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PSYCHIATRIC NEWS

Photo: Philadelphia Convention and Visitors Bureau

APA members attending the 2002 annual meeting in Philadelphia May 18 to 23 will be only a short taxi ride away from the world-renowned Philadelphia Museum of Art. One museum highlight is a free program on Wednesday evenings on a central theme. More information on the annual meeting appears on page 3.

Americans More Willing To Seek Out Treatment

A threefold increase in outpatient treatment for depression in the last decade goes hand in hand with the public's growing awareness about effective treatments and the decline in stigma surrounding mental illness.

BY EVE KUPERSANIN

A surge in outpatient treatment for depression over the past decade has led experts to speculate that education programs about mental illness and anti-stigma campaigns coinciding with improved treatments have begun to pay off.

Between 1987 and 1997, researchers found that the rates for outpatient treatment of depression more than tripled. In 1987, 0.7 percent of the American population, or 1.76 million people, received outpatient treatment for depression. A decade later, this percentage jumped to 2.3 percent, or 6.33 million people.

In addition, of those treated for depression, 44.6 percent were prescribed a psychotropic medication in 1987, compared with 79.4 percent in 1997.

These data were published in a report appearing in the January 9 *Journal of the American Medical Association* by Mark Olfson, M.D., M.P.H., and colleagues. Olfson is an associate professor of clinical psychiatry at Columbia University and the New York State Psychiatric Institute.

Olfson collected data from two surveys sponsored by the federal Agency for Healthcare Research and Quality—the 1987 National Medical Expenditure Survey and the 1997 Medical Expenditure Panel Survey. In both surveys, respondents were asked to record medical "events," such as visits to a physician, in a diary. The events were later discussed during face-to-face interviews with survey researchers.

Tens of thousands of households in the U.S. were polled for the surveys, and the data were used to determine health care utilization and sources of payments, among other things.

The researchers found an overall increase in the number of Americans who received psychotherapy for treatment of their depression over the decade under study. In 1987, 1.25 million people (.52 percent) received psychotherapy for depression compared with 3.8 million people (1.4 percent) in 1997. What is notable, however, is that the percentage of those who received psychotherapy (which included mental health counseling) declined from 71 percent to 60 percent.

Treatment was characterized by greater involvement of physicians, although the physician's specialty was not specified by the study. Almost 69 percent of people in treatment for depression visited a physician to get this treatment in 1987, increasing to 87.3 percent in 1997.

Harold Pincus, M.D., the executive vice chair of psychiatry at the University of Pitts-

see ***Depression*** *on page 30*

Stressed Budgets Lead States To Cut MH Resources

Financially strained mental health systems are increasingly unable to meet the needs of people with serious mental illnesses.

BY CHRISTINE LEHMANN

People with serious mental illness are lucky if they receive 15-minute medication checks and access to overworked case managers, according to a new report from the Bazelon Center for Mental Health Law.

The report, "Disintegrating Systems: The State of States' Public Mental Health Systems," is based on mental health commission reports and news articles from 35 states published from 1999 to 2001. The report was released in December.

Many states complained that they lacked the funding to provide adequate inpatient and outpatient mental health services to adults and children. The crisis threatens Florida's emergency behavioral health services and Ohio's "public health system's ability to meet basis access and quality demands," according to the report.

In Arkansas, funding for community mental health centers has declined by 50 percent since 1981, while the number of persons served by these centers has increased, the report states.

Many states including New York, Massachusetts, and Michigan are planning to cut their mental health budgets this year, which will adversely affect mental health services.

Experts trace the deficit in funding for community-based mental health services in particular to the deinstitutionalization movement that began in the late 1950s in the United States. "As state psychiatric hospitals were reduced in size and then eventually closed, resources previously spent on public mental health care were not invested in community-based services," according to Bazelon Executive Director Robert Bernstein, who wrote the report with Chris Koyanagi, Bazelon's director of policy.

Jon Gudeman, M.D., chair of the APA Committee on Public Funding for Psychiatric Services, told *Psychiatric News*, "It is much harder to convince legislators of the need to increase funding when services and staff are decentralized."

The Bazelon report shows that total state spending on mental health services was 30 percent less in 1997 than in 1955, when adjusted for population growth and inflation. In addition, per capita state expenditures

see ***Systems*** *on page 25*

Congress Boosts Budget For MH Research, Treatment

President George W. Bush signs a federal health spending bill with substantial increases for mental illness research and services.

BY CHRISTINE LEHMANN

In December Congress approved a 15 percent increase in funding for the National Institutes of Health (NIH), which will allow it to continue expanding its research portfolio in Fiscal 2002. President George W. Bush immediately signed the federal spending measure into law.

The increase of nearly $3 billion—which gives NIH a total budget of $23 billion—drew praise from APA and other members of the Mental Health Liaison Group for being nearly half a billion dollars more than what Bush and the House of Representatives had recommended.

Roughly 1 percent of that increase is slated for non-NIH activities, leaving the NIH with a funding increase of 14 percent, according to Lizbet Boroughs, an associate director of the APA Division of Government Relations.

