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NEWS

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APA Tells Congress ADHD Is Serious but Treatable

Representatives from APA and other organizations present data to counter arguments by several witnesses that there is an epidemic of overmedicating children diagnosed with ADHD.

government news

BY CHRISTINE LEHMANN

Attention-deficit/hyperactivity disorder (ADHD) is a real and treatable disease was the message that the House of Representatives Committee on Government Reform heard in September from witnesses representing APA, Children and Adults With Attention-Deficit/Hyperactivity Disorder (CHADD), and the National Institute of Mental Health (NIMH).

“At the other end of the discussion is the Citizens Commission for Human Rights. They challenge the legitimacy of calling ADHD a neurobiological disorder and raise serious questions about giving strong medications to young children,” said committee chair Rep. Dan Burton (R-Ind.) in his opening statement.

David Fassler, M.D., testified on behalf of APA and the American Academy of Child and Adolescent Psychiatry.

“As a psychiatrist, when I think of ADHD, I think first of the faces of children and families I have seen over the years,” said Fassler, immediate past chair of the APA Council on Children, Adolescents, and Their Families and an APA trustee. “I think in particular of a 7-year-old boy who is about to be left back in second grade due to his ‘disruptive behavior.’ And I think of a 12-year-old girl with an IQ of 130. She’s not disruptive, but she’s failing seventh grade.”

The diagnosis of ADHD requires a comprehensive assessment by a trained clinician that includes direct observation and a review of the child’s developmental, social, academic, and medical history, Fassler

testified. “It should also include input from the child’s parents and teachers, and a review of the child’s records.” He added that “schools play a critical role in identifying kids who are having problems, but should not diagnose or dictate treatment.”

He referred to two recent studies that found that children were not being overdiagnosed with ADHD or overmedicated (see page 20). Fassler told the committee that

See page 4 for a special message about the Professional Liability Insurance Program.

APA and AACAP back the following recommendations and urged Congress to do the same:

- Support the allocation of appropriate funds and resources to establish the Office of Children’s Therapeutic Research within the Food and Drug Administration as authorized under the Best Pharmaceuticals for Children Act (PL 107-109).
- Support federal comprehensive parity legislation, in particular the Mental Health Equitable Treatment Act (HR 4066).
- Support the passage of the Child Men-
please see ADHD on page 30



Photos: Mary LaVoy

Reps. Rush Holt (D-N.J.), Gary Miller (R-Calif.), and Connie Morella (R-Md.) and Sen. Paul Wellstone (D-Minn.) vow to continue the fight for parity in Congress.

Capitol Hill Symposium Sends Strong Parity Message

association news

Dozens of members of Congress and their aides hear about developments in psychiatric research and the urgent need for parity at the annual Mental Illness Awareness Week symposium sponsored by APA and NAMI.

BY CHRISTINE LEHMANN

Congress should pass parity legislation because the benefits far outweigh the minimal costs, said lawmakers and others who spoke at a symposium organized by APA and the National Alliance for the Mentally Ill (NAMI) on Capitol Hill last month.

The annual event was the 17th symposium held in October during Mental Illness Awareness Week. The goal is to educate lawmakers and their aides about the latest developments in research and treatment of mental illnesses.

APA Medical Director-Designate James Scully, M.D., said at the symposium, “The struggle in Congress to eliminate arbitrary insurance discrimination against patients seeking treatment for mental illness occurs . . . at a point in time when the diagnostic science and treatment options have never been more robust.

“We believe that the opposition to a national parity law is fostered by the insurance industry and abusive managed care practices, with their clear incentives to offer
please see Capitol Hill on page 40



APA Is Moving!

APA plans to be in its new quarters across the Potomac River in Arlington, Va., on December 23, 2002. Here's how to contact us.

New address:
1000 Wilson Boulevard
Suite 1825
Arlington, Va. 22209-3901

APA's toll-free number
will stay the same: (888) 35-PSYCH

Calif. Psychologists Handed Setback In Practice-Expansion Effort

government news

A bill permitting California psychologists to terminate involuntary commitment of seriously ill psychiatric patients without authorization from a psychiatrist was derailed at the last minute.

BY KEN HAUSMAN

Despite their early optimism, psychologists in California will not soon be gaining the right to discharge seriously mentally ill patients without the concurrence of a psychiatrist.

With the backing of influential state lawmakers, psychologists again attempted to take the legislative route to expanding their scope of practice in California, as they have with mixed results on the issues of prescribing authority and independent hospital privileges.

The bill in question, AB 470, would have granted psychologists the authority to release disabled or gravely ill psychiatric patients from a 72-hour involuntary hold without waiting for the full confinement period to elapse. Psychiatrists are currently the only ones allowed to authorize an early discharge to persons committed because they were deemed to be a danger to themselves or others or "gravely disabled as a result of a mental disorder."

The bill would have allowed a psychologist directly responsible for an individual's treatment to release him or her prematurely from a court-ordered commitment if the psychologist believes "as a result of his or her personal observations that the person no longer requires evaluation or treatment."

In addition, as is the case with psychiatrists in California, the bill would have made psychologists who authorize an early release of a person on 72-hour hold exempt from civil or criminal liability for any act by the person being released. The same would apply to psychologists who approve

the release of such an individual at the end of the 72-hour period.

The same provisions governing 72-hour involuntary holds would also have applied to psychologists treating people committed under a 14-day, 30-day, or 180-day "period of intensive treatment."

Another provision would have affected the care of suicidal patients. The bill said that a psychologist treating an involuntarily committed suicidal patient could terminate the hospitalization for "imminently suicidal persons if the psychologist believes, as a result of his or her personal observations, that the person has improved sufficiently for him or her to leave or is prepared to voluntarily accept treatment on referral or to remain on a voluntary basis in the facility providing intensive treatment."

Under current state law, only psychiatrists have this right.

The bill passed the California Senate in August and was on its way to passage in the Assembly when it was derailed through the efforts of Assembly member Helen Thomson, a long-time champion of the mentally ill and psychiatry and chair of the Assembly's Health Committee.

Unfortunately, the Assembly's failure to pass the bill "is likely to be a temporary achievement, since Helen Thomson's term in office ends in November, and the likely new chair is supporting the bill," San Jose psychiatrist Maurice Rappaport, M.D., told *Psychiatric News*.

Rappaport, who represents Area 6 on the APA Board of Trustees, added, "The *please see Psychologists on page 39*

Priority Hotel Reservations For APA Members

association news

Priority hotel reservations for APA's 2003 annual meeting in San Francisco are available during the month of December for APA members.

As an additional member benefit, housing for the 2003 annual meeting will be open to **members only** on Tuesday, December 3. Your membership number is needed to make advance hotel reservations and should be noted on all correspondence.

To make the process as simple as possible, you may register in the following ways:

- **Online at <www.psych.org>.** Click on "Members Corner" and log in, and then click on "2003 Annual Meeting" and follow housing link to Travel Planners Inc.
- **Phone at (800) 221-3531 or (212) 532-1600.** Lines are open Monday through Friday from 9 a.m. to 7 p.m. Eastern time.
- **Fax.** To reserve fewer than 10 rooms, fax to (212) 779-6128; to reserve 10 rooms or more, fax to (212) 779-6134.
- **Mail at Travel Planners Inc., 381 Park Avenue South, Third Floor, New York, N.Y. 10016.**

from the president

Reshaping APA

BY PAUL APPELBAUM, M.D.

How do you govern an organization of more than 37,000 psychiatrists? In coming up with an answer, keep in mind that these psychiatrists are of diverse backgrounds, ethnicities, and political perspectives; practice in different venues; and may have substantially varying orientations toward their clinical

work. Moreover, the organization to which they belong must not only represent their views to the outside world, but also must serve their educational and affiliative needs and set ethical and clinical guidelines for their professional behavior. Did I mention that it has nearly a \$55 million budget and is the largest publisher of psychiatric books in the world?

There you have a thumbnail sketch of the challenge we face in crafting a structure to govern our Association. To date, we have responded to the challenge with a bipartite governance arrangement. The ultimate policy-setting body with fiduciary responsibility is the Board of Trustees, with 21 voting members and a roughly equal number of nonvoting participants who sit at the Board table. At its four working meetings each year (there is also a largely ceremonial session that takes place each May at the APA annual meeting), the Board ap-



proves and monitors APA's budget, reviews the products generated by the Association's components (for example, position statements, resource documents, practice guidelines), and sets the directions for the work of the APA staff.

Although it is the functioning of the Board on which I particularly want to focus in this column, it is worth noting the other body that plays a key role in APA's governance structure. The approximately 260-member APA Assembly, with representatives elected from every district branch, meets twice a year to initiate and deliberate on the policies and directions of the Association. Action papers passed by the Assembly can ultimately make their way to the Board for adoption as APA policy. Assembly members also belong to the Area Councils, organized geographically, that meet biannually to prepare for the Assembly's meetings. I will have more to say about the structure and function of the Assembly in a subsequent column.

Overall, I think the Board does a remarkably good job of overseeing APA operations. But we ought always to be ready to ask whether it could do its job even better

*please see **From the President** on page 45*

Important Update on Liability Insurance Program

BY PAUL APPELBAUM, M.D., AND STEVEN MIRIN, M.D.

Malpractice insurance is an essential prerequisite to psychiatric practice. With the current insurance cycle driving some carriers from the market and throwing others into financial turmoil, the availability of coverage that we mostly take for granted has—for many psychiatrists—been placed in question. Unfortunately, the recent problems with Legion Insurance Company, which, for many years, issued policies to members through the program currently endorsed by APA, have brought anxiety and uncertainty to many APA members. What happened with Legion Insurance Co., and what are its implications for our member insureds? A bit of history is helpful in appreciating the current situation.

In the mid-1980s, during the last major malpractice crisis, APA created the American Psychiatric Association Insurance Trust and sponsored a program designed to provide malpractice insurance coverage for its members. In 1988 Legion Insurance Co., which is a subsidiary of Mutual Risk Management (MRM), became the insurer for the program. Until recently, Legion maintained a high rating from A.M. Best, the international insurance-rating agency.

In 2000, on the basis of its ongoing evaluation of the program, the insurance market, and members' needs, APA concluded that the program would be stronger if it were backed by the assets of a top-rated insurance carrier and one of the world's largest reinsurers. APA advisers—insurance professionals from whom we have sought counsel at every step since the beginning of the program—concurred. As a result, the program was sold to Legion. At the time of the sale, Legion was rated "A" (Excellent) by A.M. Best. It is important to note that as part of the sale transaction, the financial strength of the program was substantially enhanced to better protect the interests of APA's insured psychiatrists.

Legion continued its role as the policy-issuing insurance carrier for the program. Professional Risk Management Services Inc. (PRMS), which has served as the administrator of the program from its outset, was purchased by Legion and continues to manage the program. The Psychiatrists' Purchasing Group (PPG), another independent corporation, became the sponsor of the program and has provided educational and liaison services to insureds, as it had prior to the sale. Finally, APA agreed to endorse the insurance program for five years, until October 2005. As a condition of its endorsement, APA required the insurance carrier for the plan to maintain at least a B+ (very good) rating. At the beginning of 2002, more than 7,500 members were covered by Legion.

In February 2002 Legion was downgraded by A.M. Best from A- (superior) to B (fair), reflecting, as we understand it, problems with other Legion insurance lines. Under our contractual agreement, Legion had 120 days either to improve its rating

or to put in place a substitute insurance carrier. Accordingly, Legion and PRMS began a search for a more highly rated carrier to assume responsibility for the program.

On April 1 the insurance commissioner of Pennsylvania, who regulates Philadelphia-based Legion, petitioned the Pennsylvania Commonwealth Court to place Legion in rehabilitation. Under rehabilitation, the insurance commissioner takes control of the insurance company, oversees its finances, and maintains its day-to-day operations.

In late August the insurance commissioner petitioned the Commonwealth Court for an order of liquidation. Legion's parent corporation, MRM, has intervened and is opposing the liquidation. At this writing, the court has not made a final decision.

As soon as APA received word that Legion's A.M. Best rating had fallen below an acceptable level, a task force of APA members chaired by former APA president Harold Eist, M.D., was established to monitor the situation closely and keep our members informed. This has been a difficult and frustrating task. Although APA endorses the program, the Association has no control over any of the companies involved (that is, Legion, PRMS, and PPG), which operate as independent entities. While we don't always have immediate answers to important questions, we are working with PRMS to obtain them.

Where do things stand now? As of early May 2002, PRMS arranged for two highly rated member companies of the American International Group (AIG), one of the largest and strongest insurers in the world, to replace Legion as the insurance carrier issuing policies to members insured in the APA-endorsed program. These two companies—National Union Fire Insurance Company of Pittsburgh Pa. and Lexington Insurance Company—both carry A.M. Best's A++ (superior) rating.

At this time, one or the other of these entities is authorized to provide insurance in every U.S. state and Washington, D.C. Insured members have been contacted to inform them of their eligibility to apply for coverage with these new carriers. Despite the availability of new coverage by these strong carriers, those who are or have been insured by the program could still encounter problems. As long as Legion continues to operate in rehabilitation, it retains responsibility for defending and, if necessary, paying claims against member insureds.

But what would happen to claims if Legion were to be liquidated? Every state has a guaranty fund that covers the obligations of liquidated insurers, up to a defined cap. The amount varies from state to state. In many states the cap is \$300,000; however, levels vary from a low of \$100,000 to a high of \$1 million in New York state. Further, insurance professionals tell us that 95 percent of claims against psychiatrists settle for under \$300,000, and that plaintiffs and their attorneys have a strong incentive in these circumstances to accept the amount available from the state guaranty fund.

Nonetheless, one of the benefits of *in-please see **Liability Insurance** on page 45*

Dr. Appelbaum is APA president, and Dr. Mirin is APA medical director.

**BMS CORP
P4C**

Insurance-Crisis Plan Could Override State Benefit Laws

The Bush administration is promoting a strategy to address the problem of the uninsured with the claim that it will enable insurance companies to avoid the cost of state benefit mandates.

BY KATE MULLIGAN

The increase in the number of uninsured Americans has lent force to an idea that could threaten state parity laws.

According to the Department of Labor, 39 million Americans lack health insurance. That number has grown by about 8 million during the last decade.

The Congressional Budget Office reports that uninsured workers are usually employees of small firms. Among private sector firms with fewer than 50 employees, health benefits were offered at only 47 percent of work sites in 1999, compared with a 97 percent offering among larger firms.

According to the Department of Labor, small businesses are inhibited from offering coverage because insurers typically charge them more per employee because they are in a poor negotiating position and because of the cost of state-mandated benefits.

To address these problems, the House of Representatives passed the Quality Care for the Uninsured Act of 1999 (HR 2990), but the Senate did not act on the bill. This legislation called for establishing association health plans (AHPs) and HealthMarts, two new vehicles for offering health insurance coverage to small employers. AHPs are group health plans whose sponsors are trade, industry, professional, or similar business associations. HealthMarts are group health plans whose sponsors are small employers and health care providers.

In 2001 Rep. Ernest Fletcher (R-Ky.) and Sen. Tim Hutchinson (R-Ark.) introduced the Small Business Health Fairness

Act (HR 1774, S 858), which would amend the Employee Retirement Income Security Act of 1974 (ERISA) to establish rules governing AHPs.

Administration Supports AHPs

On September 13 the Department of Labor released a report, "Association Health Plans: Improving Access to Affordable Quality Health Care for Small Businesses."

The report called AHPs "a key part of the solution" to the problem of the uninsured. The report also praised AHPs because "by operating under federal law, [they] can avoid the cost of state benefit mandates."

It lists as an "AHP advantage" the fact that other insurance offerings are hampered by the "high cost of having to comply with the requirements of up to 50 state insurance regulators, including state-mandated benefit requirements."

On September 30 Labor Secretary Elaine L. Chao called on Congress to pass the AHP legislation. In a written statement, she said, "Association health plans would equalize the playing field for small businesses but, more importantly, would result in health insurance coverage for millions of uninsured workers and their families."

The Department of Labor report lists 32 organizations that support the proposed legislation. Among them are the National Association of Manufacturers, the U.S. Chamber of Commerce, and the National Federation of Independent Businesses.

Alice Weiss, J.D., director of Health Policy at the National Partnership for Women and Families, described some of the haz-

ards of the legislation to *Psychiatric News*.

"Since AHPs can operate across state lines, insurance companies will migrate to the states with the least-restrictive requirements in terms of parity. They will be able to offer insurance in a state without adhering to any of its hard-won consumer protections," she said.

The legislation specifies that an AHP cannot exclude any "specific disease from coverage," but does not provide protection for the kind of categories of mental disorders that generally are listed in parity legislation or for the extent of treatment that must be offered.

Advocacy Organizations Protest

With the support of APA, 26 organizations signed on to a letter about the proposed legislation sent to Sens. Thomas Daschle (D-S.D.) and Trent Lott (R-Miss.).

The letter argued that rather than improving access to insurance for small businesses, "an AHP exemption would only create a massive loophole for these plans to avoid important state reforms designed

to make coverage affordable and accessible for all small employers and their employees."

The signatories also expressed concern that an exemption from state oversight would place consumers at a much greater risk for fraud and abuse because, they alleged, the federal government has neither the enforcement tools nor the resources needed to ensure appropriate oversight of these insurance arrangements.

The signatories to the letter included insurance companies, unions, and disability advocacy organizations.

