces Available: 25.**

COURSE 10: ***MULTIMODAL TREATMENT OF EATING DISORDERS.*** **Co-Directors:** Kathryn J. Zerbe, M.D., Mae S. Sokol, M.D. **Educational Objective:** At the conclusion of this course, the participant should obtain a greater repertoire of interventions, such as pharmacological, psychodynamic, educational, nutritional, and cognitive-behavioral interventions in dealing with patients with eating disorders. **Course Level:** This is an advanced course. Participants should have knowledge of evaluation and treatment of eating disorders. **This is a revision of a course given last year. Sat., May 18, 9-4; Convention Center; Fee: Advance $150, On-Site $175; Spaces Available: 50. A basic course on this topic will be offered on Sun., May 19, 9-4. See Course 25 for details.**

COURSE 11: ***OUTCOMES: USE OF RATING SCALES.*** **Co-Directors:** Luis F. Ramirez, M.D., Martha Sajatovic, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) recognize the differences between outcomes and measurements, (2) determine the type of scales to use according to the specific program or purpose, and (3) become familiar with the interviewing and statistical techniques necessary to prepare a solid evaluation strategy. **Course Level:** This is a basic course. No previous experience or knowledge is required. **This is a revision of a course given last year. Sat., May 18, 9-4; Convention Center; Fee: Advance $150, On-Site $175; Spaces Available: 50.**

COURSE 12: ***EVIDENCE-BASED MANAGEMENT OF SAD: FOCUS ON LIGHT THERAPY.*** **Co-Directors:** Raymond W. Lam, M.D., Anthony J. Levitt, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) diagnose SAD, (2) use light therapy in clinical practice to treat SAD and other conditions, and (3) identify management issues in the use of light therapy and medications for SAD. **Course Level:** This is a basic course. No previous experience or knowledge is required. **This is a repeat of a course given last year. Sat., May 18, 1-5; Convention Center; Fee: Advance $95, On-Site $125; Spaces Available: 50. A similar course on this topic will be offered on Sun., May 19, 1-5. See Course 38 for details.**

COURSE 13: ***NEUROENDOCRINOLOGY IN MOOD DISORDER: DYSREGULATION AND TREATMENT.*** **Co-Directors:** Mark A. Frye, M.D., Natalie L. Rasgon, M.D. **Faculty:** D. Jeffrey Newport, M.D., Stuart N. Seidman, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to better understand various neuroendocrine aspects of mood disorders and update his/her knowledge of the possible treatment strategies for mood disorders involving neuroendocrine dysfunction. **Course Level:** This is a basic course. No previous experience or knowledge is required. **Sat., May 18, 1-5; Convention Center; Fee: Advance $95, On-Site $125; Spaces Available: 75.**

COURSE 14: ***CONTEMPORARY MALPRACTICE LITIGATION: A PRACTICAL GUIDE.*** **Co-Directors:** Eugene L. Lowenkopf, M.D., Abe M. Rychik, J.D. **Faculty:** Richard G. Hersh, M.D., Jacqueline M. Melonas, J.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) understand the procedures involved in medical malpractice suits, (2) participate more effectively within the legal system; (3) understand the relevant legal issues in managed care, shared treatment, and treatment of BPD, and (4) utilize risk management more effectively. **Course Level:** This is a basic course. No previous experience or knowledge is required. **This is a revision of a course given last year. Sat., May 18, 1-5; Convention Center; Fee: Advance $95, On-Site $125; Spaces Available: 50.**

WITHDRAWN

COURSE 15: ***THE EVALUATION AND MANAGEMENT OF PAIN.*** **Director:** Steven A. King, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) understand current concepts of pain and JCAHO pain standards, (2) become familiar with classification systems of pain, (3) identify the problem of pain in special populations, and (4) achieve proficiency in the management of pain. **Course Level:** This course is a basic course. No previous experience or knowledge is required. **This is a repeat of a course given last year. Sat., May 18, 1-5; Convention Center; Fee: Advance $95, On-Site $125; Spaces Available: 125.**

COURSE 16: ***DREAM TRANSLATION: ONE EMPIRICALLY BASED APPROACH.*** **Director:** Milton Kramer, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) understand that there is a scientific basis to the search for the meaning of a dream, and (2) apply a methodology to establish a dream's meaning. **Course Level:** This is a basic course. No experience or knowledge is required. **This is a revision of a course given last year. Sat., May 18, 1-5; Convention Center; Fee: Advance $95, On-Site $125; Spaces Available: 25.**

SUNDAY, MAY 19, 2002

COURSE 17: ***DSM-IV-TR CULTURAL FORMULATIONS: DIAGNOSIS AND THERAPY.*** **Director:** Russell F. Lim, M.D. **Faculty:** J. Charles Ndlela, M.D., Candace M. Fleming, Ph.D., Roberto Lewis-Fernandez, M.D., Francis G. Lu, M.D., Michael W. Smith, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) understand and describe the five parts of the DSM-IV outline for cultural formulation; (2) apply the cultural formulation to the treatment of African-American, Asian, Hispanic, and American-Indian patients; and (3) recognize how ethnicity affects psychopharmacology and psychotherapy. **Course Level:** This is a basic course. No previous experience or knowledge is required. **This is a revision of a course given last year. Sun., May 19, 8-12; Convention Center; Fee: Advance $95, On-Site $125; Spaces Available: 25.**

Course Guide
1 thru 34

COURSE 18: **THE PSYCHIATRIST AS EXPERT WITNESS.** **Director:** Phillip J. Resnick, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to give more effective expert witness testimony in civil and criminal trials. **Course Level:** This is a basic course. No previous experience or knowledge is required. **This is a repeat of a course given last year. Sun., May 19, 8-12; Convention Center; Fee: Advance $95, On-Site $125; Spaces Available: 100.**

COURSE 19: **TRAINING IN THE USE OF THE POSITIVE AND NEGATIVE SYNDROME SCALE.** **Co-Directors:** Lewis A. Opler, M.D., Paul M. Ramirez, Ph.D. **Educational Objective:** At the conclusion of this course, the participant should be able to (1) identify positive, negative, and general psychopathological symptoms in schizophrenia; (2) utilize the structured clinical interview for the Positive and Negative Syndrome Scale (PANSS) in clinical or research settings; and (3) use the PANSS in rating symptoms. **Course Level:** This is an intermediate course. Participants should have some experience interviewing patients with schizophrenia and other psychotic disorders. **This is a revision of a course given last year. Sun., May 19, 8-12; Convention Center; Fee: Advance $95, On-Site $125; Spaces Available: 25.**

COURSE 20: **THE EVALUATION AND IDENTIFICATION OF THE MAJOR DEMENTIAS.** **Director:** Raymond A. Faber, M.D. **Faculty:** Kevin F. Gray, M.D., Randolph B. Schiffer, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) evaluate all major cognitive and higher cortical functions, (2) utilize any of several cognitive and executive function screening batteries, (3) recognize the most common presentations and course of Alzheimer's disease and appreciate the behavioral disorders that most frequently complicate Alzheimer's disease, and (4) differentiate Lewy body dementia, frontotemporal dementias, and vascular dementias for Alzheimer's disease. **Course Level:** This is an intermediate course. Participants should have experience in treating patients with dementia. **This is a revision of a course given last year. Sun., May 19, 8-12; Convention Center; Fee: Advance $95, On-Site $125; Spaces Available: 100.**

COURSE 21: **ANTICONVULSANTS IN BIPOLAR DISORDER.** **Co-Directors:** Joseph R. Calabrese, M.D., Mark A. Frye, M.D. **Faculty:** Terence A. Ketter, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) treat bipolar disorder with divalproex, carbamazepine, lamotrigine, gabapentin, and topiramate; (2) have familiarity with the clinical pharmacology of the anticonvulsants available for use in adults; and (3) use algorithms in the treatment of bipolar disorder. **Course Level:** This is an intermediate course. Participants should be interested in gathering additional expertise in the pharmacologic management of bipolar disorder with anticonvulsant medication. **This is a revision of a course given last year. Sun., May 19, 8-12; Convention Center; Fee: Advance $95, On-Site $125; Spaces Available: 250.**

COURSE 22: **APPRECIATING AND ALLEVIATING SPOUSAL CAREGIVER BURDEN IN DEMENTIA.** **Co-Directors:** Sheila M. Loboprabhu, M.D., Kimberly A. Arlinghaus, M.D. **Faculty:** Ellen F. Barr, M.S.W., James W. Lomax II, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) understand experiential, spiritual, ethical, and forensic aspects of spousal caregiving for the patient with dementia; (2) understand the effects of dementia on the marital bond from a marital therapy perspective; (3) relate attachment theory to spousal caregiving in dementia; and (4) integrate couples therapy with pharmacologic treatments in the care of patients with dementia. **Course Level:** This is a basic course. No previous experience or knowledge is required. **Sun., May 19, 8-12; Convention Center; Fee: Advance $95, On-Site $125; Spaces Available: 50.**

COURSE 23: **BASIC CONCEPTS IN ADMINISTRATIVE PSYCHIATRY: CARE MANAGEMENT, LAW, AND ETHICS.** **Co-Directors:** Christopher G. Fichtner, M.D., Wesley Sowers, M.D. **Faculty:** Stephen H. Dinwiddie, M.D., William G. Wood, M.D., Steven Moffic, M.D., John A. Talbott, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to demonstrate familiarity with theories, principles, concepts, and developments relevant to administrative psychiatry and their applications in psychiatric service systems. **Course Level:** This is a basic course. While not required, administrative psychiatry experience is helpful. Participants are not required to take the two-course series. **The two-course series is suggested for those seeking certification. Sun., May 19, 9-4; Convention Center; Fee: Advance $150, On-Site $175; Spaces Available: 50. A companion course on this topic will be offered on Sat., May 18, 9-4. See Course 6 for details.**

COURSE 24: **THE SUBJECTIVE EXPERIENCE: CRUCIAL KEYS TO THERAPY AND TO THE HUMAN MIND.** **Director:** Vincenzo R. Sanguineti, M.D. **Faculty:** Donatella Marazziti, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) better understand the structure of the subjective experience and the sources of contributing data, (2) grasp the unique character of each individual mental state, and (3) use such information to gain deeper understanding and empathy in relation to patients. **Course Level:** This is a basic course. No previous experience or knowledge is required. **This is a revision of a course given last year. Sun., May 19, 9-4; Convention Center; Fee: Advance $150, On-Site $175; Spaces Available: 25.**

COURSE 25: **THERAPEUTIC INTERVENTIONS IN EATING DISORDERS: BASIC PRINCIPLES.** **Director:** David C. Jimerson, M.D. **Faculty:** Michael J. Devlin, M.D., Katherine A. Halmi, M.D., James E. Mitchell, M.D., Joel Yager, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) perform a comprehensive clinical assessment of patients with an eating disorder, (2) develop an initial treatment plan, and (3) understand the roles of short-term psychotherapy and pharmacotherapy. **Course Level:** This is a basic course. No previous experience or knowledge is required. **This is a repeat of a course given last year. Sun., May 19, 9-4; Convention Center; Fee: Advance $150, On-Site $175; Spaces Available: 50. An advanced course on this topic will be offered on Sat., May 18, 9-4. See Course 10 for details.**

COURSE 26: **MONEY MATTERS: USING THEORY IN CLINICAL PRACTICE.** **Director:** Cecilia M. Mikalac, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) understand why discussing money with patients is difficult; (2) recognize the conscious and unconscious influences of race, status, and morality in money discussions; (3) cite a range of payment policies in psychiatric practice; (4) understand and explore the basis of monetary views and practices; and (5) discuss money matters with patients without undue anxiety or defensiveness, in a manner that is both therapeutic and beneficial to the patient. **Course Level:** This is a basic course. No previous experience or knowledge is required. **This is a repeat of a course given last year. Sun., May 19, 9-4; Convention Center; Fee: Advance $150, On-Site $175; Spaces Available: 25.**

COURSE 27: **ALZHEIMER'S DISEASE: ADVANCED APPROACHES TO TREATMENT.** **Director:** William E. Reichman, M.D. **Faculty:** Constanine G. Lyketsos, M.D., David L. Sultzer, M.D., Peter M. Aupperle, M.D., Pierre N. Tariot, M.D., Jacobo E. Mintzer, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to effectively treat Alzheimer's disease using the latest clinical techniques and medications. **Course Level:** This is an intermediate course. Participants should have experience and familiarity with diagnosing and treating the principal dementia syndromes, including Alzheimer's disease. **Sun., May 19, 9-4; Convention Center; Fee: Advance $150, On-Site $175; Spaces Available: 100.**