The Mental Health Liaison Group and the Ad Hoc Group on Research Funding, of which APA is also a member, have advocated each year for specific increases in the NIH budget with the goal of doubling the total budget over a five-year period ending next fiscal year. The Ad Hoc Group on Research Funding was successful in obtaining increases of 15 percent in FY 1999 and FY 2000 and 14 percent in FY 2001 and FY 2002.

> **"We applaud their approval of the increases that will advance research and treatment of our patients."**

The Senate typically passes higher increases for NIH than does the House. The conference agreement reflects the average between the two bodies' recommendations. In 2001 the Senate passed an increase for NIH of 16.5 percent, for which the Ad Hoc Group on Research Funding had advocated, but the House passed the president's requested increase of 13.5 percent; the difference was split in conference.

Similar budget compromises were reached last December for the three institutes involved in mental health and addictive disorders. The budget for the National Institute of Mental Health (NIMH) was increased 13 percent, for a total of $1.249 billion; the budget for the National Institute on Drug Abuse (NIDA) was increased 12 percent, for a total of $888 million; and the budget for the National Institute on Alcohol Abuse and Alcoholism (NIAAA) was increased by 12 percent, for a total of $384 million, according to the final conference agreement. Last year's increases were 14 percent for NIMH and NIDA, and 16 percent for NIAAA.

Jeremy Lazarus, M.D., chair of APA's Joint Commission on Government Relations, commented to *Psychiatric News*, "We are pleased with the substantial increases for these institutes and mental health and substance abuse treatment and prevention. Congress is increasingly aware of the importance of research and treatment of those with mental illness or substance abuse. We applaud their approval of the increases that will advance research and treatment of our patients."

As the Senate and House began the appropriations process last spring, members of APA's Academic Consortium visited key representatives and aides on Capitol Hill (*Psychiatric News*, May 4, 2001) to convey the message that medical research can significantly improve people's lives.

"Patient advocates described to congressional aides how they have benefited from the newer medications," said Boroughs. "A veteran with schizophrenia said he went from being homeless and in and out of hospitals to working part time and living independently."

The budget for the Substance Abuse and Mental Health Services Administration (SAMHSA) was increased by roughly 6 percent, to $3.138 billion for FY 2002. The FY 2002 budget for the Center for Mental Health Services (CMHS), which is part of SAMHSA, is $832 million, representing an increase of 6 percent. Specific programs within CMHS were also increased:

- **The Mental Health Block Grant,** which is administered by the states to fund programs serving people with severe mental illnesses and children with severe emotional disturbances.
- **The Projects for Assistance in Transition From Homelessness (known as PATH),** which is another state-administered grant program to fund community-based services for homeless individuals with mental illness.
- **Programs of Regional and National Significance,** which include funding for new national initiatives. These include the jail-diversion program that would fund

see ***Budget*** *on page 22*

annual meeting

Here's a First Look at APA's 2002 Meeting

Outstanding educational opportunities, the latest research findings in psychiatry, and a host city that boasts history, culture, and good food—APA members attending the 2002 annual meeting in Philadelphia will want for nothing.

BY PHILIP R. MUSKIN, MD.

It is the middle of winter, and dreary February days are upon us. The month of May seems years away right about now. No better time than the present to make plans to attend the 155th APA Annual Meeting from May 18 to 23 in the city where APA was born in 1844—Philadelphia.

The headquarters for the meeting is the Pennsylvania Convention Center, which is located only a short walking distance from the Marriott and many of the other hotels available for the meeting.

Philadelphia has a tremendous amount to offer, a host of distractions from the wonderful scientific sessions that have been planned. There are numerous historic and cultural sites, a variety of types of entertainment, and culinary delights for every palate.

It is not possible to review all of the hundreds of sessions that the Scientific Program Committee has arranged for this meeting. The members of the committee and the APA staff have devoted thousands of hours of work that will culminate in what I expect to be one of the outstanding annual meetings of all time. I wish to express my personal gratitude to them for the remarkable effort it takes to plan this meeting. I would also like to thank our president, Dr. Richard K. Harding, for his confidence in appointing me to chair the committee and to work along with the Scientific Program Committee for this annual meeting.

Dr. Harding's theme for the meeting, "The 21st-Century Psychiatrist," has inspired all who submitted presentations, as you will discover when you are at the meeting. Dr. Harding's Presidential Symposium, co-chaired by Lisa Mellman, M.D., and Ronald Rieder, M.D., will focus on the topic of core competencies: "What Will the 21st Century Bring to the Training of Psychiatrists?"

This year will mark a first collaboration between APA and the Substance Abuse and Mental Health Services Administration (SAMHSA) to produce a special "track." There have been similar special tracks in collaboration with NIDA, NIAAA, and NIMH in the past. Each of the three SAMHSA centers will present a variety of sessions focused on systems of care, cur-

see ***Philadelphia*** *on page 26*

Dr. Muskin is chair of APA's Scientific Program Committee.

M.D.s Go Beyond Data In Choosing Medications

Some physicians may be using a complex set of conditions when deciding which antidepressant to prescribe. Their impressions of certain drugs, however, may not match the empirical data.