Jay Cutler, J.D., director of APA's Division of Government Relations, told *Psychiatric News*, "District branches and psychiatrists throughout the country have fought tenaciously to enact parity legislation at the state level. We will work with other organizations to do our part to ensure that their valuable work is not undone at the national level."

"*Association Health Plans: Improving Access to Affordable Quality Health Care for Small Business*" is posted on the Web at <www.dol.gov/pwba/pdf/ahp-report.pdf>. ■

AMA Honors Sen. Domenici For Commitment to Better MH Care

The AMA awards one of the Senate's most outspoken champions of better access to mental health care and improved research funding.

BY KEN HAUSMAN

Sen. Pete Domenici (R-N.M.), one of Capitol Hill's most forceful advocates for better mental health care, is being honored by the AMA for his contributions on behalf of patients with mental illness.

Domenici's nomination for the prestigious Dr. Nathan Davis Awards was submitted by APA Medical Director Steven Mirin, M.D., and Marilyn Benoit, M.D., president of the American Academy of



Child and Adolescent Psychiatry.

The Dr. Nathan Davis Awards for Outstanding Government Service are given annually by the AMA to acknowledge elected and career government officials

whose contributions "have promoted the art and science of medicine and the betterment of public health." The awards are given in three categories—U.S. Senator, U.S. Representative, and Governor or Elected Statewide Official.

In nominating Domenici, Mirin pointed out that he "has worked vigorously for many years to end all forms of discrimination against the mentally ill. . . . His leadership has been critical in achieving significant increases for research funding for the National Institute of Mental Health and for funding to expand services to the homeless mentally ill."

Mirin also praised Domenici for his successful fight more than a decade ago against a proposal to deny people with mental illness the protections of the Americans With Disabilities Act.

Most recently, Mirin noted, Domenici has been a leader, along with Sen. Paul Wellstone (D-Minn.), in the effort to enact a law that would mandate health insurance parity for mental illnesses, including substance abuse. Domenici and Wellstone recently gained a crucial recruit to the parity cause when President George W. Bush announced that he is ready to sign a full mental health parity bill (*Psychiatric News*, May 17).

APA has honored Domenici on two occasions—in 1990 with its Jacob K. Javits Public Service Award and in 1997 with its Distinguished Service Award.

The AMA will present the Davis award to Domenici and the other winners at a Washington, D.C., banquet on February 11, 2003. ■

APA Awards Congressional Ally

APA honored Rep. Marge Roukema (R-N.J.) last month with a Special Commendation Award for her "extraordinary leadership and tireless personal dedication to improving the lives of persons with mental illness."

Roukema's communications director Jim Paretti accepted the award on her behalf at the annual congressional symposium cosponsored by APA and the National Alliance for the Mentally Ill on Capitol Hill in conjunction with Mental Illness Awareness Week.

Roukema was unable to attend the event due to her treatment for cancer.

APA President Paul Appelbaum, M.D., praised Roukema for her 20 years of legislative service and in particular for leading the fight for mental health parity.

This year she is a cosponsor of the Mental Health Equitable Treatment Act (HR 4066) with Rep. Patrick Kennedy (D-R.I.), which has not moved out of committee. She also has been a leader in advocating for health insurance reform.

Roukema was an original cosponsor of the 2001 Patients' Bill of Rights, "which put medical decisions back in the hands of doctors," and the Family and Medical Leave Act, which gives job security to hard-working American families, Appelbaum said.

Paretti read from a statement by Roukema: "I am deeply honored to receive this special commendation from the American Psychiatric Association. This award carries special meaning for me. As I reflect on my career in Congress, one of my proudest endeavors has been our fight to ensure that all those who suffer from mental illness receive appropriate care. We have been working a long time to end blatant discrimination against those with mental illness."

She recounted several victories on behalf of those suffering from mental illness, including the passage of the 1996 mental health parity law and the elimination of spending caps for mental health services under Medicare.

But, "the reality is there is much more to do. Earlier today, 33 Republican cosponsors of HR 4066 sent a letter calling on the president to ensure that mental health parity legislation is passed this year. We cannot allow this discrimination to continue."

She commended APA for its efforts on behalf of patients with mental illness and pledged her continuing support "as we strive to pass parity legislation and look to the future."



Jim Paretti (left) accepts a Special Commendation Award on behalf of Rep. Marge Roukema (R-N.J.) from APA President Paul Appelbaum, M.D. Paretti is Roukema's communications director.

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VA Promotes Simple Idea: Integrate Primary, MH Care

The Department of Veterans Affairs is promoting the integration of mental health and primary care services as a promising approach to treat veterans with posttraumatic stress disorder and other illnesses.

BY KATE MULLIGAN

Psychiatrists and mental health professionals in the Department of Veterans Affairs (VA) touted the value of integrating primary care and mental health services at a recent meeting.

The occasion was the Third National Primary Care/Mental Health Conference, which was sponsored by the National Center for Post-Traumatic Stress Disorder of

the Department of Veterans Affairs in Washington, D.C., on October 7 and 8. The center promotes research into the causes and diagnosis of posttraumatic stress disorder (PTSD), with a focus on education and consultation.

VA Undersecretary for Health Robert H. Roswell, M.D., set the tone for the meeting in his keynote address, saying, "[It] is vitally important to create systems

that address the 'whole patient'—the mind, the body—in a coordinated, systematic way."

The VA has data, he pointed out, that show that when primary care services are integrated with mental health services, clinical outcomes and patient satisfaction are improved.

Roswell said, "The VA ranks well among the few organizations committed to implementing and testing truly integrated primary care/mental health models of care."

Integration of services is particularly important for patients with PTSD because, according to Roswell, "PTSD is the most common undetected anxiety disorder in primary care that has a major adverse impact on illness severity, chronicity, medical utilization, and increased overall costs to the medical system."

Research from the National Center for

PTSD shows that high users of primary care services are twice as likely to have PTSD as low service users.

Mary Schohn, Ph.D., presented data linking diagnoses frequently made in primary care settings with mental disorders. She is the chief clinical officer of the Behavioral Health Care Line of Veterans Integrated Service Network (VISN) 2. (VISNs are regional health care networks that were created in 1996 as a result of PL 104-262, which promoted deinstitutionalization.)

"PTSD is the most common undetected anxiety disorder in primary care that has a major adverse impact on illness severity. . . and increased overall costs to the medical system."

Schohn said that individuals with diabetes, for example, are twice as likely as nondiabetics to be clinically depressed.

In cardiology patients, comorbid depression appears to be the best predictor of cardiac events during the 12 months following the diagnosis of cardiac problems.

She reported that 35 percent to 40 percent of veterans in a VA primary care setting have a diagnosis of depression, PTSD, or alcohol-related disorder.

Scott Murray, Ph.D., director of the Behavioral Health Care Line, described the model of integrated care implemented in VISN 2.

Mental health care staff, which includes psychiatric nurse practitioners, psychologists, and social workers, are assigned to all primary care teams. Psychiatrists are allocated as needed.

The staff help the primary care provider identify mental health problems, serve as gatekeepers for referrals, provide brief psychotherapy interventions, and offer wellness groups.

Murray reported that use of the General Health Questionnaire, a 12-item, self-administered screening test, has resulted in a 10 percent increase in the number of patients identified in the primary care setting as needing mental health services.

VISN 2 staff developed disease-management programs in PTSD, substance abuse, hypertension, diabetes, and chronic pain.

As a result of the integration of services, the number of patients seen in mental health clinics decreased, and the number of patients seen in "lifestyle groups," such as those living with chronic illness, increased.

Kirk Strosahl, Ph.D., spoke about adapting integrated care into VA primary care settings based on his experience with health care organizations around the country. He is director of research and training for the Mountainview Consulting Group in Moxee, Wash.

Strosahl expanded on his comments in an interview with *Psychiatric News*.

"The primary care system has become the de facto mental health system," he said. Managed care and other factors have reduced the availability of mental health services. The result is that more patients with mental health disorders are seeking care for physical symptoms from primary care physicians.

continued on facing page

Johnson chairs the Ways and Means Subcommittee on Health, which held a hearing on medical error legislation in September. "The fear of legal liability has had a chilling effect on the development of the reporting and analysis of errors. These data can save lives and create a health care delivery system capable of continuous quality improvement," said Johnson in a press statement.

A Senate companion bill (S 2590) was introduced in June by Sens. James Jeffords (I-Vt.) and Bill Frist (R-Tenn.). However, some Democrats and consumer advocates oppose the legal shield for patient safety data during the discovery process, fearing that attorneys would not be able to gain access to any patient information such as medical diagnosis and treatment, according to the September 25 *iHealth Beat*.

To remedy that, Sen. Edward Kennedy (D-Mass.) introduced the Patient Safety Improvement and Medical Injury Reduction Act (S 3029) last month. This bill would allow patient and hospital records to be used in federal or state civil or administrative proceedings under certain conditions and when permitted by federal or state law.

The bill was referred to the Health, Education, Labor, and Pensions Committee, where it is awaiting action. Kennedy is chair of this committee.

The bills would establish local independent Patient Safety Organizations (PSOs) to collect and analyze medical error data and report back to health care professionals to prevent future mistakes, according to the legislation.

The PSOs would forward the confidential health information to the Center for Quality Improvement and Patient Safety, housed in the federal Agency for Healthcare Research and Quality (AHRQ).

The center would collect the information in a national medical-errors database that researchers could use to identify national trends and recommend best practices to the health care industry, according to Johnson's statement.

The legislation would also provide federal grants to encourage local health care organizations to increase their use of information technology and develop physician electronic prescribing systems to reduce medical errors.

The use of advanced prescribing software and computerized physician order systems was one of the recommendations made in the landmark 1999 Institute of Medicine report titled "To Err Is Human: Building a Safer Health System."

The report estimated that between 44,000 and 98,000 Americans die annually due to medical errors, making them the eighth-leading cause of death in the United States.

In other congressional news, the House of Representatives passed a bill last month (HR 4561) written by Rep. Bob Barr (R-Ga.) requiring federal agencies that issue proposed regulations for public comment to include an analysis of how privacy would be affected.

The bill would also allow individuals to file lawsuits against agencies whose reviews are inadequate. A companion bill (S 2492) was awaiting action in the Senate last month.

Details and summaries of the legislation can be accessed on the Web at <www.thomas.loc.gov> by searching on the appropriate bill number. ■

"By the time they receive any kind of medical attention, those disorders often have become severe," Strosahl said. He added that primary care physicians frequently have neither the time nor training to treat the disorders adequately.

He advocates an integrated model in which a team manages patient treatment. The mental health care team member provides consultation and training to the physician, engages in short-term co-management of mental health problems, and provides patient education.

The treatment approach encourages patients to develop responsibility for their own education and care.

Strosahl hopes that federal efforts will promote integration of care. In addition to the VA, the Air Force and the Department of Health and Human Services (HHS) are advocating integrated-care models. HHS's Bureau of Primary Health Care is implementing an initiative to integrate behavioral health care services in 90 percent of its community health centers within five years. ■

Congress Considers Strategy To Reduce Medical Errors

Proposed federal legislation to reduce the high incidence of treatment and medication errors would provide physicians certain protections from potential lawsuits.

BY CHRISTINE LEHMANN

Before adjourning for its winter recess last month, Congress acted on legislation that would improve patient safety and explain the privacy impact of federal rules.

To encourage physicians and health care professionals to report medical mistakes, the legislation would ensure confidentiality for anyone who reports that information.

The Ways and Means and Energy and Commerce committees of the House of Representatives approved similar patient safety bills in September, though the bills had yet to be reconciled at press time. A

key difference is that the Ways and Means bill would be included in the Medicare statute, while the Energy and Commerce version would be included in the Public Health Service Act, according to an article in the October 4 *iHealth Beat*.

The Ways and Means bill, the Patient Safety Improvement Act (HR 4889), was introduced in June by Rep. Nancy Johnson (R-Conn.) and has the support of the Bush administration.

Reports of medical mistakes by health care professionals, organizations, and facilities would be considered privileged information and shielded from the discovery process in lawsuits, according to Johnson's bill.

professionalnews

With Politics and Mental Illness, The More Things Change. . .

In 1972 an uproar over vice-presidential candidate Thomas Eagleton's ECT treatment kept him from running for office. Thirty years have passed, but most Americans remain in the dark about mood disorders.

BY EVE BENDER

About half of all Americans would rather not vote for a political candidate with a mood disorder, according to new survey findings released at an October 1 press briefing in Washington, D.C., by the Depression and Bipolar Support Alliance (DBSA).

DBSA President John Bush and Executive Director Lydia Lewis introduced the survey findings in the context of a political imbroglio that took place 30 years ago.

In the summer of 1972, presidential candidate George McGovern chose then Sen. Thomas Eagleton as his running mate. However, Eagleton was removed from the ticket in a matter of days when reports surfaced that he had undergone electroconvulsive therapy (ECT) for "nervous exhaustion."

"Looking back, many have felt that the controversy over Sen. Eagleton's nomination was both tragic and unnecessary," said Lewis.

Lewis said DBSA commissioned the survey to find out whether the same firestorm of controversy would have erupted if Eagleton were running for vice president today.

In a telephone survey in July and August, researchers interviewed 1,200 randomly selected adults. They found that 24 percent of respondents would not vote for a political candidate with a mood disorder, and an equal percentage "might not vote" for such a candidate.

Further, 25 percent said they believe that people with mood disorders are dangerous, can easily be identified in the workplace, and cannot form and maintain long-term, stable relationships. A fifth (19 percent) said that people with mood disorders should not have children.

DBSA is a patient-directed organization that provides the public with information on mood disorders. The Chicago-based organization maintains a toll-free help and referral line for those in need of assistance and runs 1,000 support groups for people with mood disorders and their families. In August the organization

changed its name from the National Depressive and Manic Depressive Association to its current name.

Living in Ignorance

Most of those surveyed admitted that they knew little about mood disorders. Just 36 percent said that they were "very" or "somewhat" knowledgeable about depression, and 16 percent considered themselves knowledgeable about bipolar disorder.

"Education is paramount," Lewis said, to eradicate stigma surrounding mood disorders. Her statement was in response to the finding that 60 percent of Americans were not interested in learning more about mood disorders.

Lewis said that this statistic will not discourage DBSA from disseminating information on mood disorders through its newsletters, speakers bureau, media projects, health fairs, and Web site. "We are proactively educating the public," she said, adding that "people won't be interested in learning about mood disorders if they are just sitting at home. That's why we are out there pushing our message."

Not All Voters Bothered

About two years ago, Rep. Patrick Kennedy (D-R.I.), one of the panelists at the press briefing, told his constituents that he had been diagnosed with and treated for clinical depression. Despite this admission, Rhode Island voters returned him to Congress with 67 percent of the vote.

Kennedy's disclosure has brought him closer to many of his constituents, he said. "People have been responsive to me about my battles with depression," he said. "I've had numerous people approach me during my days as a congressman and say, 'Thank you for what you said. I have a similar problem.' " Although many people have "self-identified," or told Kennedy about their own depression, the undercurrent of the disclosure, he said, is "let's keep this our little secret," he observed. "That's the problem."

He remarked that as the leader and co-founder of a congressional caucus on asthma, he has seen that people have no problem attending related meetings. "Yet if I held a caucus on depression, I'd be lucky to gather a handful of people."

Kennedy lamented that the National Institutes of Health devoted just \$5 of every \$100 to researching mental illness. "This speaks to the depth of the prejudice [against people with mental illnesses]." Kennedy also read a letter written September 30 by former Sen. Eagleton about attitudes toward candidates with mood disorders.

"When I was a youngster growing up in the 1930s and 1940s," Eagleton wrote, "no one would speak the 'C' word (cancer)." In later decades, "no one would speak the 'D' word (depression)."

Eagleton commented in the letter that he never criticized McGovern for dropping him from the ticket and added, "In 1972, if I was the presidential nominee and George was the vice-presidential nominee, I think I might even have dumped him. The Eagleton matter was overwhelming all of McGovern's issues."

Panelist Martha Manning, Ph.D., was in a unique position to speak about the stigma surrounding mood disorders. Manning is a clinical psychologist, award-winning advocate for people with mental illness, and author of *Undercurrents: A Therapist's Reckoning With Her Own Depression*. She has battled depression for more than 20 years.

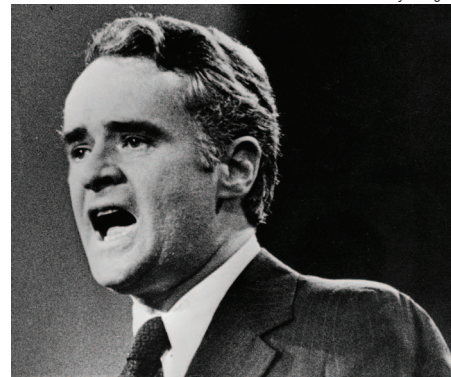
Manning relayed a story about how she is still paralyzed at times by the stigma directed at her. One Sunday night, she was relaxing at home and realized that she was out of lithium. Dressed in her worst sweat clothes, "as close as I could possibly be dressed to being in bed," she went to the grocery store to refill her prescription.

When she arrived, there were many other people waiting to refill prescriptions. Manning was standing with them "when all of a sudden from on high, the pharmacist yells down into the crowd, 'Manning?' My first mistake was when I answered, 'Yes?'"