COURSE 28: **MEDICAL ETHICS 101.** **Director:** Edmund G. Howe, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) distinguish ethical from medical issues in clinical practice, (2) use four different approaches to resolving ethical conflicts, and (3) recognize areas of ethical consensus and controversy currently faced by ethics consultants and committees in general hospital settings. **Course Level:** This is a basic course. No knowledge of bioethics is necessary. **This is a repeat of a course given last year. Sun., May 19, 9-4; Convention Center; Fee: Advance $150, On-Site $175; Spaces Available: 25.**

COURSE 29: **BUILD YOUR OWN RELATIONAL DATABASE ELECTRONIC MEDICAL RECORD.** **Director:** Daniel A. Deutschman, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) build a basic EMR for use with their patients to capture symptom and medication data, (2) understand the value of EMRs in improving quality of care and office efficiency, (3) understand where to get assistance in further development of EMRs, and (4) understand the added value of having the psychiatrist as the programmer. **Course Level:** This is an intermediate course. Participants should have modest computer experience, including e-mail, word processing, etc. **Sun., May 19, 9-4; Convention Center; Fee: Advance $150, On-Site $175; Spaces Available: 50.**

COURSE 30: **INTRODUCTION TO CORRECTIONAL PSYCHIATRY.** **Co-Directors:** James E. Dillon, M.D., Lee H. Rome, M.D. **Faculty:** Richard S. Jackson, M.D., Sanjeev Venkataraman, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) describe the nature and purposes of criminal justice systems and correctional facilities, (2) list key findings from landmark cases in correctional psychiatry, (3) describe patterns of mental illness in correctional populations, and (4) solve common problems arising in the assessment and management of mentally ill prisoners. **Course Level:** This is a basic course. No previous experience or knowledge is required. **This is a revision of a course given last year. Sun., May 19, 1-5; Convention Center; Fee: Advance $95, On-Site $125; Spaces Available: 50.**

COURSE 31: **INTEGRATIVE PSYCHOTHERAPY SUPERVISION: BASIC TOOLS.** **Director:** Paul Rodenhauser, M.D. **Faculty:** Ramona Dvorak, M.D., Albert F. Painter, Psy.D., John R. Rudisill, Ph.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) identify the principles of effective psychotherapy supervision, (2) summarize the levels of teaching/learning involved in the supervisory process, (3) recognize and apply appropriate supervision problem-solving strategies, and (4) demonstrate an improved capacity for use of multiple teaching methods in the supervisory process. **Course Level:** This is a basic course. No previous experience or knowledge is required. **This is a revision of a course given last year. Sun., May 19, 1-5; Convention Center; Fee: Advance $95, On-Site $125; Spaces Available: 25.**

COURSE 32: **CORE COMPETENCIES IN WORKPLACE PSYCHIATRY.** *APA Committee on Psychiatry in the Workplace and Academy of Organizational and Occupational Psychiatry.* **Director:** Ronald Schouten, M.D. **Faculty:** Stephen H. Heidel, M.D., Steven E. Pflanz, M.D., Marcia Scott, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) describe roles psychiatrists can play in work-related matters and ways of building relationships with clients; (2) identify contractual aspects of the employer-employee relationship; and (3) list the key features of a workplace functions assessment. **Course Level:** This is a basic course. No previous experience or knowledge is required. **Sun., May 19, 1-5; Convention Center; Fee: Advance $95, On-Site $125; Spaces Available: 50.**

COURSE 33: **PSYCHIATRIC DISORDERS IN PREGNANCY AND POSTPARTUM.** **Co-Directors:** Shaila Misri, M.D., Kristin S. Sivertz, M.D. **Faculty:** Diana Carter, M.B., Maria R. Corral, M.D., Deirdre M. Ryan, M.B. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) recognize psychiatric disorders that may occur in pregnancy and the postpartum period, and (2) identify the proper intervention strategies for such disorders. **Course Level:** This is an intermediate course. Participants should have basic knowledge in the area of pregnancy and postpartum. **This is a repeat of a course given last year. Sun., May 19, 1-5; Convention Center; Fee: Advance $95, On-Site $125; Spaces Available: 100.**

COURSE 34: **EVIDENCE-GUIDED DUAL-DIAGNOSIS TREATMENT.** **Director:** Andrew P. Ho, M.D. **Faculty:** Robert Chang, M.D., Davin A. Agustines, M.D., Carol Giannini, M.P.H., James Smith, M.D., David Haponski, M.S.W. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) identify target outcomes for patients with co-occurring substance disorders, and (2) use patient tracking and outcomes management methods to quantify impact of treatment.

Philadelphia APA's The 21st-Century Ps

Course Level: This is an intermediate course. Participants should have Web-browser familiarity and exposure to data-management tools such as Microsoft Excel, Access, or SAS/SPSS. **Sun., May 19, 1-5; Convention Center; Fee: Advance $95, On-Site $125; Spaces Available: 25. A basic course on this will be offered on Tue., May 21, 1-5. See Course 73 for details.**

COURSE 35: ***IRRESISTIBLE SLEEP: NARCOLEPSY UPDATE.*** **Director:** Lois Krahn, M.D. **Faculty:** Mark R. Hansen, M.D., Steven I. Altchuler, M.D., Jarrett W. Richardson, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) recognize the variety of narcoleptic symptoms, (2) differentiate narcolepsy from other disorders that cause excessive daytime sleepiness, (3) appropriately order diagnostic tests, (4) understand the available treatments, and (5) review several clinical scenarios commonly encountered by psychiatrists. **Course Level:** This is a basic course. No experience or knowledge is required. **This is a repeat of a course given last year. Sun., May 19, 1-5; Convention Center; Fee: Advance $95, On-Site $125; Spaces Available: 25.**

COURSE 36: ***INTEGRATING PHARMACOTHERAPY AND PSYCHOTHERAPY.*** **Co-Directors:** Barton J. Blinder, M.D., Bernard D. Beitman, M.D. Faculty: Mark G. Barad, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) identify neurobiological foundations and clinical essentials of integrating pharmacotherapy and psychotherapy in the treatment of specific psychiatric disorders, (2) recognize by case examples the special determinants that facilitate and inhibit alleviation of clinical symptoms and psychological conflict with pharmacotherapy and psychotherapy combined, and (3) distinguish in a practical way among and between the various ways in which medications and psychotherapy are combined. **Course Level:** This is a basic course. No experience or knowledge is required. **Sun., May 19, 1-5; Convention Center; Fee: Advance $95, On-Site $125; Spaces Available: 50.**

COURSE 37: ***PSYCHIATRIC INTERVENTIONS IN DISASTERS: LESSONS FROM EXPERIENCE.*** **Director:** Carol S. North, M.D. **Faculty:** Betty Pfefferbaum, M.D., Phebe M. Tucker, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) identify organizational elements of community response to disasters; (2) assess individuals exposed to disasters and other major traumas; (3) differentiate normal from pathologic responses, directing individuals to appropriate interventions; (4) describe posttraumatic mental health effects on children and adults; and (5) discuss appropriate management strategies for post-disaster PTSD in children and adults. **Course Level:** This is a basic course. No experience or knowledge is required. **This is a revision of a course given last year. Sun., May 19, 1-5; Convention Center; Fee: Advance $95, On-Site $125; Spaces Available: 100.**

COURSE 38: ***MELATONIN AND LIGHT TREATMENT OF SAD, SLEEP, AND OTHER BODY CLOCK DISORDERS.*** **Director:** Alfred J. Lewy, M.D. **Faculty:** George Brainard, Ph.D. **Educational Objective:** At the conclusion of this course, the participant should be able to add melatonin and bright light to his or her treatment regimens of winter depression, shift work maladaptation, jet lag, and certain types of sleep disorders, including those of totally blind people. **Course Level:** This is a basic course. No experience or knowledge is required. **This is a revision of a course given last year. Sun., May 19, 1-5; Convention Center; Fee: Advance $95, On-Site $125; Spaces Available: 50. A similar course on this topic will be offered on Sat., May 18, 1-5. See Course 12 for details.**

COURSE 39: ***INTRODUCTION TO TRANSCRANIAL MAGNETIC STIMULATION.*** **Co-Directors:** Ziad H. Nahas, M.D., Leon J. Grunhaus, M.D. **Faculty:** Sarah H. Lisanby, M.D., Martin P. Szuba, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) understand the physics of inducing a noninvasive neuronal depolarization, (2) address safety requirements and potential side effects, and (3) understand results of TMS clinical trials in mood and other neuropsychiatric disorders. **Course Level:** This is a basic course. No experience or knowledge is required. **Mon., May 20, 8-12; DoubleTree; Fee: Advance $95, On-Site $125; Spaces Available: 75.**

COURSE 40: ***PSYCHIATRIC CONSULTATIONS IN MEDICAL SETTINGS: THE BASICS.*** **Director:** Richard L. Elliott, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) discuss the presentation, evaluation, biopsychosocial management of depression, panic disorder, delirium, dementia, alcoholism, and somatoform disorders as they arise in medical settings; (2) discuss psychiatric approaches to common legal problems arising in medical settings; and (3) discuss psychopharmacological issues in medically ill patients. **Course Level:** This is a basic course. However, at least six months of psychiatric training is required. **Mon., May 20, 8-12; DoubleTree; Fee: Advance $95, On-Site $125; Spaces Available: 50.**

COURSE 41: ***RISK ASSESSMENT FOR VIOLENCE.*** **Director:** Phillip J. Resnick, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) identify risk factors for violence, (2) improve interviewing techniques in the assessment of dangerousness, and (3) classify different types of stalkers. **Course Level:** This is a basic course. No previous experience or knowledge is required. **This is a repeat of a course given last year. Mon., May 20, 8-12; DoubleTree; Fee: Advance $95, On-Site $125; Spaces Available: 100. A similar course on this topic will be offered on Thu., May 23, 8-12. See Course 99 for details.**

COURSE 42: ***TEACHING PSYCHIATRY? LET HOLLYWOOD HELP!*** **Director:** Steven E. Hyler, M.D. **Faculty:** Carol A. Bernstein, M.D., Michael B. First, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to enhance his or her effectiveness in teaching medical students and residents through the use of selected commercial film depictions of psychopathology, diagnosis, and therapy. **Course Level:** This is a basic course. No previous experience or knowledge is required. **This is a repeat of a course given last year. Mon., May 20, 8-12; DoubleTree; Fee: Advance $95, On-Site $125; Spaces Available: 25. A similar course on this topic will be offered on Tue., May 21, 1-5. See Course 71 for details.**

COURSE 43: ***FAMILIES AND MEDICAL ILLNESS: AN INTEGRATIVE TREATMENT APPROACH.*** **Director:** John S. Rolland, M.D. **Educational Objective:** At the conclusion of this course, the participant should be knowledgeable about: (1) a comprehensive family systems model for assessment and clinical intervention with individuals, couples, and families facing chronic disorders; (2) the interface of life cycles and multigenerational patterns; (3) family beliefs related to illness; (4) factors that impede or facilitate the patient, family, and professional relationship; (5) key clinical issues for couples and families; and (6) brief interventions and other timely and cost-effective applications of the model. **Course Level:** This is a basic course. No previous experience or knowledge is required. **This is a repeat of a course given last year. Mon., May 20, 8-12; DoubleTree; Fee: Advance $95, On-Site $125; Spaces Available: 25.**

COURSE 44: ***USING HUMANITIES TO UNDERSTAND MOOD DISORDERS.*** **Director:** Emilie S. Passow, Ph.D. **Faculty:** Jerome S. Gans, M.D., Steven D. Targum, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) use methods of literary interpretation to better understand mood disorders, and (2) recognize how careful attention to patterns of language provides subtle information useful for exploring the mind/brain connection, establishing trust between the physician and patient, and determining diagnosis and treatment. **Course Level:** This is a basic course. No previous experience or knowledge is required. **This is a repeat of a course given last year. Mon., May 20, 8-12; DoubleTree; Fee: Advance $95, On-Site $125; Spaces Available: 25.**