The pharmacist asked her loudly whether she wanted her lithium in easy-open or child-proof caps.

"It was as if the crowd pulled away from me," Manning said. In another situation, she added, she would have asked to see the supervising pharmacist to talk about the breach of confidentiality. "But this was lithium. And I was not going to go up in my crummy sweat suit with my hair standing up."

She resigned herself to saying nothing.



Hulton Archive/Getty Images

Sen. Thomas Eagleton was removed from the democratic ticket in the 1972 presidential election after revelations that he had undergone electroconvulsive therapy.

"Being assertive in this situation would have been translated into who knows how many different ways as I became justifiably angered over what was done. So I was silenced."

At times, Manning said, even medicine and psychotherapy have not kept her from contemplating suicide. Her doctors recommended that she have ECT, and she has, four times, she said. But even after decades of working with patients and combating stigma through education and advocacy, Manning is vulnerable. "Do I still feel stigmatized? Yes. Still feel flashes of shame? Yes."

APA Fights Stigma

APA Medical Director Steven Mirin, M.D., attended the briefing and expressed optimism about APA's role in erasing stigma through a variety of efforts. He later told *Psychiatric News*, "The fight against stigma has been waged on a number of fronts—in the media, where unfortunately the vestiges of stigma remain, and in the arena of public education, where APA has had a leadership role."

He explained that in the wake of last year's terrorist attacks on New York and Washington, D.C., APA's work through the National Partnership for Workplace Mental Health "is sensitizing employers to the prevalence of mental illness in our society, but also to the cost of these disorders in terms of absenteeism, lost productivity in the workplace, and human suffering."

APA created the partnership program in December 2001 to address the often-unmet mental health needs of employees. Several corporations, such as Delta Airlines, Dupont, and Coca Cola, have collaborated with APA to improve mental health in the workplace.

More information about the National Partnership for Workplace Mental Health is posted on the Web at <www.workplace-mentalhealth.org>. ■

In Memoriam

The following is a list of members whose deaths were reported to APA from July 1 to September 30.

David Abel, M.D.
William E. Abramson, M.D.
Frank L. Adelman, M.D.
William S. Allerton, M.D.
John W. Appel, M.D.
Richard B. Arnesen, M.D.
Helene Ella Aronson, M.D.
Boris M. Astrachan, M.D.
Thad J. Barringer Sr., M.D.
George W. Bischel, D.O.
William F. Blair, M.D.
Walter R. Bonime, M.D.

Milton H. Bronstein, M.D.
Paul Matthew Cadwell, M.D.
Victor Cohen, M.D.
George A. Colom, M.D.
Arlin B. Cooper, M.D.
William H. Cox Jr., M.D.
Michael G.D. Davys, M.D.
Jackson C. Dillon, M.D.
James Warren Dykens, M.D.
Brian Vigors Earle, M.D.
Donald R. Easton, M.D.
Milton Engel, M.D.
David A. Freedman, M.D.
Edwin M. Fuchs, M.D.
Robert M. Gilliland, M.D.
Paul Gray, M.D.
William Gray, M.D.
Stephen M. Greenwald, M.D.

Richard W.M. Hill, M.D.
Margaret E. Hitchman, M.D.
Marshall D. Hogan Jr., M.D.
John S. Howie, M.D.
Arthur W. Hoyt, M.D.
Charles B. Huber, M.D.
David William Kennard, M.D.
Charles H. Kramer, M.D.
Alan A. Lieberman, M.D.
Harold P. Lynn, M.D.
James L. Mathis, M.D.
Jille W. Merkelbach, M.D.
Allen Cook Miller, M.D.
Kurt M. Morbitzer, M.D.
Patricia R. Moreschi, M.D.
A. Fahrettin Oybir, M.D.
Harold A. Pike, M.D.
Henning Poulsen, M.D.

Robert David Riskind, M.D.
James Allen Shapero, M.D.
Norman B. Sher, M.D.
H. Joseph Simon, M.D.
Marvin Ralph Skolnick, M.D.
Albert J. Solnit, M.D.
Howard F. Stock, M.D.
Walter P. Streitel, M.D.
John A. Stroud, M.D.
Roy H. Tavener, M.D.
John T. Tokar, M.D.
John A. Turner, M.D.
Shirley May Van Ferny, M.D.
David Wade, M.D.
James M.A. Weiss, M.D.
Phillip H. Wells, M.D.
Jerry M. Wiener, M.D.
George Zubowicz, M.D.

An Advocate's Journey Started at Home

A profile of one of the most ardent supporters of psychiatric research shows how one mother turned concern over her daughter's schizophrenia into a mission to provide newfound hope to innumerable families living with serious mental illness.

BY EVE BENDER

When Constance Lieber began her search for information on schizophrenia, she had no idea that it would lead her to the helm of one of the largest donor-supported organizations in the world devoted to funding scientific research on schizophrenia and mood disorders.

Lieber is now president of the National Alliance for Research on Schizophrenia and Depression (NARSAD), a private, nonprofit organization that raises and distributes funds for scientific research into the causes, cures, treatments, and prevention of severe mental illnesses, primarily schizophrenia and depression.

The quest that took her through stacks of scholarly journals and to experts at the National Institute of Mental Health (NIMH) also brought her to a meeting at Columbia University in spring 1985 to gather information on the illness that had taken her only daughter prisoner years before.

During graduate school in the early 1980s, Lieber's daughter, Janice, experienced her first psychotic break. When Lieber and her husband, Stephen, took Janice to the hospital, "the doctor diagnosed her with schizophrenia and told us that she had a poor prognosis," Lieber recalled. "We were completely upset and bewildered—no one in our families had ever had schizophrenia."

Eager to improve mental health services, Lieber began serving on the boards of the Larchmont-Mamaroneck Guidance Center and the Mental Health Association of Westchester County in New York. She also attended local meetings and national conventions held by the National Alliance for the Mentally Ill.

Herbert Pardes, M.D., left his position as director of NIMH in 1984 to become director of the New York Psychiatric Institute and chair of Columbia's department of psychiatry. He held a seminar each spring at Columbia to discuss what was then known about schizophrenia, including new treatments and research findings, with family members. Pardes, a past APA president, is now president and CEO of New York Presbyterian Hospital.

At the meeting, Pardes announced the formation of a new organization dedicated to researching serious mental illness. NARSAD came to exist through the combined efforts of the National Alliance for the Mentally Ill, National Mental Health Association, National Depressive and Manic Depressive Association (whose name was recently changed to the Depression and Bipolar Support Alliance),

and American Schizophrenia Foundation. Leaders from these organizations saw the need to create a separate organization dedicated to funding nongovernmental research on brain disorders and came together to lay the foundation for NARSAD.

"After the meeting," Lieber told *Psychiatric News*, "I approached Herb [Pardes] and told him that I was interested in working with this new organization." Lieber began serving on NARSAD's board of directors that year and became president of the organization in 1989.

Pardes became president of NARSAD's scientific council, a post he still holds.

In the beginning, Lieber's goal was to "build the organization to find the causes, better treatments, and possibly a cure for mental illness." NARSAD-sponsored research, she said, has brought these goals within sight.

"I'm more hopeful now about the future of psychiatry than I ever was," she said.

As president of NARSAD, it is not uncommon for Lieber to volunteer 60 hours a week to publicize the research sponsored by the organization, organize NARSAD's annual fundraising dinner gala, and edit its quarterly newsletter.

She also fields occasional phone calls from the distraught parents of children with serious mental illness. She advises them to take the child to the closest teaching hospital for a psychiatric consultation and sometimes dispenses motherly advice. "I can give them anecdotal information as a parent."

During Lieber's tenure at NARSAD, the organization has progressed from awarding \$250,000 to 10 researchers in 1987 to more than \$20 million to 598 scientists this year. Some of this award money goes to recipients of the Lieber Prize for Outstanding Research in Schizophrenia, established by the Liebers in 1987. The Essel Foundation—a charitable foundation founded by the Liebers in 1963—provides the \$50,000 cash prize for the schizophrenia researchers. Two of its recipients, Arvid Carlsson, M.D., who won the Lieber prize in 1994, and Paul Greengard, Ph.D., in 1996, have also won Nobel prizes.

Lieber is especially proud of the ways in which NARSAD has helped its young investigators, one group of researchers who receive NARSAD funding and are eligible to win awards for their work. "Many have developed their careers and have come a long way," she said. A few have

please see Lieber on page 12



Constance Lieber: "I'm excited about how the science is going to help families living with mental illness. That is where their hope is."

More Data Show Parity Is Wanted, Affordable

Recent studies show that more than half of Americans strongly support mental health parity legislation and confirm it's affordable.

BY KATE MULLIGAN

Two recent reports offer ammunition for APA's efforts to convince Congress to pass S 543, the Mental Health Equitable Treatment Act.

On October 2 the National Mental Health Association released results of a telephone survey about public attitudes toward parity in insurance coverage for mental health care. These were among the survey's findings:

- Seventy-nine percent of respondents said that they would support parity legislation even if it increases their health insurance premiums by \$1 a month. Fifty-one percent said they strongly support such legislation. This finding was consistent among respondents in all age groups.

- Sixty-four percent of respondents said insurance companies should provide coverage for mental illness that is equal to coverage for physical illness; 18 percent said that the coverage should be greater for mental illness; 10 percent said coverage should be less for mental illness.

The Opinion Research Corporation conducted the survey in September. Completed interviews were weighted for age, sex, geographic region, and race.

Claims Data Support Parity

On September 16 the American Managed Behavioral Healthcare Association (AMBHA) released an analysis of insurance claims that showed that 85 percent of billed mental health claims are for the treatment of serious mental illness (SMI).

For purposes of the analysis, the AMBHA excluded 70 mental health disorders and conditions listed in the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV)* from its definition of SMI. For example, adjustment, sleep, and gender identity disorders were excluded.

Claims for substance abuse treatment were also excluded because they are not covered by the proposed legislation.

The analysis was based on 2001 data from 13 million mental health claims to managed care companies that cover almost 60 million people. The mental health claims totaled more than \$3 billion in billings.

In a written statement, Pamela Greenberg, AMBHA's executive director, said, "These data correspond to the experience of MBHOs [managed behavioral health care organizations] over the years. People with less serious mental disorders are not usually heavy users of the system."

According to the statement, limiting the scope of parity legislation to a subcategory of mental illnesses would increase administrative costs. AMBHA members report that it would not be cost-effective for employers, health plans, psychiatrists, and mental health professionals if they had to take time to determine whether a disorder is covered.

Use Relates to Severity

The AMBHA assertion that most of the cost of mental health claims is attributable to SMI is supported by the Congressional Budget Office (CBO) (*Psychiatric News*, June 21).

In 2001 the CBO estimated the total cost for the parity bill, S 543, to be a .9 percent increase in premiums.

In a May 22 memo, the CBO stated that the estimate was based on the assumption that the bill would require affected group health plans to cover all mental illnesses listed in the most recent edition of the *DSM*, with the exception of substance abuse disorders.

Almost all of the cost increase associated with mental health parity results from increases in payments for the treatment of people suffering from severe mental illness, according to the CBO.

Darrel Regier, M.D., director of APA's Office of Research and executive director

of the American Psychiatric Institute for Research and Education, told *Psychiatric News*, "As the CBO pointed out, and insurance companies have long known, it is easier to control costs of less-severe mental illness. The recent CBO analysis laid to rest the specious argument that covering all the *DSM* [diagnoses] would open the floodgates in terms of cost."

Earlier this year President George W. Bush endorsed mental health parity, but did not specify which mental illnesses he would like to see covered. House Republican leaders contend that requiring mental health coverage for all *DSM* disorders would drive up the health care costs for employers and employees (*Psychiatric News*, May 17).

Lieber

continued from page 11

even wound up on NARSAD's scientific council, Lieber said, such as James Kennedy, M.D., John Rubenstein, M.D., Ph.D., Hussein Manji, M.D., and Robert Malenka, M.D., Ph.D.

After being diagnosed with schizophrenia, Lieber's daughter struggled to tolerate the side effects of her medications and sometimes became sick again when she stopped taking them. "She'd say that the drugs made her sicker than she was without them and that she couldn't sit still," Lieber recalled.

Relief both from the bothersome side effects and psychosis came in the form of a new medication, Clozaril, on which one of the NARSAD board members, Herbert Meltzer, M.D., had conducted preliminary and independent research. Before beginning yet another drug regimen with her daughter, Lieber asked Meltzer, "Would you give this drug to your child?"

In July Regier testified on behalf of APA about parity to the House Energy and Commerce Subcommittee on Health. He said, "Parity opponents know full well that *DSM* requires evidence of clinically significant impairment that would be fully protected under the House and Senate parity bills. The debate over *DSM* is palpably false and designed to distract Congress from the real issue: blatant discrimination against patients with mental illness" (*Psychiatric News*, August 3).

The survey results and related material are posted on the NMHA Web site at <www.nmba.org>. The text of the Mental Health Equitable Treatment Act can be accessed at <<http://thomas.loc.gov/>> by searching on the bill number, S 543. ■

Meltzer expressed his belief in the drug's benefits, and Lieber's daughter has been relatively stable since she began taking the drug.

"Cloazril has made a great deal of difference in her life and in mine," said Lieber.

Lieber has won a number of awards for her work in the mental health arena, among them APA's Organizational Distinguished Service Award this past May.

She is also president of the Essel Foundation, which she cofounded with her husband in 1963. The foundation, which has funded a great deal of NARSAD research, initiated and supported the Williams College Neuroscience Program and the Lieber Center for Schizophrenia Research at Columbia University. In 1999 she was awarded the honorary degree of doctor of humane letters from Brooklyn College and Williams College.

"I'm excited about how the science is going to help families living with mental illness," Lieber said. "That is where their hope is." ■

Sniper Attacks Prompt SAMHSA To Offer Grants to MH Agencies

The federal Substance Abuse and Mental Health Services Administration (SAMHSA) announced last month that it will provide \$250,000 in grants to local mental health agencies in Washington, D.C., Virginia, and Maryland to assist people affected by the sniper attacks.

At least nine people had been killed and two others were wounded by mid-October in a random shooting spree across the three jurisdictions that make up the Washington metropolitan area.

Tommy Thompson, secretary of Health and Human Services, said in a press release, "We are making these resources available to help identify and meet the overwhelming human need for counseling, support, and recovery in the wake of the tragedy brought on by this murderer."

SAMHSA will also provide immediate and long-term assistance to support state and local efforts to work with schools and community organizations to reduce the traumatic sequelae of the shootings.

SAMHSA will mobilize the National Center for Child Traumatic Stress and the Safe Schools/Healthy Students Action Center, which it funds, according to the press release.

These centers will help children who are experiencing PTSD symptoms and provide teachers, students, and school administrators with written materials, Web-based information, and connections to local resources.

The press release from the Department of Health and Human Services and related information are posted on the Web at <www.hhs.gov/news>. ■

JANSSEN RISPERDAL P4C

JANSSEN RISPERDAL P4C

**JANSSEN RISPERDAL
P4C**

Magellan's Financial Crisis Causes Widespread Worry

If Magellan declares bankruptcy, insurance companies that had contracted with Magellan to provide mental health services could be held liable for unpaid claims. But those are not the only problems that could affect psychiatrists and their patients.

BY KATE MULLIGAN

Recent deterioration in the financial stability of Magellan Health Services Inc., the country's largest behavioral health care company, could raise serious issues for psychiatrists and their patients.

James Pyles, counsel of the American Psychoanalytic Association, speculated to

Psychiatric News about the impact of further financial disintegration or a Magellan bankruptcy.

"The contractual relationship is between the insurer and the patient," he said, "not between Magellan and the patient. Therefore, the insurance company is responsible for providing the benefits stipulated in the insurance policy."

However, he warned, a looming "melt-down" of Magellan might encourage that company to deny claims inappropriately and to delay payment.

In addition, an acceleration of Magellan's financial distress could lead to layoffs and the departure of qualified staff members, further exacerbating the difficulties of claims management.

An article in the October 14 *Washington Post* lends support to Pyles's contention that insurance companies that had contracted with Magellan to provide mental health services would be responsible for providing benefits in the event of Magellan's bankruptcy.

According to the article, regulatory officials in Maryland, Virginia, and the District of Columbia said that Magellan's patients would be treated and providers paid even if the company's problems worsen.

Steven B. Larsen, Maryland's insurance commissioner, told the *Post* that the insur-

ance companies that contract with Magellan would have the ultimate responsibility to make payments to providers and ensure continuity of care.

He said, "If Magellan got to the point where it couldn't pay doctors' bills, for example, the HMOs would be required to pay the physicians, and the HMOs would have to take whatever steps are necessary to ensure continuity of care."

Magellan is viewed as a third-party administrator for insurance companies. As such, it is not regulated by the agencies that have authority over the insurance business in the Washington metropolitan area.

What to Do?

Lawrence Lurie, M.D., chair of APA's Managed Care Committee, told *Psychiatric News* that a Magellan spokesperson assured him that, in the event of a bankruptcy, paying providers would be of "highest priority" to the company.

"APA is verifying with state insurance commissioners and insurance companies that contract with Magellan that those companies would be responsible for paying legitimate claims if Magellan does not honor its commitment," he said.

Lurie added, "Psychiatrists would also have an obligation to their patients to help preserve the continuity of care if those patients become covered by another carrier."