MONDAY, MAY 20, 2002

COURSE 45: ***PASS THE BOARDS! THE PART II ORAL EXAM.*** **Director:** James C.Y. Chou, M.D. **Faculty:** Gregory C. Bunt, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) understand the format of the ABPN Part II Oral Examination, (2) recognize and avoid the most common reasons that candidates fail, and (3) identify strategies and approaches that will enable participants to pass the examination. **Course Level:** This is a basic course. No previous experience or knowledge is required. **This is a repeat of a course given last year. Mon., May 20, 9-4; DoubleTree; Fee: Advance $150, On-Site $175; Spaces Available: 125. An intermediate course on this topic will be offered on Wed., May 22, 9-4. See Course 90 for details.**

COURSE 46: ***ADVANCED INTERVIEWING TECHNIQUES.*** **Director:** Shawn C. Shea, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) utilize five techniques for increasing validity, (2) utilize the interview strategy for eliciting suicidal ideation with the Chronological Assessment of Suicide Events (CASE Approach), (3) utilize a flexible strategy for rapidly arriving at a differential diagnosis on Axis II of the DSM-IV-TR, and (4) utilize practical strategies for nondefensively responding to awkward personal inquiries and for transforming patient anger. **Course Level:** This is an intermediate/advanced course. Participants should be familiar with the DSM-IV and have significant clinical experience. **This is a repeat of a course given last year. Mon., May 20, 9-4; DoubleTree; Fee: Advance $150, On-Site $175; Spaces Available: 75.**

COURSE 47: ***TRAUMATIC BRAIN INJURY: NEUROPSYCHIATRIC ASSESSMENT.*** **Director:** Robert P. Granacher, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) perform a competent traumatic brain injury assessment for either clinical or forensic purposes, (2) understand the biomechanics and pathophysiology of brain trauma, (3) understand the various psychiatric and neuropsychiatric syndromes seen following traumatic brain injury, and (4) understand the neurobehavioral outcomes of head trauma and the impact on psychosocial functioning in both adults and children. **Course Level:** This is a basic course. No previous experience or knowledge is required. **This is a repeat of a course given last year. Mon., May 20, 9-4; DoubleTree; Fee: Advance $150, On-Site $175; Spaces Available: 50.**

COURSE 48: ***DISORDERS OF THE SELF: DIFFERENTIAL DIAGNOSIS AND TREATMENT.*** **Director:** James F. Masterson, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) diagnose the personality disorders as disorders of the self, (2) use the intrapsychic structure to differentiate between the disorders, (3) identify and track the central psychodynamic triadic theme of the disorders of the self, (4) track this triadic theme to intervene around the defenses, and (5) identify and learn to manage countertransference. **Course Level:** This is an intermediate course. Participants should have some experience with the literature and patients. **This is a repeat of a course given last year. Mon., May 20, 9-4; DoubleTree; Fee: Advance $150, On-Site $175; Spaces Available: 50.**

COURSE 49: ***ADVANCES IN NEUROPSYCHIATRY.*** **Director:** C. Edward Coffey, M.D. **Faculty:** Michael R. Trimble, M.D., Mark S. George, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) relate brain anatomy and chemistry to human behavior, (2) understand the role of brain imaging in the assessment of neuropsychiatric illness, and (3) diagnose and effectively manage disorders of cognition, mood, and behavior secondary to brain disorders. **Course Level:** This is a basic course. No experience or knowledge is required. **This is a repeat of a course given last year. Mon., May 20, 9-4; DoubleTree, Fee: Advance $150, On-Site $175; Spaces Available: 175.**

COURSE 50: ***ISSUES IN TRANSPERSONAL PSYCHIATRY.*** **Director:** Bruce W. Scotton, M.D. **Faculty:** Allan B. Chinen, M.D., John R. Battista, M.D., William W. Foote, M.D., John F. Hiatt, M.D., Francis G. Lu, M.D., Bruce S. Victor, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) address intermediate level issues and controversies addressed by transpersonal psychiatry within the biopsychosocial model, (2) distinguish between pathological and therapeutic uses of transpersonal techniques, and (3) recognize the interactions between pharmacological, psychodynamic, and transpersonal approaches to psychiatric treatment. **Course Level:** This is an intermediate course. Participants should have an interest in and background reading in the field of psychiatry and spirituality. **This is a repeat of a course given last year. Mon., May 20, 9-4; DoubleTree; Fee: Advance $150, On-Site $175; Spaces Available: 25.**

Course Guide

35 thru 69

COURSE 51: **OVERVIEW AND UPDATE OF SLEEP DISORDERS MEDICINE.** **Director:** Karl Doghramji, M.D. **Faculty:** John W. Winkelman, M.D., Thomas D. Hurwitz, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) understand polysomnographic techniques and central mechanisms regulating sleep and wakefulness, (2) appreciate the prevalence and impact of sleep disorders, and (3) identify the major sleep disorders, their evaluation, and treatments. **Course Level:** This is a basic course. No previous experience or knowledge is required. **Mon., May 20, 1-5; DoubleTree; Fee: Advance $95, On-Site $125; Spaces Available: 75.**

COURSE 52: **TREATING MEDICAL STUDENTS AND PHYSICIANS.** **Co-Directors:** Michael F. Myers, M.D., Leah J. Dickstein, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) understand the role of stigma and other obstacles to care when treating medical students and physicians, (2) employ advocacy strategies on behalf of their patients, (3) appreciate the challenges when treating physicians with depression, and (4) identify transference and countertransference dynamics. **Course Level:** This is an intermediate course. Participants should have some experience in treating medical students and physicians. **This is a repeat of a course given last year. Mon., May 20, 1-5; DoubleTree; Fee: Advance $95, On-Site $125; Spaces Available: 50.**

COURSE 53: **COGNITIVE THERAPY: THE BASICS.** **Director:** Dean Schuyler, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) think cognitively about clinical problems, (2) identify automatic thoughts in his or her patients, and (3) demonstrate a range of techniques to challenge and help a motivated patient to change meanings associated with emotional distress. **Course Level:** This is a basic course. No previous experience or knowledge required. **This is a repeat of a course given last year. Mon., May 20, 1-5; DoubleTree; Fee: Advance $95, On-Site $125; Spaces Available: 100.**

COURSE 54: **ENHANCING THE DOCTOR-PATIENT RELATIONSHIP.** **Director:** Geoffrey M. Margo, M.D. **Faculty:** Katherine L. Margo, M.D., Laurel C. Milberg, Ph.D., C. Paul Scott, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) understand the usefulness of Balint groups in residency training, (2) describe the group structure and process, (3) recognize helpful group leader interventions, and (4) understand the logistic requirements and support necessary for setting up a residency group. **Course Level:** This is a basic course. No previous experience or knowledge is required. **This is a repeat of a course given last year. Mon., May 20, 1-5; DoubleTree; Fee: Advance $95, On-Site $125; Spaces Available: 25.**

COURSE 55: **ENGAGING RESISTANT AND HOSTILE PATIENTS INTO PARTICIPATORY TREATMENT.** **Director:** David Mee-Lee, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) identify ways for clinicians to better deal with resistance and hostility, and (2) demonstrate skills to assess readiness and engage patients collaboratively. **This is a repeat of a course given last year. Mon., May 20, 1-5; DoubleTree; Fee: Advance $95, On-Site $125; Spaces Available: 25.**

COURSE 56: **BRIEF PSYCHODYNAMIC PSYCHOTHERAPY: THE CORE CONFLICTUAL RELATIONSHIP THEME METHOD.** **Director:** Howard E. Book, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) list defining characteristics of brief psychodynamic psychotherapy (BPP); (2) differentiate BPP from emergency, crisis, and long-term psychotherapies concerning goals, frequency, duration, and therapist activity; (3) list inclusion criteria for brief psychodynamic psychotherapy; (4) develop a Core Conflictual Relationship Theme (CCRT) focus for any patient; and (5) summarize the defining characteristics of the beginning (sessions 1-4), middle (sessions 5-11), and termination (sessions 12-16) phases of the 16-session CCRT method of BPP. **Course Level:** This is a basic course. No previous experience or knowledge is required. **This is a revision of a course given last year. Mon., May 20, 1-5; DoubleTree; Fee: Advance $95, On-Site $125; Spaces Available: 25.**

TUESDAY, MAY 21, 2002

COURSE 57: **DRUG TREATMENT OF SCHIZOPHRENIA.** **Director:** Philip G. Janicak, M.D. **Faculty:** Stephen R. Marder, M.D., Rajiv Tandon, M.D., Rajiv P. Sharma, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) describe the clinically relevant aspects of the pharmacology of new and conventional antipsychotic drugs, and (2) understand their uses for acute and chronic schizophrenia. **Course Level:** This is a basic course. No previous experience or knowledge is required. **This is a revision of a course given last year. Tue., May 21, 8-12; DoubleTree; Fee: Advance $95, On-Site $125; Spaces Available: 100.**

COURSE 58: **THE DETECTION OF MALINGERED MENTAL ILLNESS.** **Director:** Phillip J. Resnick, M.D. **Educational Objective:** At the conclusion of this course, the participant should be more skillful in detecting deception and malingering, especially in defendants pleading not guilty by reason of insanity and litigants alleging PTSD. **Course Level:** This is a basic course. No previous experience or knowledge is required. **This is a repeat of a course given last year. Tue., May 21, 8-12; DoubleTree; Fee: Advance $95, On-Site $125; Spaces Available: 100.**

COURSE 59: **SEXUAL DISORDERS: DIAGNOSIS AND TREATMENT.** **Director:** Waguih W. Ishak, M.D. **Faculty:** Marina Bussel, M.D., Steve A. Eklund, M.D., Romana Markvitsa, M.D., Anatoly Postolov, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) recognize the importance and the factors interfering with taking an adequate sexual history, and (2) diagnose and treat sexual disorders using a biopsychosocial approach. **Course Level:** This is a basic course. No previous experience or knowledge is required. **Tue., May 21, 8-12; DoubleTree; Fee: Advance $95, On-Site $125; Spaces Available: 50. A similar course on this topic will be offered on Wed., May 22, 1-5. See Course 91 for details.**

COURSE 60: **ECT PRACTICE UPDATE.** **Director:** Charles H. Kellner, M.D. **Faculty:** Richard L. Jaffe, M.D., W. Vaughn McCall, M.D., Richard D. Weiner, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to understand and be familiar with the most current ECT techniques. **Course Level:** This is an intermediate course. Participants should refer to the APA Guidelines for the Treatment of Major Depressive Disorders. Participants are encouraged to bring cases for discussion. **This is a repeat of a course given last year. Tue., May 21, 8-12; DoubleTree; Fee: Advance $95, On-Site $125; Spaces Available: 100.**

COURSE 61: **HOW TO USE YOUR PALM PERSONAL DIGITAL ASSISTANT IN PSYCHIATRIC PRACTICE.** **Director:** John Luo, M.D. **Faculty:** Carlyle H. Chan, M.D., Charles J. Rainey, M.D., Richard A. Montgomery, M.D. **Educational Objective:** At the conclusion of this course, physicians who own a Palm Personal Digital Assistant (PDA) will: (1) know how to use their PDA efficiently and effectively; (2) master synchronizing data, exchanging information, installing software, converting data from external sources, and using various medical resources; and (3) become familiar with various hardware options. **Course Level:** This is a basic course. **Participants must bring their own PDA and cradle for use in the course. Tue., May 21, 8-12; DoubleTree; Fee: Advance $95, On-Site $125;Spaces Available: 50.**

COURSE 62: **HOW TO SET UP AND RUN A JUVENILE JUSTICE CLINIC.** **Director:** Gabriel Kaplan, M.D. **Faculty:** The Hon. Lee Forrester, Michael Swerdlow, Ph.D., Denise M. Williams-Johnson, Ph.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) list the most important items necessary to develop a new forensic youth service, (2) identify administrative and budgetary priorities, and (3) understand basic principles of the treatment of sex offenders and firesetters. **Course Level:** This is an intermediate course. Participants should have experience with treatment of adolescents, program development, or juvenile justice. **Tue., May 21, 8-12; DoubleTree; Fee: Advance $95, On-Site $125; Spaces Available: 25.**

COURSE 63: **DOING RESEARCH ON A SHOESTRING BUDGET.** **Director:** Mantosh J. Dewan, M.D. **Faculty:** Michelle T. Pato, M.D., Edward K. Silberman, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) develop ideas into research projects, (2) develop strategies for supporting projects without grant funding, and (3) get results published. **Course Level:** This is a basic course. No experience or knowledge is required. **This is a repeat of a course given last year. Tue., May 21, 8-12; DoubleTree; Fee: Advance $95, On-Site $125; Spaces Available: 25.**