Karen Sanders, director of APA's Managed Care Help Line, encourages anyone with a payment problem to call the Help Line at (800) 343-4671.

"We've developed a good system for ensuring that complaints about Magellan are resolved quickly, and we advise members to stay current in terms of payments they are owed," she said.

In a letter dated October 11 to Lurie, Jon Book, M.D., Magellan's chief medical officer, noted that "of claims paid by Magellan in August 2002, 98 percent were paid within 30 days, compared with 97 percent for claims paid in the same period in 2001."

Catherine May, M.D., president of the Washington Psychiatric Society (WPS), appointed a task force to monitor the situation and develop a plan to deal with future problems. Magellan officials had agreed to a meeting with the task force members, according to May.

Former WPS president Eliot Sorel, M.D., met with the federal Office of Personnel Management (OPM) to alert its staff to potential problems if Magellan declares bankruptcy. Many federal employees are insured by Blue Cross/Blue Shield or Aetna, which contract with Magellan for mental health services.

He told *Psychiatric News* that OPM officials were receptive to the idea of partnering with WPS and other relevant organizations to develop a contingency plan that would ensure continuity of care for patients.

Those officials also agreed that insurers that had contracted with Magellan would be held responsible for the delivery of mental health benefits specified in insurance contracts, if Magellan declares bankruptcy.

How Did It Happen?

Magellan chronicled its own financial decline in a series of press releases.

On September 30 the company issued a press release stating that it believed that the company would not be able to comply with one or more of the financial agreements with bank lenders for the quarter and fiscal year ending that date.

*please see **Magellan** on page 39*

Stigma in International Spotlight At WPA Congress in Japan

Mental health experts, policymakers, patients, and families gathered in Yokohama, Japan, this past summer to discuss issues that affect mentally ill people throughout the world at a major conference sponsored by the World Psychiatric Association.

BY DAVID MILNE

Better treatment of the mentally ill requires the universal realization that good mental health is the key to good physical health. And this will come not only with improvement of mental health care facilities, but also through elimination of mental illness stigma and partnership with the public to reach these goals through education and open discussion.

The XIIth World Congress of Psychiatry in Yokohama, Japan, in August brought these goals into sharp focus through the Citizens Forum at which the public, along with consumer groups and mental health organizations, discussed the evergreen topics of a better understanding of mental illness, reducing the stigma against psychiatric disorders, child and adolescent societal problems, the social and psychological consequences of disaster and stress, drug abuse and polypharmacy, and the prevention of alcohol-related problems.

One workshop issued an instruction manual on how to develop programs against

stigmatization and discrimination at local and national levels. The Japanese Society of Psychiatry and Neurology (JSPN), one of the organizers of the congress, officially changed the Japanese term for schizophrenia to help rectify problems of stigmatization against the estimated 600,000 schizophrenia patients in Japan and their families. The government is expected to adopt the new definition and use it in official documents.

(In Chinese characters and kanji, which are used both in Chinese and Japanese, schizophrenia is translated as "split-minded disease." The new term "togo shitcho sho," roughly meaning "integration disorder syndrome," was felt to be more suitable. The Japanese name for schizophrenia came from a translation in 1937 of the German name. The Japanese medical system is based on the German model. A Japanese representative said he also wants English-speaking countries to change the term "schizophrenia," coined in 1911 by Swiss psychiatrist Emil Bleuler.)

Delegates from South Korea and China also reported patterns of stigmatization of people with schizophrenia related to language.

Japan lags behind other developed nations in helping mentally ill people lead normal lives outside of institutions, officials at JSPN acknowledged. Only about 55 percent of schizophrenia patients are told of their diagnosis, presumably because of stigma, according to JSPN President Yuki Nichimura, so physicians are failing to meet requirements of informed consent.

Some Progress Evident

On average, the 37 countries and areas in the western Pacific region devote less than 1 percent of their health budgets to the treatment and prevention of mental disorders, said Shigeru Omi, M.D., director of the Western Pacific Region of the World Health Organization in Manila, Philippines.

One out of five people in the western Pacific region who seek the help of a health care professional suffers from a mental disorder. Of this number, only a fraction are properly diagnosed, and of those who are, fewer ever get treatment or proper care, said Omi.

But some positive responses to mental health challenges were also reported. Adults in China are receiving treatment for epilepsy; children in Cambodia are being taught to deal with stress through play and games; more Australian and Malaysian non-governmental and mental health professionals are working with their governments in areas that affect mental health. The Mon-

golian government is integrating mental health care into the primary medical health care system and training more workers in psychiatry, Omi noted.

To emphasize the enormity of the problem and the importance of governments devoting more resources for education and for training health care workers in mental health, the congress passed the "Yokohama Declaration," which calls on all countries to provide the best possible treatment for those with mental illness and to promote awareness of good mental health.

Injustices Must Be Fought

In his opening address, WPA President Juan Lopez-Ibor, M.D., said that one of the prime aims of the congress, whose theme was "Partnership for Mental Health," was to build bridges to overcome the barriers between patients and society.

"In order to do so, we have to fight many injustices that prevail in the world," he said.

In another meeting at the congress, the WPA agreed to look into allegations that China is confining political dissidents, including members of the Falun Gong sect, in psychiatric wards and forcing detainees to undergo shock therapy and medication. Falun Gong was outlawed in China in 1999 for allegedly threatening national security. The WPA plans to send a fact-finding team to China, according to Lopez-Ibor.

Similar charges were leveled by UN High Commissioner for Human Rights Mary Robinson during her visit to China earlier this year. Human Rights Watch re-

please see World Congress on page 44

Changing Your Mind May Change Your Body

A Vanderbilt professor calls for new ways to characterize medical problems and gain insight on how to ward off disease and delay death.

BY DAVID MILNE

A new paradigm for understanding health and treating illness was proposed at the XIIth World Congress of Psychiatry in Yokohama in August.

In the lecture "How the Mind Hurts and Heals the Body—The Science of Psychoendoneuroimmunology," Oakley S. Ray, Ph.D., called it "a necessary approach to health care in today's world."

"Patient-centered care is emerging as a key concept in modern medicine, because it is well known that individuals who are compliant, express interest in their treatment, and work together with their physicians have better outcomes, improved health, and faster recovery than those who do not," said Ray, a professor of psychiatry and psychology and associate professor of pharmacology at Vanderbilt University.

The validity of this approach is most evident with complex complaints, such as those involving interactions among mind, body, and culture. But it is also applies to physical ailments, although the results might not be as dramatic, according to Ray.

He said there is a need for new modes of characterizing medical problems because nonmedical factors that help people resist illness and live longer are now known.

Research is beginning to clarify how the four systems—psyche, endocrine, neuro, and immune, or PENI—interact to ensure health, fight disease, and delay death. Evi-

dence is also accumulating on what happens when the systems fail.

Fundamental to understanding PENI is an awareness that three of the systems—nervous, endocrine, and immune—have receptors on critical cells that can receive information by messenger molecules from each of the other systems, he explained.

According to the tenets of PENI, the mind or activity of the brain is the body's first line of defense against illness, aging, and death and for health and well-being.

"Our thoughts, our feelings, our beliefs, and hopes are nothing more than chemical and electrical activity in the nerve cells of our brain. It is literally true that as experience changes our brain and thoughts, that is, changing our mind, we are changing our biology," he said.

"We already know that what we believe, what we think, has both positive and negative effects on our physical health. The challenge for psychological science is to determine to what extent and what psychobiological mechanisms are involved."

He said the task of researchers is to specify the psychoendoneuroimmunological conditions under which certain illnesses occur, to identify the mechanisms involved, and to develop interventions to prevent the normal negative consequences or to enhance positive effects.

As an example, he said analyses of sud-

den deaths or heart attacks reveal that multiple mechanisms are involved. A critical factor is the threshold rate at which fibrillation occurs. He said studies have shown that "psychosocial factors influence the threshold of response" while another, prospective study concluded that while biological reasons are the primary cause for most non-sudden cardiac deaths, psychosocial factors are the most important when it comes to sudden cardiac deaths.

As the complexity of mind-body situations increases so does the difficulty of analysis and the identification of probable mechanisms. He provided two examples of complex mind-body interactions that directly addressed the issue of whether a set of beliefs can hasten the occurrence of death.

One studied Chinese Americans with different levels of conviction in Chinese culture and astrology. Two basic beliefs in Chinese astrology were most relevant: that a person's fate is strongly influenced by the astrological year of his or her birth and that each astrological year is associated with a body organ or type of illness or symptom.

When a believer in these concepts develops the illness associated with his or her birth year, the Chinese believe that their belief system has been confirmed and that an early death is probable. This study asked the simple question: When an individual committed to this astrological system develops an illness that is associated with his or her birth year, does that person die sooner than individuals with the same illness who were born in a different astrological year or with a lesser degree of commitment to the belief system? The evidence was clear: such people do, indeed, die sooner.

In short, Chinese Americans, but not Caucasians, die significantly earlier than

average (1.3 to 4.9 years earlier) if they have a combination of disease and birth year that Chinese astrology and medicine consider ill fated. The more strongly a group is attached to Chinese traditions, the more years of life are lost. These results held true for nearly all major causes of death in the study.

The second example he gave was based on the fact that many Chinese and Japanese people consider the number 4 unlucky, while white Americans do not. Cardiac mortality in Chinese and Japanese people in the United States showed a cardiac mortality peak on the fourth day of the month (1.45 ratio of observed to expected deaths for inpatients) but matched white controls did not (*Psychiatric News*, June 7).

Ray said that PENI provides the concepts and the components to change the way people view much of the world. The components of PENI are the neurotransmitters and hormones and cytokines that act as messenger molecules carrying information between the nervous, endocrine, and immune systems.

"The concepts underlying PENI are that thought processes are the functioning of the brain, and as we change our mind—our thoughts—we change our brain and therefore our body," he said.

Ray said that recent research provides compelling evidence of mind-brain-body interactions at the organismal, cellular, and molecular level that can impact on the health and quality of life of individuals.

"The consequences of shifting to this new paradigm and obtaining a clearer and better understanding of the interactions among the components of PENI will be beneficial to many, including all who work in the broad area of health care," he said. ■

international news

Culture Cannot Be Divorced From Psychiatric Care

Psychiatrists need to be culturally sensitive to patients in making diagnoses and providing treatment. They also need to keep in mind that sometimes people from cultures other than their own may not follow the culture from which they come.

BY DAVID MILNE

When an African-American truck driver said that he frequently saw the devil sitting beside him warning that his life was about to take a turn for the worse, the attending psychiatrist was about to diagnose the patient as suffering from a delusional disorder. Fortunately, the East Indian psychiatry resident, who knew little about African-American folklore, decided to ask the man about his religious beliefs. He found that the patient's story was an accepted way of speaking in many Southern communities in the United States and that it should not be taken literally but interpreted in its cultural context.

Gary E. Myers, Ph.D., M.Div., an assistant professor of medical humanities and psychiatry at Southern Illinois University School of Medicine in Springfield, relates this story to show how a little cultural sensitivity can go a long way when psychia-

trists are treating patients from cultures other than their own.

ond to teach the same subjects to family medicine residents. In his current group of 22 psychiatry residents, five are American. Most of the others are from Pakistan, India, and the Philippines.

"So I've been teaching this type of multicultural psychiatric education to a multicultural group of residents since I arrived here in the heart of Illinois—among the cornfields and all," he laughed.

From his travels and supervisory and teaching experiences with international psychiatry residents, he has amassed a large vocabulary of culturally relevant metaphors that are important to establishing connections between patients' cultures and their psychotherapy. He said that one of the biggest errors Westerners make is looking at all behavior through only their eyes.

"If a person in Southeast Asia or Malaysia began running around screaming and throwing things after a stressful event, then settled down and acted almost psychotic, a visiting Western psychiatrist who took a snapshot of that behavior isolated from its cultural context would insist that the patient be medicated. But *DSM-IV* identifies that culture-bound syndrome as 'running amok.' And if the psychiatrist were from that culture, he or she would know that this is how the patient's people deal with trauma, and the community is prepared to deal with such behavior," he said.

In an interview, Myers touched on some guidelines on practicing culturally competent psychotherapy. "Assuming that the language barrier is not insurmountable between the patient and psychiatrist, and if as the psychiatrist you know nothing about the culture of the patient, it would be best to do a quick overview to get a general idea so you are not coming in cold. At the same time, you can't overgeneralize. You have to wait and see who the patient is. Even to be culturally informed doesn't mean you know the patient and his or her culture completely."

He cautioned not to be overly apologetic because in most traditional and non-Western cultures, patients want their healer/therapist to be authoritative, and they become uncomfortable if you present yourself too much as an equal, which implies "not knowing your stuff."

Patients need to be approached in an affirmative way, he advised. "Admit that your knowledge of their culture is limited and indicate that you are interested in their cultural perspective as it relates to their treatment and would welcome their input," he said. That helps to enlist the patient as a consultant.

"Ideally, you want patients to become a contributor to your learning about their culture, which helps them to build trust in you and to educate you a bit."

He said it is a common mistake to be too quick to impose a diagnosis on behavior and attitude before you interpret this through the operative cultural context. And he warned against interpreting and pathologizing behavior that is not understood or

uncritically interpreting behavior according to one's cultural standards.

"A helpful guide to the major culture-bound syndromes is in one of the appendices of *DSM-IV*. That will give you a step forward in recognizing cultural differences, but it lacks nuance and needs supplementation by further study," he said.

For those with no prior experience of treating people from cultures different from their own, it is helpful to divide cultures into the broad categories of collectivist, primarily being traditionally Eastern, and individualist, or Western, Northwest European, and Australian.

To people from a collectivist culture, the important value is connection to the group, which tends to define them by seniority and status in the group, while in individualist cultures, the distinguishing values focus on self, self-expression, self-realization, and being related but staying apart from the group, said Myers. As one Japanese expressed it, "Everyone in the West is an individual ego and uses the pronoun 'I' a lot, while we tend to prefer consensus and belonging." A common Japanese saying expresses this aptly: "The nail that stands up gets hammered down."

"Say you have a Japanese client who is depressed over a conflict with the family because he is completing a graduate degree

aimed toward developing his career in a distinctive way that suits him, while his family really expects him to take a major role in the family business. It would be simplistic to tell your client that he should individuate and learn to separate from his family and do his own thing; that he should feel secure in what he is doing and his folks will get over it; and that he will establish the relationship on new grounds.

"That transition is possible with American families even if they are overinvolved with one another. But that's simply not the case in Japan. Your client's culture is a fundamental part of his identity. As the oldest son in his family, he has a deep obligation to this group. So you have to negotiate between cultures instead of imposing an entirely different system on him."

How an Eastern patient's problem is handled must take into account the degree to which he has been Westernized. Just because someone is Japanese or Chinese does not mean he or she is invested in those specific cultural views and values, Myers pointed out. Some young Japanese men have spiked blond hair and prefer rap music and Dr. Dre to Sumo wrestling and martial arts.

"So you have to make that determination, too, when fine-tuning your approach to cultural psychotherapy," he said. ■

IMGs Have Played Critical Role In History of U.S. Psychiatry

International medical graduates have a long, rich history of providing high-quality care to psychiatric patients in the United States, but changes in certain laws and licensing requirements affecting them may impact their future—and thus the provision of needed services—in this country.

BY DAVID MILNE

A clearer picture is emerging of international medical graduates (IMGs) in U.S. psychiatry and their influence on health care services. In a report to the XIIth World Congress of Psychiatry in Yokohama, Japan, in August, Dinu P. Gangure, M.D., a psychiatry resident at St. Luke's-Roosevelt Hospital Center at Columbia University College of Physicians and Surgeons, said that IMGs as a group bring an in-depth educational background to their clinical training in the United States. They also possess a bicultural perspective valuable in a multicultural society.

A surprising finding, said Gangure, was that in psychiatry more IMGs than U.S. medical graduates (USMGs) are likely to practice in urban areas, which was attributed to a tendency for IMGs to reside in lower-income areas of big cities. The total number of IMGs is higher now than 10 years ago, but lower than four years ago.

IMGs constitute a group of physicians whose presence on the American medical scene has become more significant over the years, and the history of IMGs in American psychiatry is closely linked to the history of mental health in this country, said Gangure. Until the 1950s, the IMGs coming to the United States were mostly European immigrants. Many gifted psychoanalysts came here to escape Nazism and enriched the already blossoming field of psychiatry.

The burgeoning growth of mental health facilities in the United States in the 1960s required an increase in personnel and was

accompanied by a rapid influx of IMGs. Most of them came for training, and many of them stayed in the United States, greatly increasing the number of psychiatrists. By 1970 some 24 percent of psychiatrists here were graduates of medical schools outside of the United States and Canada. From 1972 to 1975 the percentage of IMGs in psychiatry coming from Asia doubled, and those psychiatrists are now the group with the most rapid increase in numbers, said Gangure.

Gangure noted that in the 1990s there was a steep increase in IMGs attributed to the breakup of the Soviet Union, changes in the licensing exam, and new immigration laws. Introduction of the USMLE Steps as the unique current pathway to access training in the United States simplified the process. At the end of 1994, IMGs represented 23 percent of APA members, 32 percent of residents in psychiatry, and 45 percent of first-year residents in psychiatry.