COURSE 64: **PARTIAL HOSPITALIZATION FOR PATIENTS WITH BPD.** **Director:** Lawrence L. Kennedy, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) recognize special problems in treating this population, (2) understand partial hospital setting for treating borderline conditions, and (3) identify basic components of an intensive partial hospital for treating borderline conditions. **Course Level:** This is a basic course. No previous experience or knowledge is required. **This is a revision of a course given last year. Tue., May 21, 8-12; DoubleTree; Fee: Advance $95, On-Site $125; Spaces Available: 25.**

COURSE 65: **DAVANLOO'S INTENSIVE SHORT-TERM DYNAMIC PSYCHOTHERAPY IN CLINICAL PRACTICE.** **Director:** James Q. Schubmehl, M.D. **Faculty:** Alan R. Beeber, M.D., Tewfik Said, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) acquire a vivid sense of the forces underlying human psychopathology and a view of crucial elements of the healing process, and (2) describe main elements of Davanloo's technique and find many aspects of the presentation useful to own clinical practice. **Course Level:** This is a basic course. No previous experience or knowledge is required. **Tue., May 21, 9-4; DoubleTree; Fee: Advance $150, On-Site $175; Spaces Available: 75.**

COURSE 66: **INTRODUCTION TO COGNITIVE-BEHAVIORAL THERAPY.** **Co-Directors:** Robert M. Goisman, M.D., Philip G. Levendusky, Ph.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) recognize clinical problems responsive to cognitive-behavioral methods, and (2) describe the cognitive-behavioral treatment of anxiety disorders, depression, borderline personality, eating disorders, and schizophrenia. **Course Level:** This is a basic course. No previous experience or knowledge is required. **This is a revision of a course given last year. Tue., May 21, 9-4; DoubleTree; Fee: Advance $150, On-Site $175; Spaces Available: 50.**

COURSE 67: **MED-PSYCH DRUG-DRUG INTERACTIONS: AN UPDATE.** **Co-Directors:** Scott C. Armstrong, M.D., Kelly L. Cozza, M.D. **Faculty:** Jessica R. Oesterheld, M.D., David Benedek, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) use tables, literature, and the Internet to understand and appreciate significant drug-drug interactions, and (2) gain practical knowledge of pertinent food, psychiatric, and nonpsychiatric drug interactions. **Course Level:** This is an intermediate course. Participants should have experience with complicated medical patients. **This is a repeat of a course given last year. Tue., May 21, 9-4; DoubleTree; Fee: Advance $150, On-Site $175; Spaces Available: 150.**

COURSE 68: **BEING AN EFFECTIVE SCHOOL CONSULTANT.** **Director:** Lois T. Flaherty, M.D. **Faculty:** Trina B. Allen, M.D., Richard L. Gross, M.D., Eugenio M. Rothe, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) understand the types of school consultation, (2) identify frequent problems and effective interventions for them, (3) recognize the most frequent pitfalls of consultation, (4) summarize the laws and ethical guidelines applicable to school consultation, and (5) address special problems such as school avoidance, bullying, and the needs of African-American and Hispanic students. **Course Level:** This is an intermediate course. Participants should have knowledge of child and adolescent development and have experience evaluating children and adolescents. **Tue., May 21, 9-4; DoubleTree; Fee: Advance $150, On-Site $175; Spaces Available: 50.**

COURSE 69: **TRANSPERSONAL PSYCHIATRY: CLINICAL APPLICATIONS.** **Co-Directors:** John F. Hiatt, M.D., William W. Foote, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) use techniques for inducing nonordinary

states of consciousness, (2) understand the proper use of these techniques and identify persons suitable for them, and (3) acquire initial competency in their use to facilitate psychotherapy. **Course Level:** This is an intermediate course. Participants should have experience with spiritual practice, paranormal phenomena, or exposure to transpersonal psychiatry. **This is a repeat of a course given last year. Tue., May 21, 9-4; DoubleTree; Fee: Advance $150, On-Site $175; Spaces Available: 25.**

COURSE 70: VAGAL NERVE STIMULATION.

Co-Directors: Ziad H. Nahas, M.D., Mustafa M. Husain, M.D. **Faculty:** Linda L. Carpenter, M.D., Robert H. Howland, M.D., Mitchel A. Kling, M.D. **Educational Objective:** At the conclusion of the course, the participant should be able to recognize: (1) the different modalities by which the vagus nerve can be manipulated, (2) its anatomy, (3) how to program the Neuro Cybernetic Prosthesis, (4) the effects of cervical vagus nerve stimulation on epilepsy, and (5) other neuropsychiatric conditions. **Course Level:** This is a basic course. No previous experience or knowledge is required. **Tue., May 21, 1-5; DoubleTree; Fee: Advance $95, On-Site $125; Spaces Available: 100**

COURSE 71: I FOUND IT AT THE MOVIES: USING FILM CLIPS TO UNDERSTAND AND TEACH PSYCHIATRY.

Director: Frederick W. Engstrom, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) find suitable film clips for teaching, (2) readily access at least 30 clips suitable for teaching, (3) lead a discussion about psychiatric diagnosis using film clips, (4) teach boundary theory using film clips, and (5) recognize the limitations and strengths of films as vehicles for teaching. **Course Level:** This is a basic course. No previous experience or knowledge is required. **Tue., May 21, 1-5; DoubleTree; Fee: Advance $95, On-Site $125; Spaces Available: 100. A similar course on this topic will be offered on Mon., May 20, 8-12. See Course 42 for details.**

COURSE 72: THE ADVANCED PRACTICE OF PSYCHOTHERAPY.

Director: T. Byram Karasu, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) identify deficit and conflict-oriented diagnoses as universal pathology, (2) differentially use specific and generic therapeutic techniques, (3) integrate the sacred with the secular and transcend schools of psychotherapy, and (4) formulate a philosophical perspective that can further professional formation and personal growth. **Course Level:** This is an advanced course. Participants must be familiar with the basic concepts of psychotherapy. **This is a repeat of a course given last year. Tue., May 21, 1-5; DoubleTree; Fee: Advance $95, On-Site $125; Spaces Available: 50.**

COURSE 73: ACHIEVING EFFECTIVE DUAL DIAGNOSIS TREATMENT.

Director: John W. Tsuang, M.D. **Faculty:** Andrew P. Ho, M.D., Thomas Newton, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) identify the different drugs of abuse and their psychiatric manifestations, (2) recognize similarities between substance abuse and psychiatric disorders, (3) learn about the available pharmacological interventions for treatment of dual-diagnosis patients and possible interactions, and (4) use harm-reduction and total-abstinence strategies for treatment of dual-diagnosis patients. **Course Level:** This is a basic course. No previous experience or knowledge is required. **This is a repeat of a course given last year. Tue., May 21, 1-5; DoubleTree; Fee: Advance $95, On-Site $125; Spaces Available: 50. An intermediate course on this topic will be offered on Sun., May 19, 1-5. See Course 34 for details.**

COURSE 74: INTEGRATED MODEL FOR TREATMENT OF CO-OCCURRING PSYCHIATRIC AND SUBSTANCE DISORDERS.

Director: Kenneth Minkoff, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) identify five philosophical/clinical barriers to integrated treatment and describe how to resolve them, (2) describe the four phases of treatment/recovery in an integrated disease and recovery model for mental illness and addiction, (3) describe and implement a protocol for diagnosing psychiatric illness in the presence of substance use disorder and vice versa, and (4) describe integrated program models for treatment of dual diagnosis and specific populations addressed by each model. **Course Level:** This is a basic course. No previous experience or knowledge is required. **Tue., May 21, 1-5; DoubleTree; Fee: Advance $95, On-Site $125; Spaces Available: 100.**

COURSE 75: COMPUTERS IN PSYCHIATRY: A PRIMER.

Director: Robert S. Kennedy, M.A. **Faculty:** Carlyle H. Chan, M.D., John Luo, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) understand how the latest hardware and software meet the needs of the contemporary psychiatrist, (2) understand the current technologies that are important for obtaining and utilizing clinical and educational information, and (3) recognize the power of the Internet as a resource for the practice of psychiatry. **Course Level:** This is a basic course. No previous experience or knowledge is required. **This is a revision of a course given last year. Tue., May 21, 1-5; DoubleTree; Fee: Advance $95, On-Site $125; Spaces Available: 50.**

COURSE 76: MULTICULTURAL APPROACH TO THE TREATMENT OF WOMEN.

Director: Susan R. Downs, M.D. **Faculty:** Ellen Haller, M.D., Sylvia W. Olarte, M.D., Gloria Pitts, D.O., Alice C. Tso, M.D. **Educational Objective:** At the conclusion of this course, the participant should be more sensitive to the multiple issues encountered when working with women who are members of minority groups. **Course Level:** This is a basic course. No previous experience or knowledge is required. **This is a repeat of a course given last year. Tue., May 21, 1-5; DoubleTree; Fee: Advance $95, On-Site $125; Spaces Available: 25.**

COURSE 77: ARTS AND HUMANITIES FOR SELF-RENEWAL.

Director: Paul R. Miller, M.D. **Faculty:** Margaret Nazarey, M.S.N. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) describe how arts and humanities can help us to renew ourselves, our sensibilities, and our souls; (2) be shared experientially with peers; and (3) strengthen his or her ability to attend to patients and to educate students by expanding empathic understanding and selfhood. **Course Level:** This is a basic course. No previous experience or knowledge is required. **Tue., May 21, 1-5; DoubleTree; Fee: Advance $95, On-Site $125;Spaces Available: 25.**

COURSE 78: SEXUAL HARASSMENT: PSYCHOLOGICAL AND LEGAL ASPECTS.

Director: Gail E. Robinson, M.D. **Faculty:** Renee L. Binder, M.D., Sharyn A. Lenhart, M.D., Michael F. Myers, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) demonstrate knowledge of the definition, etiology, consequences, and gender differences in the experience and perception of sexual harassment; (2) assess and treat the psychological impact on the victim; (3) understand the role of the expert witness in these cases; and (4) summarize basic principles for preventing sexual harassment. **Course Level:** This is a basic course. No previous experience or knowledge is required. **This is a revision of a course given last year. Tue., May 21, 1-5; DoubleTree; Fee: Advance $95, On-Site $125; Spaces Available: 25.**

WEDNESDAY, MAY 22, 2002

COURSE 79: COGNITIVE THERAPY FOR SEVERE MENTAL DISORDERS.

Director: Jesse H. Wright, M.D. **Faculty:** Monica A. Basco, Ph.D., Michael E. Thase, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) utilize cognitive therapy (CT) interventions for severe depression; (2) apply CT techniques to symptoms of severe depression, psychosis, and bipolar disorder; and (3) address treatment adherence problems. **Course Level:** This is an intermediate course. Participants should be familiar with principles and practices of cognitive therapy. **This is a revision of a course given last year. Wed., May 22, 8-12; DoubleTree; Fee Advance $95, On-Site $125; Spaces Available: 50.**

COURSE 80: INSANITY DEFENSE EVALUATIONS.

Director: Phillip J. Resnick, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to systematically evaluate criminal defendants and formulate well-reasoned opinions about criminal responsibility. **Course Level:** This is a basic course. No previous experience or knowledge is required. **This is a repeat of a course given last year. Wed., May 22, 8-12; DoubleTree; Fee: Advance $95, On-Site $125; Spaces Available: 50.**

COURSE 81: INTERPERSONAL PSYCHOTHERAPY.

Director: John C. Markowitz, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to understand the basic rationale and techniques of interpersonal psychotherapy for depression and key research supporting its use. **Course Level:** This is an intermediate course. Participants should be experienced in psychotherapy and the treatment of depression. Participants are required to read the following: Weissman MM, Markowitz J, Klerman GL, *Comprehensive Guide to Interpersonal Psychotherapy*, New York, Basic Books, 2000. **This is a revision of a course given last year. Wed., May 22, 8-12; DoubleTree; Fee: Advance $95, On-Site $125; Spaces Available: 50. A basic course on this topic will be offered on Sat., May 18, 9-4. See Course 7 for details.**

COURSE 82: EVIDENCE-BASED MEDICINE: AN INTRODUCTION FOR PSYCHIATRISTS.