In response to concerns that IMGs might be lacking in basic technical skills, such as history taking, physical examinations, and communicating with patients in spoken English, the Educational Commission for Foreign Medical Graduates (ECFMG) mandated in July 1998 that IMGs must pass the Clinical Skills Assessment (CSA) to become certified by the ECFMG. Since then there has been a decrease in the IMG growth rate, Gangure reported. According to James W. Thompson, M.D., M.P.H., the former di-

please see IMGs on page 44

"Ideally, you want patients to become a contributor to your learning about their culture, which helps them to build trust in you. . . ."

trists are treating patients from cultures other than their own.

"This example of a resident's sensitivity being heightened and the willingness to ask additional questions regarding the cultural context of the patient's story resulted in the best interpretation of the patient's symptoms," he said at the XIIth World Congress of Psychiatry in Yokohama, Japan, in August.

Myers emphasized that globalization places new demands on psychotherapists to practice culturally competent psychotherapy. His interest in breaching psychotherapeutic cultural barriers came about in a roundabout way. His interest had originally been in the interface between psychology and religion, and his Ph.D. is in theology and personality studies.

"I was employed by the United Methodist Church to evaluate the spiritual and emotional well-being of missionaries and their families when they returned from their assignments abroad. Through this work I was pressed not only to consider the religious beliefs of patients, but also their cultural experiences. This exposure to cross-cultural therapy developed into my academic focus on taking religion and culture into account when doing psychotherapy," he said. He is an ordained United Methodist minister but has never been a missionary.

During his teaching career Myers has won two Templeton Awards, the first to develop curricula in religion, spirituality, and culture for psychiatry residents, and the sec-

LILLY ZYPREXA P4C

Data Refute Claims of ADHD Overmedication, Congress Told

Two studies cited by APA during recent congressional testimony provide strong evidence that children with ADHD are not overmedicated, but in fact may be undermedicated.

BY JIM ROSACK

APA Trustee-at-Large David Fassler, M.D., a child and adolescent psychiatrist in private practice in Burlington, Vt., cited the results of two studies to prove a point when he testified about attention deficit/hyperactivity disorder (ADHD) and its treatment on Capitol Hill last month (see page 1).

"These studies underscore the impor-

ance of obtaining a careful and comprehensive evaluation, and that was one of the messages we were trying to convey," Fassler told *Psychiatric News*.

His testimony during a hearing by the House Committee on Government Reform, which looked at the prevalence of ADHD and questions surrounding the prescription of stimulant medications, emphasized that "there is no evidence of wide-

spread overtreatment with medication." In contrast, he testified, the studies indicate that there are areas of the country where the majority of children with ADHD are not receiving appropriate and effective treatment.

"The findings from these studies are consistent with previous reports suggesting that overdiagnosis and/or overtreatment of ADHD is not a widespread phenomenon," Fassler told *Psychiatric News*. "This certainly doesn't mean that it does not occur or is not a problem in specific communities. However, the current literature suggests that we have a much larger problem with underdiagnosis and undertreatment."

Few Children Treated

Fassler said the two studies were particularly useful because each had a unique point of view.

The first study he cited in his testimony was by Peter Jensen, M.D., now Ruane Professor of Child Psychiatry in the Center for the Advancement of Children's Mental Health at Columbia University. The study appeared in the July 1999 issue of the *Journal of the American Academy of Child and Adolescent Psychiatry* and looked at the diagnosis and treatment of ADHD in four communities across the country.

Jensen and his colleagues assessed 1,285 children in Atlanta, New Haven, Conn., Westchester County, N.Y., and San Juan, P.R. The communities were selected because of their demographic diversity.

Jensen found rates of ADHD to be quite variable, ranging from a low of 1.6 percent in San Juan to a high of 9.4 percent in Atlanta; 5.1 percent of all the children met *DSM-III-R* criteria for ADHD. Interestingly, Fassler said, only 12.1 percent of those children had been treated with stimulant medications. In contrast, out of the 1,285 children who were prescribed stimulant medications, Jensen found only eight who did not meet diagnostic criteria; however, these children did show significant (but subthreshold) symptoms of the disorder.

Similar Results Obtained

The second study Fassler cited is believed to be the first of its kind, and its results may significantly alter the way the mental health field looks at ADHD and the use of psychostimulant medications.

"The current literature suggests that we have a much larger problem with underdiagnosis and undertreatment."

The study, by Mayo Clinic researchers, followed all children who were born (just over 5,700) between 1976 and 1982 in Rochester, Minn., and continued to live in the area after age 5. The report of the study appeared in the March *Archives of Pediatrics and Adolescent Medicine*.

The study team, led by William J. Barbarese, M.D., an assistant professor of pediatrics and adolescent medicine at Mayo Medical School in Rochester, had unusually broad access to both medical and school records and were able to review all of the records for each child to identify clinical diagnoses of ADHD. They also had access to supportive documentation that could indicate symptoms that fulfill *DSM-IV* criteria or positive results from an ADHD-related questionnaire.

The researchers split the cohort into four subpopulations: those identified as "definite ADHD"—having a clinical diagnosis and at least one of the two types of supportive documentation; those identified as "probable ADHD"—having a clinical diagnosis but no supportive documentation, or no clinical diagnosis but both types of supportive documentation; those having "questionable ADHD," with no clinical diagnosis, but at least one type of supportive documentation; and a subpopulation of "not ADHD" individuals, comprising all other subjects.

The highest estimate the authors calculated for the cumulative incidence of ADHD at age 19 was 16 percent. That figure included the "definite" plus the "probable" plus the "questionable" subpopulations. The lowest estimate, comprising only the "definite" group, was 7.4 percent.

continued on facing page

Link Found Between ADHD and Brain Size

Youngsters with attention-deficit/hyperactivity disorder have been found to have smaller brain volumes than youngsters without it. The smaller volumes do not seem to be due to medication used for the disorder.

BY JOAN AREHART-TREICHEL

Could attention-deficit/hyperactivity disorder be related, at least in part, to brain-volume abnormalities?

Such a question is not as far out as it seems. A new study has found that children with the disorder have smaller brain volumes than those without it—and regardless of whether they take medication to treat the disorder.

The study was conducted by F. Xavier Castellanos, M.D., of the New York University Child Study Center, and colleagues and reported in the October 9 *Journal of the American Medical Association*.

Castellanos and his coworkers launched their study at the Child Psychiatry Branch of the National Institute of Mental Health in Bethesda, Md., in 1991. They recruited from the local community 152 young people with attention-deficit/hyperactivity disorder (ADHD) ranging in age from 5 to 18 years. They appeared to have equally severe ADHD symptoms, since they met identical diagnostic and symptom-severity criteria. The researchers also recruited from the local community 139 young people without the disorder who matched the subjects in age and gender and who were willing to serve as controls.

Castellanos and his team used magnetic resonance imaging (MRI) to measure the brain volumes of the subjects and controls at the start of the study and periodically during the following decade. The areas of the brain that they assessed included the cerebrum, cerebellum, gray and white matter of the four major lobes of the brain, and caudate nucleus.

Interestingly, in the group identified as having definite ADHD, 86.5 percent had been prescribed stimulant medication as treatment; in the group having probable ADHD, 40 percent were prescribed a stimulant; and 6.6 percent of those with questionable ADHD had received a prescription for a stimulant. Of those who were identified as “not ADHD,” 0.2 percent had received a prescription for a stimulant medication.

“Once again,” Fassler testified, “this very carefully conducted study simply doesn’t support the argument that ADHD is generally overdiagnosed or overtreated. In fact, as the authors point out, even in a community with excellent access to medical care, one child in five with ADHD was receiving no treatment with medication.”

An abstract of “Are Stimulants Overprescribed? Treatment of ADHD in Four U.S. Communities” can be accessed on the Web at <www.jaacap.com> by clicking on “Contents” and then on the July 1999 issue. An abstract of “How Common Is Attention-Deficit/Hyperactivity Disorder? Incidence in a Population-Based Birth Cohort in Rochester, Minn.” is posted at <<http://archpedi.ama-assn.org/issues/v156n3/abs/poa10326.html>>. ■

Finally, they used the MRI scan results to compare the brain volume of the subjects with that of the controls, both at the start of the study and over the subsequent decade.

At the start of the study, the researchers found that the cerebral volume of the subjects was about 3 percent smaller than that of the controls and that the cerebellar volume of the subjects was about 4 percent smaller than that of the controls, even when age, height, weight, and other possibly confounding factors were taken into consideration. These differences were statistically significant.

The initial scans also revealed that the volumes of other brain regions measured were smaller in the subjects as well—again, a statistically significant difference.

Second, they compared initial MRI scan results for only 49 subjects out of the total 152 subjects with those of the controls. These 49 subjects had never received any medication for their disorder, thus allowing the researchers to determine whether medication might have explained the smaller brain volumes that they had found in their subjects. However, it did not seem to, as smaller brain volumes were found in these subjects as well. For instance, both cerebral volume and cerebellar volume were about 6 percent smaller in these subjects than in the controls, and white matter was about 11 percent smaller—again, statistically significant differences.

“In fact, findings were generally as striking for the unmedicated patients with ADHD as for those who were being treated with medications, and were more pronounced for white matter volumes,” the scientists pointed out in their study report.

Finally, they compared MRI scans of all subjects in subsequent years with those taken of the controls in that same period to see whether the initial smaller brain volumes noted in both medicated and unmedicated subjects remained smaller over time. The answer was yes, with the exception of the volume of the caudate nucleus—it caught up with that of the controls.

Thus, it looks as though youngsters with ADHD may have smaller brain volumes than young people without the disorder, that the smaller volumes are not due to medical treatment for the disorder, and that the smaller volumes mostly stay smaller than normal as youngsters with the disorder age, Castellanos and his team concluded.

Whether the smaller volumes play any causal role in the disorder, however, remains to be determined.

The study was financed by the National Institute of Mental Health, Division of Intramural Research Programs.

An abstract of the study, “Developmental Trajectories of Brain Volume Abnormalities in Children and Adolescents with Attention-Deficit/Hyperactivity Disorder,” is posted on the Web at <<http://jama.ama-assn.org/issues/v288n14/abs/joc20194.html>>. ■

Post-9/11 ‘Symptoms’ Don’t Add Up to Disorders

Research on the mental health effects of 9/11 hasn’t yielded all the information that many people would like to know, but it does shed light on the post-9/11 psyche. This is the second in a two-part series.

BY JIM ROSACK

Experts in disaster and trauma mental health seem to agree on a few issues regarding September 11, 2001. They agree that the studies claiming to quantify the mental health effects of the terrorist attacks in terms of posttraumatic stress disorder (PTSD) or depression did not really do so. What the studies do show, they also agree, is an array of “reactions” or “responses” following the attacks.

Yet few, if any, of those experts now see those findings as “symptoms.” And no one yet knows the significance of those reactions and responses.

Several experts in trauma and disaster mental health interviewed by *Psychiatric News* agreed that the studies published to date have not used rigorous enough methods to make clinical diagnoses of PTSD or depression in their subjects (*Psychiatric News*, October 18, September 6).

Yet the experts also generally agree that the studies do provide a rich trove of data on early, acute reactions to a highly abnormal and traumatic event.

“A key remaining question is,” noted Carol North, M.D., a professor of psychiatry at Washington University in St. Louis, “what is the meaning of so many ‘symptoms’ [as the studies themselves use the term] if there is no real disorder?”

North said her studies of victims of the bombing of the Alfred P. Murrah Federal Building in Oklahoma City in 1995, as well as studies following other disasters, suggest that these “symptoms” largely consist of *DSM-IV* criterion B (intrusion) and criterion D (hyperarousal) symptoms that in the absence of the third core group of symptoms making up PTSD, criterion C (avoidance and numbing symptoms), do not necessarily indicate that an individual is functionally impaired.

“In fact, [criteria B and D symptoms] start to resolve very quickly,” North noted. “I would tend to think of these as ‘reactions’ or ‘responses’ rather than symptoms. The

question is, Symptoms of what, if there is no illness?”

North and others interviewed by *Psychiatric News* agreed that the events of 9/11 provided a “natural, real-world laboratory” for studying the mental health impact of a horrendous event. Yet trying to conduct rigorous research on acute stress reactions and PTSD development has proved to be extremely difficult.

Diagnostic Rigor Lacking

The scope of the World Trade Center disaster was such that trying to study the effect on direct victims was nearly impossible. It was estimated that roughly 160,000 persons were directly affected by the collapse of the WTC complex—including people who died, people who were evacuated from the towers, people who were physically present on the streets below, rescue workers, and the families of each of these.

North and others knew early on that the victims of the disaster would be at extremely high risk of developing posttraumatic disorders. Yet quantifying those disorders would be an overwhelming task.

“In Oklahoma City, we did full diagnostic interviews on a very small population, relative to the number of direct victims in New York City,” North said. “Yet it took us months to complete structured clinical interviews. It was a cumbersome, labor-intensive process that was logistically very difficult.” In addition, she said, it takes time and money.

North was not the only one thinking of studying the WTC victims in those early days. Researchers at Cornell University, Columbia University, New York State Psychiatric Institute, Disaster Psychiatry Outreach, and the New York Academy of Medicine all floated grant proposals, as did several others throughout the country. Only a few have published the results of their efforts, in part because some of the research is still under way. Many have not published any data, because they were significantly

Predictors of More Severe Stress?

In some of the published studies of reactions to 9/11 events, certain symptoms appear to be more suggestive than others of a greater degree of functional impairment and the development of threshold PTSD, some experts maintain. These limited findings echo previous research on trauma victims, including those in Oklahoma City following the 1995 bombing of the Alfred P. Murrah Federal Building.

Criterion C for PTSD in the *DSM-IV-TR* includes “persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness,” as displayed by a number of different presentations. Carol North, M.D., a professor of psychiatry at Washington University in St. Louis, told *Psychiatric News* that her work in Oklahoma City with direct victims of the bombing showed that avoidance and numbing symptoms that appeared soon after the event were highly predictive of developing full PTSD in the following months.

North believes it might be possible to identify trauma victims who may be at higher risk of developing PTSD by looking for early presentation of criterion C symptoms. These individuals could be followed more closely and offered earlier intervention, if necessary.

John Markowitz, M.D., an associate professor of psychiatry at Cornell University Medical College, agreed. “Criterion C is how you handle or process the event,” he told *Psychiatric News*. “Either you handle it or you don’t. And if you can’t process it, then maybe you end up with PTSD.”

Roxanne Cohen Silver, Ph.D., a professor of psychology and behavioral sciences at the University of California at Irvine, has studied responses to traumatic events for more than 20 years and believes that the criterion C symptom group may indeed help identify persons who are going to have more difficulty as time goes on following a trauma. “Criterion C relates to function,” she told *Psychiatric News*. “I’ve seen it across other data sets; ruminations and rethinking of the events don’t necessarily impair functioning, but the group C symptoms do suggest dysfunction. Day-to-day function should be the key to who might require intervention.”

delayed in their efforts or never got the study approved. Others had difficulty getting grant or institutional review board approvals.

“I ended up doing the research with my own money,” said Lynn DiLisi, M.D., a professor of psychiatry at New York University and principal investigator of a study by Disaster Psychiatry Outreach, a New York nonprofit foundation. DiLisi’s results have just recently been accepted for journal publication. DiLisi, North, and others applied to the National Institute of Mental Health for rapid grant approval; however, each was turned down, with indications that the institute did not believe the studies proposed were feasible—largely for the same reasons cited by North.

What Does It All Mean?

Randall Marshall, M.D., the director of trauma studies at the New York State Psychiatric Institute and a professor of psychiatry at Columbia University, noted that in the diagnosis and treatment of PTSD “there’s always been this sort of fuzzy boundary between a really normative reaction to an empirical trauma and the emergence of chronic PTSD. It really is not at all clear where you draw the boundary, and I am not sure we’ll ever get it clear.”

In a sense, though, said DiLisi, the data that were collected “back up what we already thought—that there is a very large group of people who suffered early, acute stress reactions, which by four to six months were resolving.”

North calls these responses or reactions “distress or subdiagnostic distress, which is perfectly normative.” She said that data from the directly affected victims her team interviewed in Oklahoma City bear this out. “And it serves to separate the responses from psychopathology. Otherwise, we can inadvertently trivialize the experiences and disorders of directly exposed people with PTSD.”

Studies Present ‘Snapshots’

“Most of the studies published thus far have been snapshots of acute responses,” said Roxanne Cohen Silver, Ph.D., a professor of psychology and behavioral sciences at the University of California at Irvine. Sil-

ver strongly agrees with North, noting that in her post-9/11 report, she did not use the term “PTSD.”

“I do believe that it really depends upon what your discipline is. An epidemiologist is very likely to report on numbers of specific diagnoses,” Silver noted. She believes the reactions reported in the studies to date simply represent the vast range of coping and resolution mechanisms inherent in humans, and as such, she said, they are normal.

Interestingly, though, regardless of the researchers’ background and experience, experts also agreed that the studies provide data on one very important clinical question—whether any specific reaction or response is more predictive of more severe stress and potential development of PTSD (see box above).

Locating Appropriate Treatment

So what have we learned?

“My interpretation is,” said North, “that after a disaster, we need to subdivide the population into who is psychiatrically ill and who is subdiagnostically stressed, and then use that distinction to direct people to the appropriate kind of treatment.”

North is still planning to study the direct victims of the WTC collapse to see whether she can obtain data to compare their longitudinal course with that of the direct victims of Oklahoma City.

“I’d like to see research focus on therapeutics and interventions at this point,” noted Marshall. Although it’s important to follow the levels of symptoms over time, he said, the whole point of the epidemiological research is to steer and direct therapeutic interventions accordingly.

DiLisi agreed and noted that research on early interventions could be pivotal. “The question is, Do you give them medications very early on and, if so, what medication? Or do you treat them with one sort or another of talk therapy? There’s really nothing in the literature yet on early intervention. We need that. It’s important to know, if there’s another disaster, how you mobilize your mental health resources. And we’ll always wonder if there was something different we could have done to minimize the impact of 9/11, so long after the event.” ■

Where to Find Studies

The following research articles on the mental health effects of the September 11 terrorist attacks, discussed in this *Psychiatric News* series, are posted on the Web.

- **“Psychological Sequelae of the September 11 Terrorist Attacks in New York City”:** <http://content.nejm.org/cgi/content/abstract/346/13/982>
- **“Mental Health Needs in New York State Following the September 11 Attacks”:** <http://jurban.oupjournals.org/cgi/content/abstract/79/3/322>
- **“Effects of the World Trade Center Attack on NYC Public School Students”:** www.nycenet.edu/offices/spss/wtcneeds/firstrep.pdf
- **“Psychological Reactions to Terrorist Attacks”:** <http://jama.ama-assn.org/issues/v288n5/abs/joc20110.html>
- **“A National Survey of Stress Reactions After the September 11, 2001, Terrorist Attacks”:** <http://content.nejm.org/cgi/content/abstract/345/20/1507>
- **“Nationwide Longitudinal Study of Psychological Responses to September 11”:** <http://jama.ama-assn.org/issues/v288n10/abs/joc21181.html>
- **“Determinants of Counseling for Children in Manhattan After the September 11 Attacks”:** <http://ps.psychiatryonline.org/cgi/content/abstract/53/7/815>

ODYSSEY SURMONTIL P4C

Will-to-Live Profile Helps Tailor Cancer Patients' Care

The will to live varies considerably among terminal cancer patients, and patients tend to fit one of five different psychological profiles, a new study reveals.

BY JOAN AREHART-TREICHEL

“Living with death looking over my shoulder is a new experience,” a terminal cancer patient commented recently. But how does having “death looking over your shoulder” affect a terminal cancer patient’s will to live?

The answer is that it varies, with patients reacting in one of five different ways, a study

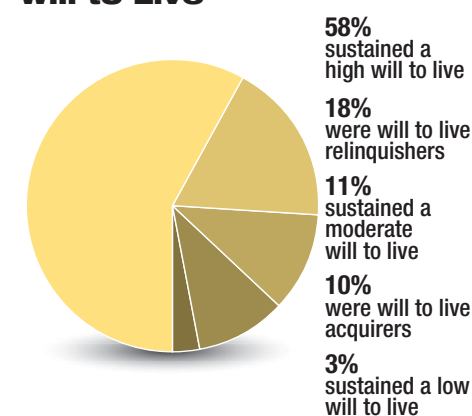
reported in the October *Psychosomatics* suggests.

The study was conducted by Harvey Chochinov, M.D., Ph.D., a professor of psychiatry and family medicine at the University of Manitoba in Winnipeg, Canada, and Douglas Tataryn, Ph.D. As William Breitbart, M.D., chief of the psychiatry service at Memorial Sloan-Kettering Cancer Center in New York City, told *Psychiatric*

News, the study is valuable because it deals with a subject that has not been addressed by psychiatric palliative care researchers, including himself.

Chochinov and Tataryn recruited subjects from patients newly admitted to the Riverview Palliative Care Unit in Winnipeg. All patients admitted to the unit at this time had a primary diagnosis of terminal cancer, notably terminal cancer of the lung or digestive systems. After admission, each patient was given 24 to 48 hours to adjust to the ward routine before being approached for the study. The patient’s medical status was then reviewed with the ward staff, and patients who were too cognitively impaired, weak, or ill to participate in the study were not approached. Also, not all of the patients asked to participate in the study wanted to participate. The researchers ultimately got 168 subjects, ranging in age from 31 to 89 years.

Terminal Cancer Patients' Will to Live



Source: Harvey Chochinov, M.D., Ph.D., and Douglas Tataryn, Ph.D., *Psychosomatics*, October 2002

Twice daily until the end of their stay on the unit, the subjects took the Edmonton Symptom Assessment System, a self-report instrument consisting of a series of visual scales designed specifically for use with palliative patient populations. The average stay was 22 days. The scales assess pain, anxiety, depression, a sense of well-being, shortness of breath, nausea, activity, drowsiness, and appetite. For this study, an additional will-to-live visual scale was added.

The investigators then statistically analyzed the data to ascertain the pattern of each subject’s will to live over time. They found that the subjects fit one of five different will-to-live trajectory profiles. Ninety-five (58 percent) of the subjects had sustained a high will to live; 29 (18 percent) were will-to-live relinquishers; 19 (11 percent) had a sustained moderate will to live; 16 (10 percent) were will-to-live acquirers; and five (3 percent) had a sustained low will to live.

Chochinov and Tataryn also determined the extent to which membership in each of the five will-to-live profiles could be explained by initial symptom characteristics and patient demographic variables. For instance, subjects with sustained high will to live had the lowest levels of anxiety, were more likely to be religious, and had the lowest prevalence of colon cancer. Subjects who acquired will to live over their hospital course had the highest prevalence of colon cancer, were admitted with the highest levels of nausea, were most likely to be living with a partner, and were most likely not to be religious. Subjects with sustained low will to live had the highest levels of anxiety—more than three times that of the group with sustained high will to live; the highest levels of shortness of breath (about three times that of the other groups); and the lowest rate of living with a partner.

Some of these discoveries, Chochinov explained to *Psychiatric News*, should help both psychiatrists and family physicians “improve the quality of palliative care provided to patients approaching death.”

For instance, the fact that subjects with sustained high will to live had low levels of anxiety and tended to be religious suggests that finding ways to control anxiety and to provide spiritual support might be valuable components of high-quality end-of-life care for terminal cancer patients. Since the will-to-live acquirers had the highest prevalence of colon cancer and the highest level of nausea upon being admitted to the palliative unit, it suggests that even for those nearing death, pharmacological relief of nausea might very well help patients reestablish a will to live.

please see Will to Live on page 26

they determined how many subjects in each succumbed to either acute stress disorders or PTSD. This way they could see how the repressive-coping types compared with the other three types.

They found that 31 percent of their subjects were anxiety types, 26 percent were defensive types, 25 percent were successful anxiety-repression types, and 17 percent were low-anxiety types.

They found that 36 percent of the anxiety types, 21 percent of the defensive types, 4 percent of the successful anxiety-repression types, and none of the low-anxiety types experienced acute stress disorder.

They found that 19 percent of the anxiety types, 17 percent of the failed anxiety-repression types, 7 percent of the successful anxiety-repression types, and 20 percent of the low-anxiety types experienced PTSD.

When *Psychiatric News* asked Ginzburg whether there might be a contradiction between their finding that no low-anxiety subjects experienced acute stress disorder and their finding that 20 percent of them experienced PTSD, she replied that there was not. The reason, she explained, is that other researchers have found that levels of anxiety experienced immediately after a stressful event are only marginally predictive of whether a person will ultimately experience PTSD.

So, putting all these findings together, they suggest that “the repressive coping style may promote adjustment to traumatic stress, both in the short and longer term,” Ginzburg and her coworkers concluded. In other words, this coping style appeared to be superior to both anxiety and defensiveness in preventing acute stress disorder, and superior to anxiety, defensiveness, and low anxiety in preventing PTSD.

The findings are useful to psychiatrists, Bleich told *Psychiatric News*, in that they “promote knowledge of the possible psychiatric consequences of myocardial infarction and suggest a direction for early intervention and therapy when needed.”

The study was financed by the Israeli Ministry of Health and the Sarah Peleg Research Foundation.

The study, “Repressive Coping Style, Acute Stress Disorder, and Posttraumatic Stress Disorder After Myocardial Infarction,” is posted on the Web at <www.psychosomaticmedicine.org/cgi/content/full/64/5/748>. ■

Adjustment to Trauma-Related Stress Helped by Repressive Coping Style

Those who repress their anxiety seem to be better shielded against heart attacks and PTSD than those who experience anxiety or try to repress it but fail.

BY JOAN AREHART-TREICHEL

Ever since the 1970s, certain people have been known to be anxiety repressors. That is, their heart rate, blood pressure, muscle tone, and other physiological measures reveal that they experience anxiety, yet they manage to repress conscious thoughts about their anxiety.

What's more, persons who have had heart attacks are known to be in danger of both acute stress disorder and posttraumatic stress disorder (PTSD).

Thus, some Israeli researchers decided to conduct a study to find out how good an anxiety-repression coping style is at shielding patients from acute stress disorder and

from PTSD. As they reported in the September/October *Psychosomatic Medicine*, the coping style seems to be effective.

Karni Ginzburg, Ph.D., a lecturer at Tel Aviv University School of Social Work; Zahava Solomon, Ph.D., a professor there; and Avi Bleich, M.D., chair of psychiatry, selected as their subjects more than 100 patients who had been hospitalized for a heart attack. While the subjects were hospitalized, they filled out a 58-item psychological questionnaire to reveal whether they were anxiety types (persons who feel anxious when threatened with dangerous situations), defensive types (individuals who try to repress their

anxiety but fail), successful anxiety-repression types (individuals who tend to repress their anxiety and succeed at it), or low-anxiety types (persons who experience little anxiety when faced with threatening situations).

While in the hospital, the subjects were also assessed with the Stanford Acute Stress Reaction Questionnaire, which is based on *DSM-IV* criteria, to determine whether they were suffering from acute stress disorder. Seven months later, they were evaluated at home with the PTSD Inventory, a self-report questionnaire based on *DSM-IV* criteria, to determine whether they had PTSD.

As Ginzburg explained to *Psychiatric News*, clinical interviews are definitely preferred when a diagnosis of PTSD is made for clinical purposes. However, for their study purposes, they believed that their standardized self-report questionnaire was superior, not just because it was easier to administer, but because it had both high validity and high specificity.

After Ginzberg and her coworkers analyzed their data to categorize their subjects in one of the four stress-reaction groups,



COMPILED BY JIM ROSACK

Regulatory Briefs

• The Food and Drug Administration granted final marketing approval to Reckitt Benckiser to distribute Subutex (buprenorphine HCl) and Suboxone (buprenorphine HCl/naloxone HCl) for the treatment of opioid dependence. Under the Drug Addiction Treatment Act of 2000, prescription of either medication is limited to physicians who have met certain qualifying and registration requirements. Buprenorphine is classified as a Schedule III narcotic under the Controlled Substances Act.

• The Office of the Inspector General of the Department of Health and Human Services filed notice on October 3 in the *Federal Register* of its "Draft OIG Compliance Program Guidance for Pharmaceutical Manufacturers." The notice of the draft guidance also calls for public comment before December 2. Under the new guidance, the government warned drug companies that they must not offer financial incentives or "other tangible benefits" to doctors, pharmacists, or other health care professionals to prescribe or recommend any particular drug or to switch patients from one medication to another. IG Janet Rehnquist indicated that many common practices used in marketing and sales of prescription drugs "could run afoul of federal fraud and abuse laws." The draft guidance is posted on the Web at <www.seniors.gov/articles/1002/draft-pharma-guide.htm>.

• Generic manufacturer Barr Laboratories was successful in its court fight against Shire over the ADHD medication Adderall. Barr

had sued after Shire invoked its right to block automatic approval of Barr's application to market a generic version of the mixed amphetamine salts preparation. The court agreed with Barr that Shire's patent had expired, and subsequently the FDA approved Barr's application to market the generic.

• Overseas, the Irish Medicines Board on October 16 ordered GlaxoSmithKline to recall all stocks of Seroxat (the EU brand of paroxetine) released to wholesalers because the patient leaflet for the Irish market fails to warn about possible suicidal behavior. The company had worked with the board to change the wording in the leaflets at the end of 2001 and added new wording saying, "Suicidal thoughts may increase in the first few weeks of treatment." The board said that's not good enough. Regulators want stronger wording "to include a reference to suicidal behavior and depression," the board said in a statement.

Industry Briefs

• Citing IMS Health's National Prescription Audit data, Wyeth Pharmaceuticals said last month that its combined serotonin/norepinephrine reuptake inhibitor, Effexor (venlafaxine), is now the fastest-growing product in the \$13 billion U.S. antidepressant market. The reason for the surge in sales, the company asserted in a press release, is the result of a new analysis of pooled data that the company said concludes that Effexor was more effective than Lilly's Prozac (fluoxetine), GlaxoSmithKline's Paxil (paroxetine), and Solvay's Luvox (fluvoxamine) in an eight-week study of achieving remission with antidepressant therapy.

• A company-funded study presented at the European Stanley Foundation Conference on Bipolar Disorder in Freiburg, Germany, in mid-September examined the use of AstraZeneca's Seroquel (quetiapine) as an adjunctive medication to mood stabilizers in the treatment of acute mania. The study suggests that the atypical antipsychotic is safe and effective in reducing symptoms of acute mania and the psychotic symptoms that sometimes accompany it. Nearly twice as many patients treated with Seroquel saw full resolution of their symptoms (based on Young Mania Rating Scale scores) than patients who received placebo. Typical side effects of Seroquel, including somnolence, headache, and dry mouth, were noted in this study.

• A company-funded multicenter clinical trial of 248 children between the ages of 6 and 13 with ADHD indicates that Cephalon's Provigil (modafinil) significantly improved symptoms on the teacher-completed school version of the ADHD Rating Scale IV. The greatest significance was seen with a dose of 300 mg once a day. The side effects were consistent with Provigil's current labeling, with insomnia being the most frequently reported.

• Psychiatric Genomics, a Gaithersburg, Md., company specializing in the development of small-molecule drugs for treatment of mental illness, announced last month a collaborative agreement with the National Institute of Psychiatry and Neurology in Budapest, Hungary. The agreement allows company researchers to use the institute's collection of central nervous system tissue

from both normal controls and people diagnosed with mental illness.

• Forest Laboratories announced late last month that it was pulling its application for approval of memantine for the treatment of moderate-to-severe Alzheimer's disease. The company, which had filed the application July 31, will refile incorporating new clinical trials data (reported in this column last month) indicating that memantine is a safe and effective adjunct treatment to existing treatment with Pfizer's Aricept (donepezil). The company hopes to refile the application by the end of the year.

• In a similar move, Johnson and Johnson's Ortho-McNeil division, according to *IMS Health*, has delayed its long-awaited application to market Topamax (topiramate) for acute mania. The company is said to be awaiting analysis of very recently completed clinical trials for inclusion in the application.

Research Briefs

• Olanzapine (Lilly's Zyprexa) was significantly superior to haloperidol in reducing negative symptoms in elderly patients with chronic schizophrenia during an acute exacerbation, according to a small Israeli study (20 patients). PANSS total score decreased (that is, showed improvement) from 84 at baseline to 65 after six weeks of treatment with olanzapine, but decreased only from 79 to 74 with haloperidol. PANSS negative scores decreased from 19 at baseline to 15 on olanzapine, but increased (worsened) from 18 to 20 on haloperidol. CGI scores decreased with both medications; however, olanzapine was associated with a significantly greater reduction (improvement). Both groups of subjects experienced roughly equal weight gain.

(*Prog NeuroPsychopharmacol and Biol Psychiatry* 2002; 26:1199-1202)

• Low-dose risperidone (Janssen's Risperdal) at 2 mg a day is effective in significantly reducing both positive and negative symptoms by eight weeks in acutely psychotic, neuroleptic-naïve patients with a first episode of a psychotic disorder. Although efficacy—measured with the Brief Psychiatric Rating Scale and the CGI, among other scales—was not significantly different between doses of 2 mg and 4 mg, the lower dose was associated with significantly lower levels of motor dysfunction.

(*J Clin Psychiatry* 2002; 63:885-891)

• Quetiapine appears to hold promise in reducing psychotic behavior in patients with Alzheimer's disease while not causing a deterioration in cognitive function, according to a new study from Ohio State University researchers. In the 12-week study, patients were given doses of 50 mg to 150 mg and assessed using the ADAS-Cog and NPI. Patients receiving quetiapine showed significant decreases in delusions and aggression based on NPI scores. ADAS-Cog scores showed no statistically significant change over the 12 weeks.

(*Alzheimer Dis Assoc Disord* 2002; 16:128-130)

• In a separate study of 30 adolescents with mania or mixed bipolar I disorder, adding quetiapine to existing divalproex treatment was associated with a statistically significant improvement in scores on the Young Mania Rating Scale (YMRS) compared with divalproex alone. Eighty-seven percent of

patients taking the combination experienced a 50 percent or greater reduction in their YMRS score, compared with 53 percent of those taking divalproex plus placebo. No significant difference was seen in baseline to endpoint in safety measures, although sedation (rated as mild to moderate) was significantly more common in patients taking the combination.

(*J Am Acad Child Adolesc Psychiatry* 2002; 41:1216-1223)

• Treating generalized anxiety disorder (GAD) with medication lowers the risk of developing comorbid depression, according to an analysis of data from the National Comorbidity Survey. Among the nearly 8,100 individuals studied, however, there was no significant association between either having seen a mental health professional for GAD or having received a prescription for an anxiolytic and lower risk of depression. Only patients who took the medication had a lower risk of major depression.