Director: Gregory E. Gray, M.D. **Faculty:** Letitia A. Pinson, M.D., Gabrielle F. Beaubrun, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) formulate answerable clinical questions; (2) describe the best sources for obtaining answers; (3) critically appraise reports of clinical trials, systematic reviews, and practice guidelines for validity, importance, and clinical applicability; and (4) apply the results to individual patients. **Course Level:** This is a basic course. No previous experience or knowledge is required. **Wed., May 22, 8-12; DoubleTree; Fee: Advance $95, On-Site $125; Spaces Available: 25.**

COURSE 83: PERSONALITY DISORDERS: COMBINED INTERPERSONAL AND PHARMACOTHERAPY.

Director: Roy O. Resnikoff, M.D. **Educational Objective:** At the conclusion of this course, the participant will learn when and how to address personality rigidities using an integration of: (1) current awareness of interpersonal personality polarities, (2) historical dynamic stories, and (3) medication for biological temperaments. In addition, the participant will learn how to therapeutically utilize his or her own personality characteristics in relationship to patients. **Course Level:** This is an intermediate course. Participants should have basic therapy and pharmacotherapy experience. **Wed., May 22, 8-12; DoubleTree; Fee: Advance $95, On-Site $125; Spaces Available: 25.**

COURSE 84: OFFICE-BASED TREATMENT OF OPIATE-DEPENDENT PATIENTS.

American Academy of Addiction Psychiatry and APA Council on Addiction Psychiatry. **Co-Directors:** Eric C. Strain, M.D., Thomas R. Kosten, M.D. **Faculty:** H. Westley Clark, M.D., David Fiellin, M.D., Herbert D. Kleber, M.D., Laura F. McNicholas, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) identify the clinically relevant pharmacological characteristics of buprenorphine, (2) describe the resources needed to set up office-based treatment with buprenorphine for patients with opioid dependence, and (3) list at least five factors to consider in determining if the patient is an appropriate candidate for office-based treatment with buprenorphine. **Course Level:** This is an intermediate course. Participants should have basic knowledge of diagnosis and treatment of patients with substance abuse disorders. **This is a revision of a course given last year. Wed., May 22, 8-5; DoubleTree; Fee: Advance $190, On-Site $250; Spaces Available: 100.**

COURSE 85: PSYCHOTHERAPY OF BORDERLINE PERSONALITY.

Co-Directors: Otto F. Kernberg, M.D., Frank E. Yeomans, M.D. **Faculty:** John F. Clarkin, Ph.D., Eve Caligor, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) understand the basic concepts and techniques of effective psychotherapy for borderline patients, including object-relations theory and the treatment contract, and (2) understand the strategies, tactics, and techniques of therapy. **Course Level:** This is a basic course. No previous experience or knowledge is required. **This is a revision of a course offered last year. Wed., May 22, 9-4; DoubleTree; Fee: Advance $150, On-Site $175; Spaces Available: 75.**

Course Guide

70 thru 102

COURSE 86: **HOW TO PRACTICE EVIDENCE-BASED PSYCHIATRY.** **Director:** David R.S. Haslam, M.D. **Faculty:** John Geddes, M.R.C., Elliot M. Goldner, M.D., David M. Gardner, Pharm.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) formulate a clinical question that is both searchable and answerable in response to a therapeutic problem, (2) search effectively and efficiently for the best available published evidence to answer the therapeutic question, (3) critically appraise the acquired randomized control trial evidence for its validity and applicability, and (4) apply these findings to everyday clinical practice. **Course Level:** This is a basic course. Expertise in statistics or epidemiology is not required. **This is a revision of a course given last year. Wed., May 22, 9-4; DoubleTree; Fee: Advance $150, On-Site $175; Spaces Available: 50.**

COURSE 87: **CARING FOR REFUGEES AND SURVIVORS OF TORTURE.** **Director:** Linda Piwowarczyk, M.D. **Faculty:** Michael A. Grodin, M.D., Ricardo Restrepo, M.D., Terence M. Keane, Ph.D. **Educational Objective:** At the conclusion of this course, participants should be able to: (1) describe the problems of refugees and survivors of torture from a human rights, public health, and psychiatric perspective; (2) recognize mental health sequelae of uprooting, torture, and related trauma; and (3) recognize the risk factors for torture and mental health problems in this patient population. **Course Level:** This is a basic course. No previous experience or knowledge is required. **Wed., May 22, 9-4; DoubleTree; Fee: Advance $150, On-Site $175; Spaces Available: 50.**

COURSE 88: **A PRACTICAL APPROACH TO HERBS AND NUTRIENTS IN PSYCHIATRY.** **Co-Directors:** Richard P. Brown, M.D., Patricia L. Gerbarg, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) recognize common herbs, nutrients, and hormones used by psychiatric patients, and (2) identify indications, dosages, side effects, and brands of such agents for anxiety, depression, sleep, cognitive, sexual enhancement, PMS, and migraine (based upon recent research). **Course Level:** This is a basic course. No previous experience or knowledge is required. **This is a repeat of a course given last year. Wed., May 22, 9-4; DoubleTree; Fee: Advance $150, On-Site $175; Spaces Available: 150.**

COURSE 89: **THE ASSESSMENT AND TREATMENT OF CHILD MOLESTERS.** **Director:** John M. Bradford, M.B. **Faculty:** Gene G. Abel, M.D., Graham G. Glancey, M.B., J. Paul Fedoroff, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) understand the theoretical framework for the assessment and treatment of child molesters; (2) demonstrate a working knowledge of the behavioral, pharmacological, and psychosocial treatments for the conditions; (3) obtain a basic understanding of the present ethical and legal issues involved in these conditions; and (4) understand the factors associated with sexual offender recidivism. **Course Level:** This is a basic course. No previous experience or knowledge is required. **This is a repeat of a course given last year. Wed., May 22, 9-4; DoubleTree; Fee: Advance $150, On-Site $175; Spaces Available: 25. A similar course on this topic will be offered on Tue., May 21, 8-12. See Course 59 for details.**

COURSE 90: **THE BIOPSYCHOSOCIAL FORMULATION: AN APPROACH TO ORAL BOARD PRESENTATIONS.** **Co-Directors:** Robert M. Rohrbaugh, M.D., William H. Campbell, M.D. **Faculty:** Catherine Chiles, M.D., Paul D. Kirwin, M.D., Richard Belitsky, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) systematically organize historical data into meaningful diagnostic categories, and (2) develop a comprehensive biopsychosocial formulation suitable for oral board presentations. **Course Level:** This is an intermediate course. Participants should be board-eligible. **Wed., May 22, 9-4; DoubleTree; Fee: Advance $150, On-Site $175; Spaces Available: 50. A basic course on this topic will be offered on Mon., May 20, 9-4. See Course 45 for details.**

COURSE 91: **SLEEP MEDICINE UPDATE: ADVANCED TOPICS.** **Director:** Thomas D. Hurwitz, M.D. **Faculty:** Max Hirshkowitz, Ph.D., Lois Krahn, M.D. **Educational Objective:** At the conclusion of the course, the participant should: (1) be familiar with recent information on basic sleepy physiology, pharmacological influences on sleep, and clinically relevant topics of parasomnias and narcolepsy, and (2) be able to interpret the reports generated by clinical sleep laboratory studies. **Course Level:** This is an intermediate course. Participants should be familiar with basic concepts of sleep architecture and sleep disorders and should have completed the basic course on sleep medicine. **Wed., May 22, 1-5; DoubleTree; Fee: Advance $95, On-Site $125; Spaces Available: 50. A basic course on this topic will be offered on Mon., May 20, 1-5. See Course 51 for details.**

COURSE 92: **COGNITIVE THERAPY FOR SCHIZOPHRENIA.** **Co-Directors:** Jesse H. Wright, M.D., Aaron T. Beck, M.D. **Faculty:** Jan L. Scott, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) describe the biological-cognitive-behavioral model for treatment of schizophrenia, (2) use cognitive therapy methods for treating positive and negative symptoms of schizophrenia, and (3) employ cognitive therapy methods for improving medication compliance. **Course Level:** This is an intermediate level course. Participants should have a basic understanding of cognitive-behavioral principles. **Wed., May 22, 1-5; DoubleTree; Fee: Advance $95, On-Site $125; Spaces Available: 50.**

COURSE 93: **ADVANCED ASSESSMENT AND TREATMENT OF ADD.** **Director:** Thomas E. Brown, Ph.D. **Faculty:** Jefferson B. Prince, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) understand emerging new models of ADD and research-based modifications in its assessment, (2) adequately assess complicated cases of ADD, (3) understand how medication treatments should be modified to deal with psychiatric and/or medical complications, and (4) develop treatment plans to address complicated ADD across the life cycle. **Course Level:** This is an advanced course. Participants should have basic professional education and clinical experience in the assessment and treatment of ADHD. **This is a revision of a course given last year. Wed., May 22, 1-5; DoubleTree; Fee: Advance $95, On-Site $125; Spaces Available: 150.**

COURSE 94: **CPT CODING AND DOCUMENTATION 2002.** **Director:** Chester W. Schmidt Jr., M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) understand both evaluation and management codes, as well as the psychiatric evaluation and therapeutic procedure codes, and (2) document the provision of services denoted by the above two sets of codes. **Course Level:** This is a basic course. No previous experience or knowledge is required. **This is a revision of a course given last year. Wed., May 22,1-5; DoubleTree; Fee: Advance $95, On-Site $125; Spaces Available: 50.**

COURSE 95: **IMPROVING MEDIA COVERAGE OF SUICIDE: THE ROLE OF THE PSYCHIATRIST.** *American Foundation for Suicide Prevention.* **Co-Directors:** Herbert Hendin, M.D., Kathleen Jamison, Ph.D. **Faculty:** Dwight L. Evans, M.D., Madelyn Gould, Ph.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) understand the dangers of bad coverage of suicide and the benefits of good coverage, (2) recognize the difference in actual stories, and (3) advise the press on how to avoid one and achieve the other. **Course Level:** This is an advanced course. Participants should have knowledge of suicide. **Wed., May 22, 1-5; DoubleTree; Fee: Advance $95, On-Site $125; Spaces Available: 25.**

COURSE 96: **TREATMENT OF CREATIVE PATIENTS.** **Director:** Albert Rothenberg, M.D. **Educational Objectives**: At the conclusion of this course, the participant should be able to: (1) understand specific types of cognitive creative processes, (2) evaluate salient research and understand relationships between creativity and psychopathology, and (3) effectively treat creative patients. **Course Level:** This is an intermediate course. Participants should have clinical experience, knowledge of research principles, and creative interests. **Wed., May 22, 1-5; DoubleTree; Fee: Advance $95, On-Site $125; Spaces Available: 25.**

THURSDAY, MAY 23, 2002

COURSE 97: **ETHICAL DECISION MAKING IN CLINICAL PRACTICE.** **Director:** Stephen A. Green, M.D. **Faculty:** Sydney Bloch, M.D. **Educational Objective:** At the conclusion of this course, participants should: (1) be versed in the theoretical underpinnings of ethical decision making, and (2) be able to apply that knowledge to clinical situations. **Course Level:** This is a basic course. No previous experience or knowledge is required. **Thu., May 23, 8-12; DoubleTree; Fee: Advance $95, On-Site $125; Spaces Available: 50.**

COURSE 98: **THE MISSING PIECE OF THE PUZZLE: TIC DISORDERS IN ADULTS WITH OCD OR ADD.** **Director:** Maria A. Pugliese, M.D. **Faculty:** J. Paul Hieble, Ph.D., Michael N. Rubenstein, M.D., Orrin Palmer, M.D., Sue Levi-Pearl, Mary Lou Reaver, R.N. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) recognize simple and complex motor and vocal tics in adults with other disorders, (2) know how to differentiate between compulsions and complex motor tics, (3) understand the basic anatomy and pharmacology of tic disorders, and (4) learn effective treatments. **Course Level:** This is a basic course. No previous experience or knowledge is required. **Thu., May 23, 8-12; DoubleTree; Fee: Advance $95, On-Site $125; Spaces Available: 50.**

COURSE 99: **ASSESSING THE RISK FOR VIOLENCE.** **Director:** Bradley R. Johnson, M.D. **Faculty:** Judith Becker, Ph.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) summarize what is currently known about the prediction of future violence in both patient and forensic settings, and (2) learn how to administer, or where to obtain, a number of violence-risk prediction scales. **Course Level:** This is a basic course. No previous experience or knowledge is required. **Thu., May 23, 8-12; DoubleTree; Fee: Advance $95, On-Site $125; Spaces Available: 50. A similar course on this topic is being offered on Mon., May 20, 8-12. See Course 41 for details.**