(*Am J Psychiatry* 2002; 159:1935-1937)

• Exposure to tricyclic antidepressants or fluoxetine during fetal development does not appear to be associated with adverse effects in a child's global, IQ, or language development or temperament among children in preschool and in the first to third grades. In contrast, a mother's depression is associated with less cognitive and language achievement by her children. As a result, the study's authors concluded, adequate antidepressant therapy should be initiated and maintained during pregnancy and postpartum.

(*Am J Psychiatry* 2002; 159:1889-1895) ■

clinical & research news**Will to Live**

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Other of their findings, Chochinov and Tataryn pointed out in their report, may be relevant to the controversy over physician-assisted suicide. For instance, previous studies suggested that patients who wanted to end their lives through physician-assisted suicide suffered considerably from anxiety and lack of social support, like the sustained low will-to-live subjects. Thus, one way to help such patients might be to alleviate their anxiety and bolster their social support, Chochinov and Tataryn believe.

Some of the study's results also imply that the will to live might influence survival in terminal cancer patients. Specifically, those with a sustained moderate will to live lived longest, on average 190 days after being admitted to the unit, and those with a sustained low will to live died soonest, on average 28 days after being admitted to the unit. However, as Chochinov explained to *Psychiatric News*, these findings should be treated with extreme caution as he and Tataryn did not set out to study survival and as they did not control for variables that might have influenced survival.

The study was funded by the National Cancer Institute of Canada, the Canadian Cancer Society, and the Project on Death in America of the Open Society Institute.

The study, "Predicting the Trajectory of Will to Live in Terminally Ill Patients," is posted on the Web at <<http://psy.psychiatryonline.org/cgi/content/full/43/5/370>>. ■

PFIZER ARICEPT P4C

Agony of Ecstasy Includes Extensive Neural Damage

Just one night of Ecstasy use may destroy the endings of serotonergic neurons and especially of dopaminergic neurons, a new study implies. Researchers are afraid that this damage might open Ecstasy users to Parkinson's later in life.

BY JOAN AREHART-TREICHEL

The illegal drug Ecstasy heightens sensations, gives a euphoric rush, reduces anxiety, and increases sensitivity to others. So it's no wonder that so many American youth are enamored of it.

But the price they are paying for even one "Ecstatic" night might be high, a new

nonhuman primate study suggests. The price is substantial damage to brain neurons that use either the neurotransmitter serotonin or the neurotransmitter dopamine, especially the latter.

The study was conducted by George Ricaurte, M.D., an associate professor of neurology at Johns Hopkins University School of Medicine, and colleagues. Results from

the study appeared in the September 27 *Science*.

Ricaurte and his colleagues wanted to evaluate the neurotoxic potential of Ecstasy (officially known as 3,4-methylenedioxymethamphetamine, or MDMA) when it is consumed at a typical all-night Ecstasy party. So they injected five squirrel monkeys with an Ecstasy dosage of 2 mg/kg three different times at three-hour intervals, for a total dose of 6 mg/kg.

Three of the five monkeys tolerated the drug without any apparent difficulty. The fourth monkey became less mobile and had an unstable, tentative gait after the second dose and therefore was not given the third planned dose. The fifth monkey developed hyperthermia—one of the main side effects of Ecstasy—and died within hours of receiving the last dose of the drug.

Two weeks later, the brains of the three

monkeys that had received Ecstasy were then compared with the brains of the three control monkeys to determine what effects Ecstasy had had on the former. The Ecstasy-exposed brains were found to have a reduction in axons of neurons that use the neurotransmitter serotonin, as well as a reduction in axons of neurons that use the neurotransmitter dopamine. Axon reduction in dopaminergic neurons was especially noticeable.

The researchers then repeated their experiment on baboons to see whether their

"Clearly, the implications of these findings. . . should serve as a warning to those thinking about using Ecstasy."

findings were unique to squirrel monkeys. They were not, they found. Again Ecstasy produced extensive loss of axons in both serotonergic neurons and dopaminergic neurons, especially the latter.

"These findings suggest that humans who use repeated doses of MDMA over several hours are at high risk for incurring severe brain dopaminergic neural injury (along with significant serotonergic neurotoxicity)," the investigators concluded in their study report. "This injury, together with the decline in dopaminergic function known to occur with age, may put these individuals at increased risk for developing Parkinsonism and other neuropsychiatric diseases involving brain dopamine/serotonin deficiency, either as young adults or later in life."

Glen Hanson, Ph.D., D.D.S., acting director of the National Institute on Drug Abuse, was quoted in a Johns Hopkins press release as saying, "Clearly, the implications of these findings are cause for concern and should serve as a warning to those thinking about using Ecstasy."

Some other scientists have also conducted nonhuman primate studies to explore the impact of Ecstasy on the brain. They too found damage to neurons that use serotonin, but not to neurons that use dopamine. The reason they did not find any damage to dopaminergic neurons, Ricaurte and his team believe, may be because those researchers followed a more spaced-out dosing schedule than they had.

The study was funded by U.S. Public Health Service grants.

The study, "Severe Dopaminergic Neurotoxicity in Primates After a Common Recreational Dose Regimen of MDMA ('Ecstasy')," is posted on the Web at <www.sciencemag.org/cgi/content/full/297/5590/2260>. ■

Study Measures Therapy Use Under Managed Care

Although managed care increased dramatically between 1987 and 1997, the overall rate of outpatient psychotherapy use in the United States did not decrease during this decade, a new study reveals.

BY JOAN AREHART-TREICHEL

As usage of managed behavioral health care has risen in recent years, many may assume that outpatient psychotherapy may be endangered as a psychiatric treatment option.

The situation, however, may not be as grim as it seems, according to a study of mental health care data collected in 1987 and in 1997.

The study, published in the November *American Journal of Psychiatry*, found no marked change in the overall rate of outpatient psychotherapy use in the United States from 1987 to 1997, even though that decade saw a dramatic expansion in managed behavioral health care. Further, more economically disadvantaged Americans appear to have had access to outpatient psychotherapy in 1997 than in 1987.

The encouraging news comes from Mark Olfson, M.D., an associate professor of clinical psychiatry at Columbia University College of Physicians and Surgeons; Steven Marcus, Ph.D., a research assistant professor in the School of Social Work at the University of Pennsylvania; Benjamin Druss, M.D., an associate professor of psychiatry and public health at Yale University School of Medicine; and Harold PinCUS, M.D., executive vice chair of psychiatry at the University of Pittsburgh School of Medicine and director of the RAND-University of Pittsburgh Health Institute.

In 1987 and again in 1997, the Agency for Healthcare Research and Quality conducted surveys to provide national estimates of the use of, expenditures for, and financing of health care services in the United States. Both were conducted with samples of the American civilian, noninstitutionalized population and were designed to provide nationally representative estimates. The first survey, the National Medical Expenditure Survey, was published in 1989; the second survey, the Medical Expenditure Panel Survey, was published in 2000.

Olfson and his colleagues used data from these two surveys to determine how outpatient psychotherapy use in 1997 compared with that in 1987. They found that there was no statistically significant change in the overall rate of outpatient psychotherapy use (3 per 100 persons in 1987 and 4 per 100 in 1997).

They also found a statistically significant increase in the use of outpatient psychotherapy by the unemployed and the poor in 1997 as compared with 1987—specifically, 5 per 100 unemployed persons in 1997 versus 3 in 1987, and 5 per 100 poor persons in 1997 versus 4 in 1987.

Olfson and his colleagues pinpointed another change in outpatient psychotherapy use between 1987 and 1997 that would generally be considered less favorable for psychotherapy: The use of long-term outpatient psychotherapy appears to have declined during this decade. Specifically, 16 percent of survey respondents reporting use of outpatient psychotherapy in 1987 said they received 20 visits or more, compared with only 10 percent of those reporting use

of outpatient psychotherapy in 1997—a highly significant statistical difference.

In contrast, the percentage of people getting fewer than 20 visits of outpatient psychotherapy annually seems to have been about the same in 1997 as in 1987. For instance, 37 percent of survey respondents reporting use of outpatient psychotherapy in 1987 said that they received three to 10 visits, compared with 40 percent of survey respondents in 1997—a difference that is not statistically significant.

Moreover, from 1987 to 1997 there was a marked increase in outpatient psychotherapy use provided by physicians. Specifically, only 48 percent of survey respondents getting outpatient psychotherapy in 1987 reported making one or more psychotherapy visits to a physician, compared with 65 percent of survey respondents in 1997.

In contrast, little change appears to have occurred between 1987 and 1997 in the proportion of psychotherapy provided by psychologists. Specifically, 32 percent of survey respondents receiving outpatient psychotherapy in 1987 reported making one or more psychotherapy visits to a psychologist, compared with 35 percent of survey respondents in 1997.

Thirteen percent of survey respondents who said they received outpatient psychotherapy in 1997 reported making one or more psychotherapy visits to a social worker. (However, this figure was somewhat higher than the 7 percent reported in 1987.)

The study was supported by a grant from the Robert Wood Johnson Foundation.

The study, “National Trends in the Use of Outpatient Psychotherapy,” is posted on the Web at <<http://ajp.psychiatryonline.org>> under the November issue. ■

Errata

- *Psychiatric News* regrets an error made in the October 4 cover story regarding incoming APA Medical Director James Scully, M.D. It was reported that Scully had served in Vietnam as a member of the Navy SEALs. This information was based on comments that third-party sources had made to *Psychiatric News* but were not confirmed with Scully. When Scully saw the error in the published issue, he immediately informed *Psychiatric News* about it. Scully never stated he was a navy SEAL or that he had served in Vietnam.

- “From the President” in the September 20 issue contained an error regarding the scope of the HIPAA medical privacy regulations. They apply only to entities (including individual practitioners) that transmit information for covered transactions electronically (or have others do it on their behalf), not to those that merely store or word process such information. We regret the error. ■

letters to the editor

A Variant of Bipolar Disorder?

The letter from Dr. John Sobor in the May 6 issue was like a breath of fresh air. I too feel compelled to respond to the subject of bipolar disorder in children and to the study by Dr. Barbara Geller, "Two-Year Prospective Follow-Up of Children With a Pre-pubertal and Early Adolescent Bipolar Disorder Phenotype," which was reported in the June 21 issue.

I have great respect for researchers and their efforts to expand our knowledge of psychiatry. Similarly, I respect the lessons derived from clinical experience. Over the course of nearly 30 years of clinical practice, I have evaluated and treated many children and adolescents like those now labeled "bipolar" by some psychiatrists. These children do not have bipolar disorder as it has been defined traditionally. They seem to have a disorder that does not fit into our existing diagnostic categories. Why, then, are we willing to treat them with medications that have serious side effects and do not improve their condition?

In my experience, behavioral interventions, appropriate environmental support, and, when clearly indicated, medication to treat specific symptoms have been the keys

to improvement for many of these children.

I should hope that as physicians we would not label children as young as 7 years old (sometimes even younger) with a serious, chronic mental health disorder when alternative explanations may well exist. Let us offer families hope, when we can, that their children may improve.

BARBARA FAVAZZA, M.D.
Columbia, Mo.

Understanding Risks

I would like to clarify some of the statements in the article "Studies Closing In on Diabetes, Psychiatric Illness Link," which appeared in the July 5 issue.

This article discusses the links between diabetes and atypical antipsychotics. In one section this article reports on diabetes alerts issued by Japanese and British regulatory agencies for olanzapine, as well as on a presentation of diabetes adverse reports compiled by a group from the FDA and me. An endocrinologist is then quoted as saying that when "patients and even physicians hear these kinds of reports, they just freak out" and that "only solid research will help answer the questions."

I would like to respond to these quotes because they may serve to cast doubt in the

readers' minds about the actions taken by regulatory agencies charged with public protection, as well as our research.

Society as a whole benefits from pharmaceutical drug discovery and refinement of older therapies with newer agents. Every drug that has beneficial effects also has side effects. By many accounts, atypical antipsychotic drugs are breakthrough treatments that have improved the lives of thousands of patients. So the real issue here is not about denying the benefits of these drugs but about understanding their risks with appropriate use to prevent unnecessary harm. The purpose of postmarketing surveillance reports and regulatory label changes is to alert consumers and professionals to adverse effect signals that have become more apparent since the drug was marketed and taken by several tens of thousands of real-world patients.

If one waited until causality was proven before publishing an adverse event report or issuing a public alert, then essentially we would have no adverse effects listed on any drug label at the time of its initial approval. Causality is impossible to prove in many situations for a variety of reasons, including the nature of registration trials and lack of long-term controlled trials in real-world samples.

Therefore, it is vital for all of us to treat regulatory actions and postmarketing ad-

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

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

verse event reports seriously. When a critical mass of certain adverse events or deaths emerges, the burden lies on the manufacturer to prove a drug does not cause this problem. The burden does not lie with patients, clinicians, or regulatory agencies to prove a drug is unsafe. One prospective naturalistic study has suggested that approximately 36 percent of patients taking clozapine over a five-year period may be diagnosed with diabetes (*Am J Psychiatry*, 2000; 157: 975-981), a rate of about 7 percent a year. This rate is several-fold higher than that reported by other studies with shorter drug-exposure periods. Currently, no one knows what the true rates of treatment-emergent diabetes are with any atypical *please see Letters on page 39*

ADHD

continued from page 1

tal Health Service Expansion Act (HR 5078) sponsored by Reps. Patrick Kennedy (D-R.I.) and Ileana Ros-Lehtinen (R-Fla.) that would encourage recruitment into all children's mental health professions.

"Finally, we fully support and appreciate the efforts of the current administration, through the New Freedom Commission on Mental Health, to focus increased attention on the diagnosis and treatment of all psychiatric conditions, including those that affect children and adolescents," Fassler said.

Positive Feedback Received

Fassler told *Psychiatric News* in a follow-up interview, "I received a lot of positive feedback from people around the country who read news articles about the hearing or saw my interview afterward with CNN. They appreciated that APA and the academy spoke out about what's known about the science of the disorder." The hearing clearly showed, he emphasized, "that we still have work to do in educating the public, including elected officials, that a lot of people are affected by psychiatric disorders and that the disorders are real and treatable."

Richard Nakamura, Ph.D., acting director of NIMH, testified that many studies "have established the safety and efficacy of stimulants and psychosocial treatments for alleviating the symptoms of ADHD. NIMH research has indicated that the two most effective treatment modalities for elementary schoolchildren with ADHD are closely monitored medication treatment and a treatment that combines medication with intensive behavioral interventions."

Also testifying was Clarke Ross, chief executive officer of CHADD, who stressed the importance of "the evidence-based assessment and treatment guidelines of the American Academy of Pediatrics and AACAP."

The guidelines emphasize the importance of multimodal treatment, which includes parental education on diagnosis,

treatment, and specific behavior management techniques; an appropriate educational program; individual and family counseling when needed; and medication when required, said Ross.

His son Andrew, now 11 years old, was diagnosed with ADHD at an early age, he noted. "Multimodal treatment as described in the guidelines including medication has provided. . .the support that Andrew needs in order to thrive and flourish."

Opposition Testifies

Lisa-Marie Presley, the daughter of Elvis Presley, testified on behalf of the Citizens Commission on Human Rights, affiliated with the Church of Scientology. She mentioned the "totally needless and tragic drugging of innocent children" and said that teenagers on powerful psychiatric drugs committed more than half of the recent teenage shooting sprees, resulting in 19 deaths and 51 wounded, according to her statement.

Mary Ann Block, D.O., an osteopathic physician from Texas, told the committee, "There is no valid test for ADHD. The diagnosis is completely subjective. While some compare ADHD to diabetes, there is no comparison because ADHD cannot be objectively measured, and amphetamines are not made by the body or needed for life."

Patricia Weathers, a mother from New York state, testified that school officials coerced her into putting her son Michael on Ritalin, which along with an antidepressant had "horrendous side effects," according to her statement.

Weathers maintained that the school expelled her son when she stopped giving him drugs and called child protective services charging her and her husband with medical neglect. This charge that was later ruled unfounded, she said.

Weathers has filed a lawsuit against the school system. Her complaint is that she was not told about the controversy surrounding the disorder including the validity of ADHD tests, warnings about medication side effects, and studies showing that

States Remove Schools From ADHD Fray

Virginia and Illinois recently enacted legislation to prohibit teachers in public schools from recommending that students be given psychotropic drugs.

Similar to the Connecticut law that went into effect last year (*Psychiatric News*, August 17, 2001) the Virginia and Illinois laws enacted in April and July, respectively, restrict the role of school health staff, educators, and administrators to recommending that a student be evaluated by an appropriate medical practitioner. School personnel, in addition, must obtain the written consent of the student's parent or guardian before consulting with the practitioner, according to the laws. Additional provisions in the Illinois law require that each school board adopt and implement a policy that a student cannot be disciplined because the parent or guardian refused to administer or consent to the administration of psychotropic medications, according to the law (PL 92-663).

Each school board's policy must also require that at least once every two years certified school personnel and administrators are trained in current best practices on the identification and treatment of attention deficit disorder and attention-deficit/hyperactivity disorder (ADHD), the application of "nonaversive" behavioral interventions in the school environment, and the use of psychotropic medication for school-age children, according to the law.

Clarke Ross, chief executive officer of Children and Adults with ADHD (CHADD), told *Psychiatric News*, "We support this type of legislation that requires parents be informed and consent to evaluations and the use of psychotropic medications. This may encourage more appropriate communication between teachers, parents, and medical practitioners."

Ross added that CHADD supports the Illinois provisions with a few caveats. "We believe the current best practices are the guidelines developed by the American Academy of Pediatrics and the American Academy of Child and Adolescent Psychiatry that recommend multimodal treatment. We don't want to see school boards develop policies that require that medication be used only as a last resort," said Ross.

At least 25 states have introduced bills, regulations, or resolutions in the last few years to limit the use of psychotropic medications in school children, according to Ross.

"Other than the Connecticut bill, legislation enacted last year focused on requiring state agencies or commissions to study the use of psychotropic medications or develop standards for their administration to youth," said Ross.

A summary of related state legislative actions as of February 2002 and CHADD's legislative position can be accessed on the CHADD Web site at <www.chadd.org> by clicking on "Press Releases 2002."

Ritalin can lead to substance abuse, according to her statement.

Bruce Wiseman testified that numerous states have introduced or passed legislation or regulations to limit the use of psychotropic medications by children (see box). He recommended that the House committee develop federal legislation to prohibit schools from making medication of children a condition of staying in school, protect parents from losing child custody if they refuse to medicate their

child, and require that parents be informed about alternatives to psychotropic drugs.

Burton responded that such legislation is beyond the scope of Congress. The No Child Left Behind Act of 2001 (PL 107-110) prohibits federal officials and employees from interfering with state and local education issues.

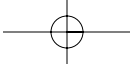
Fassler's testimony is posted on the APA Web site <www.psych.org/pub_pol_adv/adhd_testimony92602.cfm>. ■

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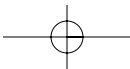
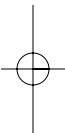
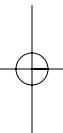
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Magellan

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In that case, the banks would have the right to accelerate debt maturity. If Magellan could not receive a waiver from that acceleration, “the company would not have the liquidity necessary to repay debt.”

According to the press release, Magellan was continuing negotiations with Aetna, its largest customer, regarding renewal of its contract on January 1, 2004.

In a press release dated October 8, Magellan announced that it had been notified by the New York Stock Exchange that its stock price and market capitalization were not sufficient for continued listing. At the time of the announcement, Magellan had a capitalization of \$5.3 million, well below the required \$15 million for listing.

In October 2001 the stock had traded as high as \$12.58, according to the Dow Jones Newswires. Immediately before being delisted, the stock was selling at \$.28 a share. As of October 16, it was selling at \$.03 a share.

The October 14 *Washington Post* article quoted a Standard and Poor’s analyst as saying that the current financing structure needs to be addressed because it is saddling the company with too much debt.

According to the *Post*, another analyst predicted that if Aetna does not renew its contract, Magellan would be forced to file for Chapter 11 bankruptcy.

According to Magellan’s Web site, the company serves more than 70 million members and is responsible for 32.5 percent of all behavioral health care and employee assistance program enrollees.

Related information is posted on Magellan’s Web site at <www.magellanhealth.com/corporate/spotlight/index.html>. ■

letters to the editor

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antipsychotic, and causality is not proven. However, if a drug with a million patient-years of exposure were to precipitate diabetes at a rate of 3 percent to 7 percent a year, then there would be an estimated 30,000-70,000 cases of treatment-emergent diabetes mellitus. Because atypical antipsychotics will be taken by millions of individuals for decades, large pragmatic trials conducted by neutral parties to address causality and relative risk differences are essential.

In the interim, I urge readers to educate themselves fully by relying on neutral sources of information and monitor their patients’ well-being.

(Disclosure: I have received research grants and consulting honoraria from Lilly, Janssen, and the manufacturers of all atypical antipsychotics and have been a member of Lilly’s Zyprexa Diabetes Advisory panel.)

P. MURALI DORAISWAMY, M.B.B.S.
Durham, N.C.

Psychologists

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psychologists, through their political action committee and personal contacts with legislators, seem to have garnered majority support for the bill.”

The bill had been vigorously opposed by the California Psychiatric Association and the California Medical Association, among others. The medical association told legislators that the bill “dangerously increases the scope of practice of psychologists” and that decisions about whether a potentially dangerous mentally ill person is released must be made in light of the individual’s entire medical condition.

The bill had the backing of a coalition of state psychologist groups and the California Mental Health Directors Association, which maintains that such a law would improve the efficiency of an often cumbersome public mental health system.

Rappaport said that he doubted that the lawmakers considering this bill had grasped

the serious quality-of-care issues that would be incurred by such a law. “For example, since there are many underlying physical and medical problems that can cause or contribute to serious mental impairment,” he emphasized, where and when will psychologists gain the medical training to conduct “an adequate medical examination to identify important medical problems before a patient is discharged?”

He has no doubt that this bill “is part of the strategy of psychologists to be able to practice medicine by ultimately getting prescriptive authority.”

The California Psychiatric Association, Rappaport noted, “is launching a drive aimed at both member and nonmember psychiatrists to raise funds to support an education program for the public and legislators that will provide information” about why the proposal is unwise from the standpoints of public safety and quality of care. This is in preparation for the bill’s likely reappearance in the next legislative session. ■



James Scully, M.D.: “The struggle over parity is the story of triumph of science over stigma and ignorance. This discrimination must stop.”



Herbert Pardes, M.D.: “. . . [R]esearch funding transforms people’s lives, gives us ways to overcome mental illness, and returns patients to full functioning.”

Capitol Hill

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discriminatory and limited coverage for those with mental illness.”

He explained what parity legislation would and wouldn’t do. Both the House Mental Health Equitable Treatment Act (HR 4066) and the companion bill in the Senate (S 543) would leave medical-necessity determinations up to the health plan and give employers and insurance companies wide latitude in benefit design and management of services delivered.

“These and similar bills are not mandates but should be properly viewed as coverage conditions,” said Scully.

He also addressed the argument by opponents that parity for all mental disorders codified in *DSM-IV* is too broad. “NIH’s and NIMH’s research applications, FDA treatment indications for new products, and legal determinations of competence to stand trial are all predicated on widely accepted *DSM* criteria,” said Scully.

“The struggle over parity is the story of triumph of science over stigma and ignorance. This discrimination must stop,” he emphasized.

Sen. Paul Wellstone (D-Minn.), cosponsor with Sen. Pete Domenici (R-N.M.) of the Senate-passed parity bill, emphatically agreed. Wellstone called on President George W. Bush to live up to his promise of working with Congress to see that parity gets passed this year.

The House parity bill has languished due to opposition by key Republicans.

Rep. Rush Holt (D-N.J.), whose son is a psychiatrist and wife is an internist, said, “It doesn’t make sense to train upcoming physicians to treat the whole person, as my wife does, and not have health care coverage for one in five people with mental disorders.”

Holt and his colleagues in the House, including Reps. Gary Miller (R-Calif.), Connie Morella (R-Md.), and Howard Coble (R-N.C.), praised APA and NAMI for their efforts to push parity forward and vowed to continue to fight for parity legislation on Capitol Hill.

APA President Paul Appelbaum, M.D., also took the opportunity to praise the editorial board of the *Washington Post* for its advocacy of parity in a September 9 editorial (*Psychiatric News*, October 4). “The arguments about cost, poor timing, and parity being too broad didn’t hold water.”

Appelbaum presented a Special Commendation award to Rep. Marge Roukema (R-N.J.) (see box on page 6) for her “extraordinary leadership and tireless personal dedication to improving the lives of people with mental illness.”

Herbert Pardes, M.D., president and CEO of New York Presbyterian Hospital and symposium moderator, described the revolution in research and treatment of mental illness. “When people ask me what the

federal government, in particular the National Institute of Mental Health, does for us, I tell them that research funding transforms people’s lives, gives us ways to overcome mental illness, and returns patients to full functioning,” said Pardes, a former director of NIMH and a past president of APA.

Richard Nakamura, Ph.D., NIMH acting director, said the World Health Organization reported last year that the burden of mental illness is a leading cause of disability worldwide.

He presented slides of brain images taken of the hippocampus region to illustrate its reduced size in a person with depression compared with that in a person without depression. Nakamura also showed brain images of adolescents with schizophrenia and those without the disorder that vividly illustrated the extensive loss of neurons associated with the disorder.

Suzanne Vogel-Scibilia, M.D., a NAMI board member and a clinical psychiatrist in Beaver County, Pa., described her journey with bipolar illness, which began in adolescence. “Without adequate mental health coverage, I couldn’t afford inpatient treatment and often had to choose between buying food or medication.”

She called on members of Congress to pass parity legislation to ease the financial burden on patients and their families. ■

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IMGs

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rector of APA's Division of Education, Minority, and National Programs, the number of IMGs matching into psychiatry dropped by 10 percent, while the number of USMGs increased by 10 percent (*Psychiatric News*, May 3).

A point of contention among IMGs pursuing ECFMG certification is that the CSA exams are given only in Philadelphia once a year, making it difficult for some of them to take the qualifying exam. According to the May 3 *Psychiatric News* article, this concerned Thompson, as a decreased pool of IMGs would hurt several medical specialties, and psychiatry has increasingly relied on IMGs over the last several years.

Gangure reported that from the beginning of the certification process in 1998 through 2001, the number of IMG candidates taking the Step I examination dropped

by 45.5 percent (36,983 to 16,828), and those registered for Step 2 dropped by 38.1 percent (31,751 to 12,122). The number of ECFMG certificates issued each year dropped from a range of 9,000 to 12,000 from 1995 to 1998 to fewer than 6,000 from 1998 to 2001.

It is important to be aware of differences among IMGs, Gangure said. One aspect is that the designation of IMG does not automatically imply the person's legal status in the U.S. Some IMGs are American-born citizens who went to medical schools overseas; others are naturalized American citizens who decided to enter residency training; some immigrated to the U.S. to be with their families; while still others are here on various types of visas permitting them to work for varying lengths of time in the U.S. To avoid confusion, it is good to know that IMGs are a heterogeneous group of physicians.

The most important question remains

of how best to meet Americans' need for psychiatric services, Gangure pointed out. Thousands of needy people lack psychiatric care simply because there aren't enough psychiatrists in certain areas. If a map of underserved areas is superimposed over a map of the distribution of psychiatrists throughout the U.S., it becomes clear that some large metropolitan areas have an overabundance of psychiatrists, while rural and poor urban areas are lacking in coverage. Programs like loan forgiveness for USMGs and J-1 visa waivers for IMGs could reestablish an equilibrium between the distribution of psychiatrists and needs in the country.

Another area of major interest is the highest level of research in psychiatry, Gangure said. He advocates continuing to attract the best minds to psychiatric research, from both the pool of USMGs and IMGs, to assure the fastest advance of psychiatric knowledge.

Since Gangure's study, a "special com-

munication" by Gerald P. Whelan, M.D., and colleagues of the Educational Commission for Foreign Medical Graduates titled "The Changing Pool of International Medical Graduates Seeking Certification Training in U.S. Graduate Medical Programs" in the September 4 *JAMA* states that "IMGs consistently represent approximately one-fourth of both the physician workforce and the graduate medical education (GME) population of the United States."

Gangure believes that IMGs as a group have the potential to infuse the American psychiatric stream of thought with universal values and make important contributions to psychiatric education and research. ■

World Congress

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ported that Chinese psychiatric archives reveal "a longstanding misuse of psychiatry for politically repressive purposes, one that resembles that of the former Soviet Union."

Chinese officials have denied the charges. Under WPA rules, if China refuses to accept the inspection team, Chinese psychiatrists might be expelled from the association.

In 1983 similar charges of psychiatric abuse led the then Soviet Union to withdraw from the WPA before it would have been expelled. In 1989 Russian psychiatrists were re-admitted after hundreds of confined dissidents were released.

The six-day congress, the first of its kind held in Asia, was opened by Crown Prince Naruhito and attracted more than 6,200 psychiatrists, mental health professionals, patients, and their families. Half of the attendees were from Japan, and the rest were from 111 other countries.

Among the representatives of APA in attendance was APA President-elect Marcia Goin. "The meeting in Yokohama was characterized by gracious hospitality, thoughtful outreach, and a panoply of excellent educational opportunities," she commented after the congress. "The pageant of the opening ceremonies was heightened by the presence of the crown prince and princess, who gave forth a sense of cordial gentility. At the final banquet the Japanese dignitaries were at their fun-loving best, singing traditional chants and welcoming the assembled group to enjoy the pleasures of their wonderful country."

Despite the gargantuan program—more than 300 symposia, 52 workshops (even one on organizing a successful congress), dozens of lectures, and hundreds of papers delivered in English, Japanese, Spanish, French, and Russian with simultaneous interpretations—attendees managed to get in some sightseeing, sip green tea, and munch on sushi and tempura. The program and abstracts filled three volumes of 300 pages each, weighing a hefty 3 kilos. So diehards who didn't get their fill at the congress had plenty to read on the plane back home.

The next WCP meeting will be held in Cairo in September 2005. ■

from the president

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and—in these times of fiscal stringency for APA—whether it could do its job more efficiently. This is precisely the question that was posed at the September Board meeting. The Long-Range Budget and Planning Task Force of the Board, which I have been privileged to chair, looked closely at the structure of the Board and made recommendations for significant changes.

The task force's report to the Board began with the observation that Board meetings involve an extraordinarily large number of people. Researchers on group interaction have demonstrated that the optimal size of any decision-making body is eight to 12 members. (It is no accident that juries, entrusted with decisions of extraordinary consequence, are composed of 12 jurors.) Many of our largest corporations have boards of this size, overseeing operations larger than APAs by two to three orders of magnitude. Larger boards limit the time available for members to participate in deliberations and the back-and-forth discussion that can be fruitful in addressing complex problems. Decisions regarding those issues on which all members feel compelled to comment can take an unreasonably long time.

How then did APA arrive at the situation where we have 21 elected board members and a roughly equal number of other participants? For the best of reasons—I think—even if the end result is problematic. To make sure that all segments of our

profession are represented, the voting Board consists of six officers, seven Area Trustees, three Trustees-at-Large (with one slot reserved for an early career psychiatrist), the three most recent past presidents, a member-in-training trustee, and the speaker of the Assembly. On the Board as nonvoting members are the member-in-training trustee-elect and certain past presidents. Alone among organizations, we have considered past presidents to be nonvoting members of the Board for life and have paid for them to attend meetings and sit at the Board table; two years ago our members agreed to end the practice prospectively, but all presidents who assumed office prior to 2001 are still entitled to attend Board meetings in perpetuity. Also around the table, also without a vote, are four additional resident representatives, a representative from the Committee of Black Psychiatrists, and the speaker-elect of the Assembly.

Our task force recommended a number

of changes designed to make the Board more functional and more efficient by reducing its size. We suggested reducing voting members to 17 by cutting two past presidents (keeping only the immediate past president), eliminating one of our two vice presidents, and combining the positions of secretary and treasurer. While acknowledging the wisdom that many past presidents contribute to Board discussions, the task force recommended ending the practice of retaining them on the Board as nonvoting members. And we suggested that only voting members actually sit at the Board table, a practice common to most governing boards.

After extended discussion, the Board took what I consider to be several steps in the right direction. The second vice-president post was eliminated, and a secretary-treasurer will replace the two positions that exist now. At its next meeting, the Board will experiment with seating only voting members at the Board table, arranging non-

voting members and guests in an outer ring. But the Board voted not to change any of the practices with regard to past presidents.

This is the first time that the APA Board has decreased in size—no easy task for any group—and even if I believe we didn't go far enough, I think the Board deserves credit for moving in the right direction. To become effective, the changes will need to be approved through the bylaws' amendment process and then phased in over the next several years.

As we cope with serious challenges to our abilities to treat our patients, we need to be as lean and functional an organization as possible. With our component structure reshaped last spring, cutting its cost in half and emphasizing electronic and telephonic communication, and with substantial cuts to be made in the coming fiscal year in our budget for staff, we are taking the steps to do the job our members expect of us. Now the Board has followed suit.

In a later column, I will tell you about a proposal to reshape the Assembly into a more effective deliberative body. ■

association news

Liability Insurance

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surance is to offer security from even a small chance of personal risk, and APA fully understands why many member insureds remain concerned about their liability in the event of a Legion liquidation. Thus, APA has steadily urged PRMS to identify a mechanism for providing "prior-acts" coverage options for our members. APA was told that members who had claims-made or modified occurrence coverage and who are continuing with National Union or Lexington may have coverage for claims arising from acts while they were insured by Legion. The extent of such retroactive coverage is specifically described in each new National Union or Lexington policy. Since individual circumstances differ, insureds are encouraged to review their policies carefully and to call PRMS if they have any questions.

We have also been encouraging PRMS and various insurance consultants to find a suitable alternative for insureds who may not have sufficient retroactive coverage and may wish to purchase "prior-acts" coverage. As of this writing, some options are being investigated by PRMS and consultants, but it is too early to say whether any such option will prove to be feasible. We will keep you informed of any progress on this front.

In a piece like this, it is impossible to address all the nuances of this situation that may affect our member insureds. If you have specific questions about your policy, please contact PRMS by phone at (800) 245-3333 or by e-mail at update@prms.com. As we learn more, we will use the pages of *Psychiatric News* and other means as appropriate to keep you updated. Updates are also being posted on the PRMS Web site at www.psychprogram.com. ■