COURSE 100: **BACK TO THE FUTURE: THE EVOLUTIONARY FRAMEWORK FOR PSYCHIATRY.** **Director:** John R. Evaldson, M.D. **Faculty:** Mark Erickson, M.D., Annette J. Hollander, M.D., David Mullen, M.D., Daniel R. Wilson, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) understand the fundamental ways evolution has organized human development and psychopathology, and (2) start to use that to organize other knowledge and treatment. **Course Level:** This is an intermediate course. Knowledge of human development and psychopathology typical for psychiatrists, psychologists, or other professionals is required. **Thu., May 23, 9-4; DoubleTree; Fee: Advance $150, On-Site $175; Spaces Available: 50.**

COURSE 101: **PTSD: AN HISPANIC UPDATE OF A UNIVERSAL PROBLEM (IN SPANISH).** *American Society of Hispanic Psychiatry.* **Director:** Luis F. Ramirez, M.D. **Faculty:** Jose M. Canive, M.D., Dora Cardona, M.D., Roxana Galeno, M.D., Daniel Toledo, M.D., Alarçon Renato, M.D. **Educational Objective:** At the conclusion of this course, the participant should be able to: (1) recognize the basic symptoms of posttraumatic stress disorder, (2) discuss the different types of PTSD, (3) be familiar with the concept of resilience, (4) be familiar with the psychobiology of PTSD, and (5) organize a plan for treatment of patients with PTSD. **Course Level:** This is a basic course. No previous experience or knowledge is required. **Participants must speak and understand Spanish. Thu., May 23, 9-4; DoubleTree; Fee: Advance $150, On-Site $175; Spaces Available: 50.**

COURSE 102: **THE CONCEPTUAL BASIS OF PSYCHIATRY.** **Co-Directors:** S. Nassir Ghaemi, M.D., David H. Brendel, M.D. **Director:** At the conclusion of this course, the participant should be able to understand conceptual and philosophical aspects of psychiatric practice and research. **Course Level:** This is a basic course. No previous experience or knowledge is required. **Thu., May 23, 9-4; DoubleTree; Fee: Advance $150, On-Site $175; Spaces Available: 25.**

JANSSEN RISPERDAL

P4C

Parity

continued from page 1

amendment would have barred any limits on mental illness treatment and financial requirements that are not imposed on the treatment of other medical illnesses. That means that health plans must have the same limits on the frequency of treatment; number of visits or days covered; and the same deductibles, coinsurance amounts, copayments, and other cost-sharing requirements.

Despite some limitations, APA leaders believed that the new legislation was an acceptable compromise for the time being.

APA President Richard Harding, M.D., called the conferees' decision to extend the limited 1996 bill a "stop-gap measure. It is difficult to understand the objections of a few key House members to the Domenici-Wellstone parity amendment, given the failure of House committees to so much as hold a hearing on parity, let alone mark up any meaningful parity legislation over the past six years."

Although parity fared well in the Senate, it did not do so in the House. The House's version of the Domenici-Wellstone bill was the Mental Health and Substance Abuse Parity Act (HR 162), which was introduced by Marge Roukema (R-N.J.) a year ago. It languished in the health subcommittees of the Ways and Means, Education and the Workforce, and Energy and Commerce committees since last February. Roukema and Rep. Patrick Kennedy (D-R.I.), another key parity supporters and House conferee, urged conferees last November to support the parity amendment in a letter signed by 224 House members, according to Roukema's office.

That wasn't enough to persuade the House Republican conferees, who complained that the parity amendment wasn't approved by the Ways and Means, Education and the Workforce, and Energy and Commerce committees, according to a report in the December 10, 2001, *CQ Daily Monitor*. The Republican chairs of those committees wrote to House conferees opposing the amendment.

Moreover, Jay Cutler, J.D., director of APA's Division of Government Relations, said business coalitions and antipsychiatry groups lobbied against the parity amendment. But he was heartened by Rep. Ralph Regula's (R-Ohio) pledge last month to work with Rep. Kennedy on the language in the final Labor-HHS report authorizing the relevant House committees to take action on parity this year. ■

legal news

Weston

continued from page 15

Since that time, the family has backed his decision to refuse medication, based on the possibility that if Weston is tried for the murders, he could face the death penalty. U.S. Attorney General John Ashcroft has the final say on whether Weston will be eligible for the death penalty if he is convicted of the killings.

Shortly after the shootings, authorities sent Weston to a federal prison in Butner, N.C., where he has spent much of his time in an isolation cell. He has been deteriorating both mentally and physically, according to testimony from prior hearings.

When the Supreme Court denied Weston's appeal last month, Weston's attorney acknowledged that the fight to keep Weston off medications had ended and that his client would probably be medicated soon. ■

Smoking

continued from page 17

mothers of the individuals had ever been hospitalized for psychiatric or substance-abuse problems was ascertained from the Danish psychiatric register. Whether any of the individuals had experienced pregnancy or delivery complications was discovered in national obstetric records. And whether the mothers of any of the individuals had smoked during the last three months of pregnancy—and if so, how much—was determined via interviews with the mothers during pregnancy or shortly after delivery.

Then, in 1994, Brennan and her colleagues determined which of the 8,000 individuals who were included in their study had gone on, as adults, to engage in criminal acts. The researchers used as their source the Danish criminal register. The crimes included murder, robbery, rape, assault, illegal possession of a weapon, theft, breaking and entering, fraud, forgery, blackmail, and embezzlement, among others.

Brennan and her team then used the data that had been collected about the 8,000 subjects back in 1959-61 and the data they collected in 1994 to answer this question: Was there a link between maternal smoking during the last three months of pregnancy and offspring committing crimes?

They analyzed their data for male and female offspring separately. They also considered socioeconomic status, pregnancy complications, parents' psychiatric or substance-abuse problems, or other factors that might have distorted their findings.

They discovered that there was indeed a link between maternal smoking during the last three months of pregnancy and criminal behavior in both male and female offspring. Even more intriguing, there was a dose-response relationship between maternal smoking during the last three months of pregnancy and criminal behavior in both male and female offspring (see chart on page 17).

The dose-response relationship was especially evident in the male offspring. Some 25 percent of male subjects whose mothers had smoked no cigarettes at all during the last trimester of pregnancy were arrested for crimes; about 32 percent of male subjects whose mothers had smoked one to two cigarettes during the last trimester had been arrested; about 34 percent whose mothers had smoked three to 10 cigarettes a day during the last trimester had been arrested; and some 38 percent whose mothers had smoked more than 10 cigarettes daily during the last trimester had been arrested.

And in yet another arm of their study, Brennan and her coworkers wanted to find out whether there was a link between maternal smoking during the last three months of pregnancy and offsprings' substance abuse. Once again, they used data that had been collected about the 8,000 subjects back in 1959-61, but also data that they had collected about the subjects in 1999. And these data, which they culled from the Danish psychiatric register, revealed which of the subjects had been hospitalized for abusing substances. And once again, they took into consideration factors that might have confounded their results.

The researchers found a significant relationship between maternal smoking during the last trimester of pregnancy and offspring abusing substances. As with the link between maternal smoking and criminal behavior, the association with substance abuse included female as well as male offspring. And once again the association was a dose-response one.

Then Brennan and her coworkers combined the two arms of their study to see whether the relationships between maternal smoking and criminality and substance abuse among offspring might be intertwined.

First they attempted to find out whether the connection between maternal prenatal smoking and substance abuse in offspring might be due to the offsprings' committing crimes, and that criminal activity in turn then lured them into substance abuse. However, they found the link to be independent of any criminal behavior.

They then tried to determine whether the tie between maternal prenatal smoking and criminal activity in offspring might actually be due to offspring abusing substances, and that abuse in turn pointing them toward criminal activity. They found that this was not the case for the male offspring, but that it was so for the female ones.

The researchers thus concluded that "maternal prenatal smoking is related to criminal and substance-abuse outcomes in male and female offspring." But the smoking–criminal behavior link in female offspring appears to be explained by an increased risk for substance abuse that then leads to an increased risk for arrest, they add.

Psychiatric News asked Brennan whether she and her colleagues plan more studies along this line. "We are going to do a study on self-reports of crime and how they are related to maternal smoking during pregnancy," she replied. "This study will also be based in Denmark."

The study report, "Relationship of Maternal Smoking During Pregnancy With Criminal Arrest and Hospitalization for Substance Abuse in Male and Female Adult Offspring," can be found on the Web at <http:ajp.psychiatryonline.org> by searching under the January issue. ■

Suicide

continued from page 5

about the illness, is usually not in effective treatment, and if prescribed medication, is usually noncompliant," said Jamison.

The noncompliance rate for lithium, for example, hovers around 50 percent, with a relapse rate slightly above that.

"It's incredibly hard to convince an 18-year-old to stay on lithium when the side effects can cause acne, weight gain, a tremor, a lack of coordination in sports, and slowness in thought," said Jamison.

She also explained why she was noncompliant for many years. "I had to deny that I could have another psychotic episode in order to get out of bed each morning. But, I also had euphoric manias that left cocaine in the dust in terms of enjoyment, intensification of the senses, high energy, and quick thinking. I am convinced that you have to treat the manic type of bipolar disorder as two separate disorders. Euphoric manias are extremely addictive biologically and psychologically. You have an incredible system in your brain that always wants to recapture that high," said Jamison.

Sticking With Treatment

Jamison eventually stayed on lithium, which she credits with keeping her alive. Multiple studies have shown a ninefold reduction in the suicide rate when patients stay on lithium, she pointed out.

She found psychotherapy helped her live with her illness. Research has shown that combining lithium with cognitive-behavioral therapy increased compliance and reduced the relapse rate significantly, according to Jamison.

The suicide rate for adolescents aged 15 to 19 appears to have declined in the last few years, said Jamison. "One reason may be that physicians are recognizing depression earlier and prescribing antidepressants."

However, the link between antidepressant use and suicide-risk reduction has not been studied in the United States, because drug companies exclude people who have attempted suicide or describe severe suicidal ideation, said Jamison.

She referred to a recent Swedish study showing that when general physicians were taught to recognize depression in all age groups and use antidepressants in effective doses the suicide rate decreased dramatically.

Where's the Outrage?

In spite of treatments that can save lives, knowledge of the biological underpinnings of mental illness and suicide, and public health strategies to reduce the suicide rate, "the effort seems remarkably unhurried," said Jamison. "Every 17 minutes, someone in America commits suicide. Where are the public concern and outrage?"

"Looking at suicide—the sheer numbers, the pain leading up to it, and the suffering left behind—is harrowing. For every moment of exuberance in science or success in government, there is a matching and terrible reality of the deaths themselves, the young deaths, the violent deaths, the unnecessary deaths," said Jamison, reading from her 1999 book *Night Falls Fast: Understanding Suicide*.

"Like many of my colleagues who study suicide, I have seen the limitations of our science, been privileged to see how good some doctors are, and am appalled by the callousness and incompetence of others. Mostly, I have been impressed by how little value our society puts on saving the lives of those who are in such despair as to want to end them," said Jamison. ■

Bipolar

continued from page 16

rogue gene—in other words, evidence that a subject had inherited a copy of the maverick gene from each parent. The researchers then determined what percentage of healthy subjects, what percentage of bipolar-with-panic subjects, and what percentage of bipolar-without-panic subjects had two copies of the gene variant and compared the percentages for the three groups.

Whereas only 19 percent of controls contained two copies of the gene variant, 20 percent of subjects with bipolar plus panic did. The 20 percent was not significantly different from the 19 percent of controls. But 32 percent of bipolar-without-panic subjects contained two copies of the gene variant, the scientists discovered. The 32 percent differed significantly from the 19 percent of controls.

These findings thus shore up previous evidence that the 5-HTT gene variant plays some role in bipolar disorder. But they also suggest that the variant is only implicated in pure bipolar, not in bipolar plus panic.

Indeed, when taken all together, "these results suggest that bipolar disorder with and without comorbid panic disorder represent distinct genetic forms of this mood disorder," Charles Nemeroff, M.D., chair of psychiatry at Emory University School of Medicine, writes in an editorial accompanying the study report.

In fact, if bipolar without panic is genetically distinct from bipolar with it, it raises some "fascinating questions," Nemeroff pointed out. For example, he asked, "Do these two groups differ in course of illness, vulnerability to comorbid medical disorders such as coronary artery disease, and treatment response?"

Nemeroff's comments prompted *Psychiatric News* to ask Rotondo whether he and his colleagues will now be trying to answer some of these questions. The answer was yes. "There is already evidence from several studies that panic disorder and high-anxiety levels in the context of bipolar disorder predict greater severity, poorer prognosis, and resistance to pharmacological treatments," Rotondo explained. "Therefore, we will be working not just on replicating our initial findings on a larger sample, but on trying to understand the impact of panic disorder on the outcome and treatment response of bipolar disorder patients."

The study was financed in part by the Institute for the Treatment and Prevention of Depression and Anxiety in Milan, Italy.

The study report, "Catechol O-Methyltransferase, Serotonin Transporter, and Tryptophan Hydroxylase Gene Polymorphisms in Bipolar Disorder Patients With and Without Comorbid Panic Disorder," is posted on the journal's Web site at <http:ajp.psychiatryonline.org> under the January issue. ■

Web Site

continued from page 6

of Health and Human Services. Both the foundation and the agency are interested in promoting scientifically based healthcare decisions.

After receiving the award, Osser spoke about the international impact of the Psychopharmacology Algorithm Project Web site. He said that he and Patterson are "getting feedback from unbelievable corners of the world." Perhaps most impressive, he said, is China's interest in the site (see box on page 6).

What the Web site really boils down to, Osser said, is that a "virtual consultant" asks a psychiatrist questions about a specific patient that the psychiatrist wants guidance on treating—say, one with depression without psychotic features. The consultant will then lead the psychiatrist to the most appropriate treatment for that patient, and evidence backing the consultant's recommendation will also be provided.

The algorithms in the Psychopharmacology Algorithm Project are based on high-quality empirical research studies, but also on some uncontrolled studies, compilations of expert opinion, and practice guidelines derived from clinical experience (*Psychiatric News*, June 15, 2001).

The Web address of the Psychopharmacology Algorithm Project is <www.mhc.com/Algorithms>. ■

CLASSIFIED

P4C

ZYPREXA® (Olanzapine) Tablets
ZYPREXA® ZYDIS® (Olanzapine) Orally Disintegrating Tablets

Brief Summary: Please consult package insert for complete prescribing information.

INDICATIONS AND USAGE: For the treatment of schizophrenia. Efficacy of oral ZYPREXA at maintaining treatment response for up to 8 months in schizophrenic patients has been demonstrated. For the short-term treatment of acute manic episodes associated with Bipolar I Disorder.

CONTRAINDICATIONS: Known hypersensitivity to olanzapine.

WARNINGS: Neuroleptic Malignant Syndrome (NMS)—NMS is a potentially fatal symptom complex that has been reported in association with administration of antipsychotic drugs, including olanzapine. Management includes immediate discontinuation of antipsychotic drugs and other drugs not essential to concurrent therapy; intensive symptomatic treatment and medical monitoring; and treatment of any concomitant serious medical problems as appropriate. Patients requiring antipsychotic drug treatment after recovery from NMS should be carefully monitored since recurrences have been reported.

Tardive Dyskinesia (TD)—A syndrome of potentially irreversible, involuntary, dyskinetic movements may develop in patients treated with antipsychotic drugs. Although the prevalence of TD appears to be highest among the elderly, especially elderly women, it is impossible to predict, at the inception of antipsychotic treatment, which patients are more likely to develop the syndrome. If signs and symptoms of TD appear in a patient on olanzapine, consider drug discontinuation.

PRECAUTIONS: Orthostatic Hypotension—Olanzapine may induce orthostatic hypotension associated with dizziness; tachycardia; and in some patients, syncope (incidence, 0.6%, 15/2500). These risks may be minimized by initiating therapy with 5 mg QD and titrating more gradually to target dose when hypotension occurs. Use with particular caution in patients with known cardiovascular disease, cerebrovascular disease, and conditions which predispose to hypotension.

Seizures—During premarketing testing, seizures occurred in 0.9% (22/2500) of olanzapine-treated patients, regardless of causality. Use cautiously in patients with a history of seizures or with conditions that potentially lower the seizure threshold.

Hyperprolactinemia—As with other drugs that antagonize dopamine D_2 receptors, olanzapine elevates prolactin levels; a modest elevation persists during chronic administration.

Tissue culture experiments indicate that approximately one third of human breast cancers are prolactin dependent in vitro. However, neither clinical nor epidemiologic studies have shown an association between chronic administration of this class of drugs and tumorigenesis in humans; the available evidence is considered too limited to be conclusive.

Transaminase Elevations—In placebo-controlled studies, clinically significant ALT (SGPT) elevations (≥3 times the upper limit of normal) were observed in 2% (6/243) of patients exposed to olanzapine compared to none (0/115) of the placebo patients. None of these patients experienced jaundice. In two of these patients, liver enzymes decreased toward normal despite continued treatment and in two others, enzymes decreased upon discontinuation of olanzapine. The fifth patient, seropositive for hepatitis C, had persistent enzyme elevation for 4 months after discontinuation; the sixth had insufficient follow-up to determine if enzymes normalized.

Among about 2400 patients with baseline SGPT ≤90 IU/L, 2% (50/2381) had asymptomatic SGPT elevations to >200 IU/L. Most were transient changes that tended to normalize while olanzapine treatment was continued. Among all 2500 clinical trial patients, about 1% (23/2500) discontinued treatment due to transaminase increases.

Exercise caution in patients who have signs and symptoms of hepatic impairment; preexisting conditions associated with limited hepatic functional reserve; or concomitant treatment with potentially hepatotoxic drugs (*see* Laboratory Tests, below).

Potential for Cognitive and Motor Impairment—Somnolence was a commonly reported (olanzapine 26% vs placebo 15%), dose-related adverse event associated with olanzapine in premarketing trials. Somnolence led to discontinuation in 0.4% (9/2500) of patients (*see* Information for Patients, below).

Body Temperature Regulation—Use appropriate care when prescribing olanzapine for patients who will be experiencing conditions that may contribute to an elevation in core body temperature.

Dysphagia—Esophageal dysmotility and aspiration have been associated with antipsychotic drug use. Two olanzapine-treated patients (2/407) in 2 studies in patients with Alzheimer's disease died from aspiration pneumonia during or within 30 days of the termination of the double-blind portion of their respective studies; there were no deaths in placebo-treated patients. One of these patients had experienced dysphagia prior to the development of aspiration pneumonia. Aspiration pneumonia is a common cause of morbidity and mortality in patients with advanced Alzheimer's disease. Olanzapine and other antipsychotic drugs should be used cautiously in patients at risk for aspiration pneumonia.

Suicide—The possibility of a suicide attempt is inherent in schizophrenia and in bipolar disorder, and close supervision of high-risk patients should accompany drug therapy. Prescriptions for olanzapine should be written for the smallest quantity of tablets consistent with good patient management, in order to reduce the risk of overdose.

Concomitant Illnesses—Olanzapine should be used with caution in patients with clinically significant prostatic hypertrophy, narrow angle glaucoma, or a history of paralytic ileus.

In a fixed-dose study of olanzapine 5, 10, and 15 mg/day and placebo in nursing home patients (mean age 83 years) having various psychiatric symptoms in association with Alzheimer's disease, the following treatment-emergent adverse events were reported in each and every olanzapine-treated group at an incidence of twofold or more in excess of the placebo-treated group or in at least 2 olanzapine patients if no placebo-treated patient was reported to have experienced the event: somnolence, abnormal gait, fever, dehydration, back pain. Discontinuations (olanzapine vs placebo) due to abnormal gait (1% vs 0%), accidental injury (1% vs 0%), and somnolence (3% vs 0%) were considered drug related. As with other CNS-active drugs, use olanzapine with caution in elderly patients with dementia.

Because of the risk of orthostatic hypotension with olanzapine, use caution in cardiac patients.

Information for Patients—Patients should be advised of the risk of orthostatic hypotension, especially during the initial titration period and with the concomitant use of drugs that may potentiate the orthostatic effect of olanzapine (e.g., diazepam, alcohol). Caution patients about operating hazardous machinery, including automobiles, until they determine that therapy with olanzapine does not affect them adversely. Advise patients to notify their physician if they become or intend to become pregnant during therapy with olanzapine; not to breast-feed an infant; to avoid alcohol; and to inform their physicians of any prescription or OTC medications they are taking or plan to take. Advise patients regarding appropriate care in avoiding overheating and dehydration. Advise phenylketonurics that ZYPREXA ZYDIS tablets contain phenylalanine.

Laboratory Tests—Periodic assessment of transaminases is recommended in patients with significant hepatic disease.

Drug Interactions—Use caution when olanzapine is taken in combination with other centrally acting drugs and alcohol. Olanzapine may enhance the effects of certain antihypertensive agents. Olanzapine may antagonize the effects of levodopa and dopamine agonists. Agents that induce CYP1A2 or glucuronyl transferase enzymes (e.g., omeprazole, rifampin) may cause an increase in olanzapine clearance. Inhibitors of CYP1A2 (e.g., fluvoxamine) could potentially inhibit olanzapine elimination. Because olanzapine is metabolized by multiple enzyme systems, inhibition of a single enzyme may not appreciably decrease olanzapine clearance. Activated charcoal (1 g) reduced the C_{max} and AUC of olanzapine by about 60%. Single doses of cimetidine (800 mg) or aluminum- and magnesium-containing antacids did not affect the oral bioavailability of olanzapine. Carbamazepine (200 mg bid) causes an approximately 50% increase in the clearance of olanzapine. Higher daily doses of carbamazepine may cause an even greater increase in olanzapine clearance. Neither ethanol (45 mg/70 kg single dose) nor warfarin (20 mg single dose) had an effect on olanzapine pharmacokinetics. Fluoxetine at 60 mg (single or multiple doses) causes a small increase in the C_{max} of olanzapine and a small decrease in olanzapine clearance; however, the impact of this factor is small in comparison to the overall variability between individuals, and dose modification is not routinely recommended. In vitro data suggest a clinically significant pharmacokinetic interaction between olanzapine and valproate is unlikely.

Olanzapine is unlikely to cause clinically important drug interactions mediated by the enzymes CYP1A2, CYP2C9, CYP2C19, CYP2D6, and CYP3A. Single doses of olanzapine did not affect the pharmacokinetics of imipramine/desipramine or warfarin. Multiple doses of olanzapine did not influence the kinetics of diazepam/N-desmethyldiazepam, lithium, ethanol, or biperiden. However, coadministration of either diazepam or ethanol potentiated the orthostatic hypotension observed with olanzapine. Multiple doses of olanzapine did not affect the pharmacokinetics of theophylline or its metabolites.

Carcinogenesis, Mutagenesis, Impairment of Fertility—The incidence of liver hemangiomas and hemangiosarcomas in female mice was significantly increased in one carcinogenicity study at 2 times the maximum human dose (mg/m² basis), but not in another study at 2-5 times the maximum human dose (mg/m² basis). In this study there was a high incidence of early mortalities in males in the 30/20 mg/kg/day group. The incidence of mammary gland adenomas and adenocarcinomas was significantly increased in female mice given olanzapine at 0.5 times the maximum human dose (mg/m² basis), and in female rats at 2 times the maximum human dose (mg/m² basis). In other studies, serum prolactin measurements of olanzapine showed elevations up to 4-fold in rats at the same doses used in the carcinogenicity studies. The relevance for human risk of the finding of prolactin mediated endocrine tumors in rodents is unknown. No evidence of mutagenic potential for olanzapine has been found.

In rats, male mating performance was impaired at a dose of 11 times the maximum recommended human daily dose (mg/m² basis) and female fertility was decreased at a dose of 1.5 times the maximum human daily dose (mg/m² basis). Discontinuance of treatment reversed the effects on male mating performance. In female rats the precoital period was increased and the mating index reduced at 2.5 times the maximum human dose (mg/m² basis). Diestrous was prolonged and estrous delayed at 0.6 times the maximum human dose (mg/m² basis); therefore, olanzapine may produce a delay in ovulation.

Pregnancy Category C—In rats and rabbits at doses equivalent to 9 and 30 times the maximum recommended human daily dose respectively (on an mg/m² basis), no evidence of teratogenicity was observed. In rats, early resorptions and increased numbers of nonviable fetuses were observed at 9 times the maximum human dose (mg/m² basis), and gestation was prolonged at 5 times the maximum human dose (mg/m² basis). In rabbits, fetal toxicity (increased resorptions and decreased fetal weight) occurred at a maternally toxic dose of 30 times the maximum human dose (mg/m² basis). Placental transfer occurs in rat pups.

There are no adequate and well-controlled studies in pregnant women. Olanzapine should be used in pregnancy only if the potential benefit justifies the potential risk to the fetus.

Parturition in rats was not affected by olanzapine; its effect on labor and delivery in humans is unknown.

Olanzapine was excreted in milk of lactating rats. It is not known if olanzapine is excreted in human milk; women receiving olanzapine should not breast-feed.

Use in Pediatric and Geriatric Patients—Safety and effectiveness in pediatric patients have not been established.

In patients with schizophrenia, there was no indication of any different tolerability of olanzapine in the elderly compared to younger patients. Studies in patients with various psychiatric symptoms in association with Alzheimer's disease have suggested there may be a different tolerability profile in these patients. As with other CNS-active drugs, use with caution in elderly patients with dementia. Consider a lower starting dose for any geriatric patient in the presence of factors that might decrease pharmacokinetic clearance or increase the pharmacodynamic response to olanzapine (*see* PRECAUTIONS and DOSAGE AND ADMINISTRATION).

ADVERSE REACTIONS: The following findings are based on a clinical trial database consisting of 4189 patients with approximately 2665 patient-years of exposure, including patients with schizophrenia, bipolar mania, or Alzheimer's disease. See the full prescribing information for details on these trials.

Associated with Discontinuation—Overall there was no difference in the incidence of discontinuation due to adverse events (olanzapine vs placebo: schizophrenia, 5% vs 6%; bipolar mania 2% vs 2%). Discontinuations in schizophrenia trials due to increases in SGPT were considered to be drug related (olanzapine 2% vs placebo 0%; *see* PRECAUTIONS).

Commonly Observed Adverse Events—In 6-week, placebo-controlled, premarketing schizophrenia trials, the most common treatment-emergent adverse events associated with olanzapine (incidence ≥5% and not observed at an equivalent incidence with placebo; olanzapine incidence at least twice that for placebo) were: postural hypotension, constipation, weight gain, dizziness, personality disorder (COSTART term for nonaggressive objectionable behavior), and akathisia. In 3- and 4-week placebo-controlled bipolar mania trials, the most common treatment-emergent adverse events associated with olanzapine were: asthenia, dry mouth, constipation, dyspepsia, increased appetite, somnolence, dizziness, and tremor.

Adverse Events with an Incidence >2%—The following treatment-emergent events were reported at an incidence of ≤2% with olanzapine (≥2.5 mg/day), and at a greater incidence with olanzapine than with placebo in short-term placebo-controlled trials in patients with schizophrenia, bipolar mania, or Alzheimer's disease (olanzapine N=532, placebo N=294): *Body as a Whole*—accidental injury, asthenia, fever, back pain, chest pain; *Cardiovascular*—postural hypotension, tachycardia, hypertension; *Digestive*—dry mouth, constipation, dyspepsia, vomiting, increased appetite; *Hemic and Lymphatic*—ecchymosis; *Metabolic and Nutritional*—weight gain, peripheral edema; *Musculoskeletal*—extremity pain (other than joint), joint pain; *Nervous System*—somnolence, insomnia, dizziness, abnormal gait, tremor, akathisia, hypertonia, articulation impairment; *Respiratory*—rhinitis, cough increased, pharyngitis; *Special Senses*—amblyopia; *Urogenital*—urinary incontinence, urinary tract infection.

Dose Dependency of Adverse Events in Short-Term, Placebo-Controlled Trials—Extrapyramidal Symptoms: In an acute-phase controlled clinical trial comparing placebo and 3 fixed daily doses of olanzapine (5±2.5, 10±2.5, 15±2.5 mg) in schizophrenia, the incidence of treatment-emergent EPS was assessed by categorical analyses of formal rating scales. There was no significant difference between any dose of olanzapine and placebo in the incidence of parkinsonism (patients with a Simpson-Angus Scale total score >3) or akathisia (patients with a Barnes Akathisia global score ≥2).

In the same clinical trial, when treatment-emergent EPS was assessed by spontaneously reported adverse event terms, only akathisia events (COSTART terms akathisia and hyperkinesia) showed a statistically significantly greater incidence with the 2 higher doses of olanzapine than with placebo. The incidence of patients reporting any extrapyramidal event was significantly greater than placebo only with the highest dose of olanzapine (15+2.5 mg/day).

Other Adverse Events: Dose-relatedness of adverse events was assessed using data from a clinical trial involving 3 fixed dosage ranges. The following treatment-emergent events showed a statistically significant trend: asthenia, dry mouth, nausea, somnolence, tremor.

Vital Sign Changes—Olanzapine is associated with orthostatic hypotension and tachycardia (*see* PRECAUTIONS).

Weight Gain—In placebo-controlled 6-week schizophrenia studies, weight gain was reported in 5.6% of olanzapine patients (average 2.8-kg gain) compared to 0.8% of placebo patients (average 0.4-kg loss); 29% of olanzapine patients gained greater than 7% of their baseline weight, compared to 3% of placebo patients.

Laboratory Changes—Olanzapine is associated with asymptomatic increases in SGPT, SGOT, and GGT and with increases in serum prolactin and CPK (*see* PRECAUTIONS). Asymptomatic elevation of eosinophils was reported in 0.3% of olanzapine patients in premarketing trials. There was no indication of a risk of clinically significant neutropenia associated with olanzapine treatment in the premarketing database.

ECG Changes—Analyses of pooled placebo-controlled trials revealed no statistically significant olanzapine/placebo differences in the proportions of patients experiencing potentially important changes in ECG parameters, including QT, QTc, and PR intervals. Olanzapine was associated with a mean increase in heart rate of 2.4 BPM compared to no change among placebo patients.

Other Adverse Events Observed During Clinical Trials—The following COSTART terms reflect treatment-emergent events reported with olanzapine at multiple doses ≥1 mg/day in clinical trials (4189 patients, 2665 patient-years of exposure). Although these events occurred during treatment with olanzapine, they were not necessarily caused by it. *Frequent* events occurred in ≥1/100 patients; *infrequent* events occurred in 1/100 to 1/1000 patients; *rare* events occurred in <1/1000 patients.

Body as a Whole—*Frequent:* dental pain, flu syndrome, intentional injury, suicide attempt; *Infrequent:* abdomen enlarged, chills, chills and fever, face edema, malaise, moniliasis, neck pain, neck rigidity, pelvic pain, photosensitivity reaction; *Rare:* hangover effect, sudden death.

Cardiovascular—*Frequent:* hypotension; *Infrequent:* bradycardia, cerebrovascular accident, congestive heart failure, heart arrest, hemorrhage, migraine, pallor, palpitation, vasodilatation, ventricular extrasystoles; *Rare:* arteritis, atrial fibrillation, heart failure, pulmonary embolus.

Digestive—*Frequent:* increased salivation, thirst; *Infrequent:* dysphagia, eructation, fecal impaction, fecal incontinence, flatulence, gastritis, gastroenteritis, gingivitis, hepatitis, melena, mouth ulceration, nausea and vomiting, oral moniliasis, periodontal abscess, rectal hemorrhage, stomatitis, tongue edema, tooth caries; *Rare:* aphthous stomatitis, enteritis, esophageal ulcer, esophagitis, glossitis, ileus, intestinal obstruction, liver fatty deposit, tongue discoloration.

Endocrine—*Infrequent:* diabetes mellitus; *Rare:* diabetic acidosis, goiter.

Hemic and Lymphatic—*Frequent:* leukopenia; *Infrequent:* anemia, cyanosis, leukocytosis, lymphadenopathy, thrombocythemia, thrombocytopenia; *Rare:* normocytic anemia.

Metabolic and Nutritional—*Infrequent:* acidosis, alkaline phosphatase increased, bilirubinemia, dehydration, hypercholesteremia, hyperglycemia, hyperlipemia, hyperuricemia, hypoglycemia, hypokalemia, hyponatremia, lower extremity edema, upper extremity edema, water intoxication; *Rare:* gout, hyperkalemia, hypernatremia, hypoproteinemia, ketosis.

Musculoskeletal—*Frequent:* joint stiffness, twitching; *Infrequent:* arthritis, arthrosis, bursitis, leg cramps, myasthenia; *Rare:* bone pain, myopathy, osteoporosis, rheumatoid arthritis.

Nervous System—*Frequent:* abnormal dreams, emotional lability, euphoria, libido decreased, paresthesia, schizophrenic reaction; *Infrequent:* alcohol misuse, amnesia, antisocial reaction, ataxia, CNS stimulation, cogwheel rigidity, coma, delirium, depersonalization, dysarthria, facial paralysis, hypesthesia, hypokinesia, hypotonia, incoordination, libido increased, obsessive compulsive symptoms, phobias, somatization, stimulant misuse, stupor, stuttering, tardive dyskinesia, tobacco misuse, vertigo, withdrawal syndrome; *Rare:* akinesia, circumoral paresthesia, encephalopathy, neuralgia, neuropathy, nystagmus, paralysis, subarachnoid hemorrhage.

Respiratory—*Frequent:* dyspnea; *Infrequent:* apnea, aspiration pneumonia, asthma, atelectasis, epistaxis, hemoptysis, hyperventilation, laryngitis, pneumonia, voice alteration; *Rare:* hiccup, hypoventilation, hypoxia, lung edema, stridor.

Skin and Appendages—*Frequent:* sweating; *Infrequent:* alopecia, contact dermatitis, dry skin, eczema, maculopapular rash, pruritus, seborrhea, skin ulcer, vesiculobullous rash; *Rare:* hirsutism, pustular rash, skin discoloration, urticaria.

Special Senses—*Frequent:* conjunctivitis; *Infrequent:* abnormality of accommodation, blepharitis, cataract, corneal lesion, deafness, diplopia, dry eyes, ear pain, eye hemorrhage, eye inflammation, eye pain, ocular muscle abnormality, taste perversion, tinnitus; *Rare:* glaucoma, keratoconjunctivitis, macular hypopigmentation, miosis, mydriasis, pigment deposits lens.

Urogenital—*Frequent:* amenorrhea,* hematuria, metrorrhagia,* vaginitis*; *Infrequent:* abnormal ejaculation,* breast pain, cystitis, decreased menstruation,* dysuria, female lactation, glycosuria, impotence,* increased menstruation,* menorrhagia,* polyuria, premenstrual syndrome,* pyuria, urinary frequency, urinary retention, urination impaired, uterine fibroids enlarged,* vaginal hemorrhage*; *Rare:* albuminuria, gynecomastia, mastitis, oliguria, urinary urgency.

(*Adjusted for gender.)

Postintroduction Reports—Reported since market introduction and temporally (not necessarily causally) related to ZYPREXA therapy: diabetic coma and priapism.

DRUG ABUSE AND DEPENDENCE: Olanzapine is not a controlled substance. In animal studies, olanzapine was shown to have little or no potential of abuse or physical dependence at oral doses 8 to 15 times the maximum daily human dose (on an mg/m² basis). While clinical trials in humans did not reveal any tendency for any drug-seeking behavior, it is not possible to predict on the basis of this limited experience the extent to which a CNS-active drug will be misused, diverted, and/or abused once marketed. Evaluate patients carefully for a history of drug abuse, and observe such patients closely for signs of misuse or abuse of olanzapine.

DOSAGE AND ADMINISTRATION: Usual Dose—Administer once daily without regard to meals. Schizophrenia: Begin with 5-10 mg/day with a target dose of 10 mg/day within several days. Dosage adjustments, if indicated, should occur at intervals of not less than 1 week. Bipolar mania: Begin with 10 or 15 mg/day. Dosage adjustments, if indicated, should occur at intervals of not less than 24 hours.

Special Populations—Schizophrenia and bipolar mania: The recommended starting dose is 5 mg in patients who are debilitated, who have a predisposition to hypotensive reactions, who otherwise exhibit a combination of factors that may result in slower metabolism of olanzapine, or who may be more pharmacodynamically sensitive to olanzapine.

ZYPREXA is a registered trademark of Eli Lilly and Company.
ZYDIS is a registered trademark of R. P. Scherer Corporation.
ZYPREXA ZYDIS (olanzapine orally disintegrating tablets) is manufactured for Eli Lilly and Company by R. P. Scherer DDS Limited, United Kingdom, SN5 8RU.

PV 3394 AMP [021601]

Eli Lilly and Company
Indianapolis, IN 46285, USA

www.lilly.com

LILLY ZYPREXA
P4C