BY JIM ROSACK

A new survey of prescribing practices in the treatment of depression indicates that some clinicians are not relying solely on the literature to help them choose which antidepressant to prescribe for a patient. In addition, the survey of physicians attending a psychopharmacology review course reveals that many physicians may have impressions about certain drugs that are not backed up by the data.

"Despite there being a lack of evidence of a significant difference in efficacy between older and newer agents, clinicians perceive the newer agents to be more efficacious than the older drugs," said lead author Timothy Petersen, Ph.D., a clinical instructor in psychology at Harvard Medical School and a researcher at the Depression Clinical and Research Program at Massachusetts General Hospital. The hospital's program is headed by Maurizio Fava, M.D., who cowrote the study.

The survey of prescribing habits was given to attendees at the hospital's psychopharmacology review course in fall 2000. Similar surveys have been given to attendees for several years.

The 2000 survey, which was published in the January issue of *Progress in Neuro-Psychopharmacology and Biological Psychiatry*, asked 10 questions of the nearly 800 attendees at the review course. More than 430 returned responses to the survey prior to the start of the course. Questions were geared toward three general areas: whether clinicians believe one class of antidepressants is more efficacious than the others, whether clinicians prefer to prescribe one class of antidepressants over the others, and which particular antidepressants the clinicians associated with particular side effects.

"Overall, the responses indicated that clinicians are using not only more sources of input, but more complex decision trees to make their prescribing decisions than would generally be thought," Petersen told *Psychiatric News*.

Perhaps the most revealing results were the answers to the first three questions. When asked whether they believed that one antidepressant is more efficacious than another, respondents split almost down the middle, with 51 percent saying no, 49 percent yes.

Of the respondents who indicated yes to the first question, half believed SSRIs are more efficacious, and a quarter believed an SNRI (venlafaxine) was more efficacious (see chart below). Interestingly, after responding in the first question that one antidepressant was more efficacious, 7 percent indicated multiple choices for which one when they answered the second question.

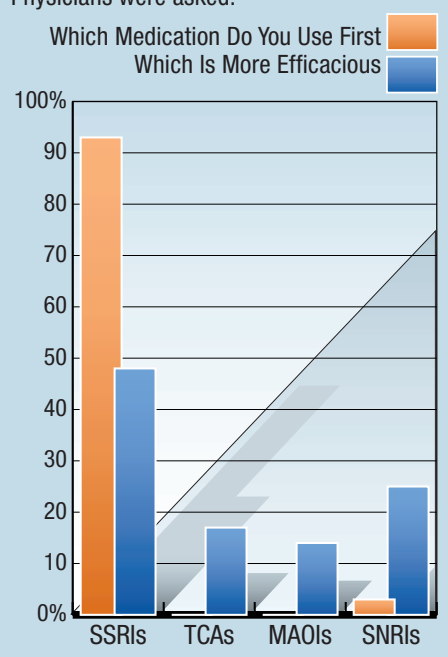
"In the third question, 93 percent of respondents indicated SSRIs when asked whether or not they prefer to prescribe one antidepressant over the others," Peterson said. "But the question asks about preference, not necessarily practice. Just because they're indicating a preference for SSRIs doesn't mean they are always prescribing them," he added.

Petersen noted that few head-to-head data exist comparing the efficacy of various antidepressants. He said that neither of the two most widely cited documents, the Agency for Health Care Policy and Research's (AHCPR) "Treatment of Depression: Newer Pharmacotherapies," published in 1999, or APA's Practice Guideline for the Treatment of Patients With Major Depressive Disorder, revised last year, support the overwhelming preference seen in the survey.

The AHCPR report concluded that, in its review of more than 300 randomized trials, there was "no evidence to suggest significantly different efficacy between classes of antidepressants or between individual antidepressant agents." APA's guideline concludes, "The effectiveness of antidepressant medications is generally comparable between classes and within classes of medications." The guideline recommends that medication be selected using other criteria, such as side effects, cost, his-

see ***Antidepressants*** *on page 32*

Prescribing Practices
Physicians were asked:



Source: "A Survey of Prescribing Practices in the Treatment of Depression," *Prog. Neuropsychopharmacol. Biol. Psychiatry*, January 2002.

More than 90 percent of physicians in a psychopharmacology course said they prefer prescribing an SSRI to patients needing an antidepressant.

NASA Addresses Mental Health Of Mars-Mission Members

When the National Aeronautics and Space Administration sends astronauts to Mars, it will want to safeguard their mental and physical health. So it asked the Institute of Medicine to suggest ways it can protect the well-being of its space voyagers.

BY JOAN AREHART-TREICHEL

Many Americans thought it was impossible. But in 1969 the United States got a manned spacecraft to the moon and back. During the 1980s and 1990s, some Americans had similar doubts about an international space station. Yet it too came to pass. So there is little reason to think that the National Aeronautics and Space Administration's (NASA) plan to send astronauts to Mars, perhaps as early as 2014, will not become a reality.

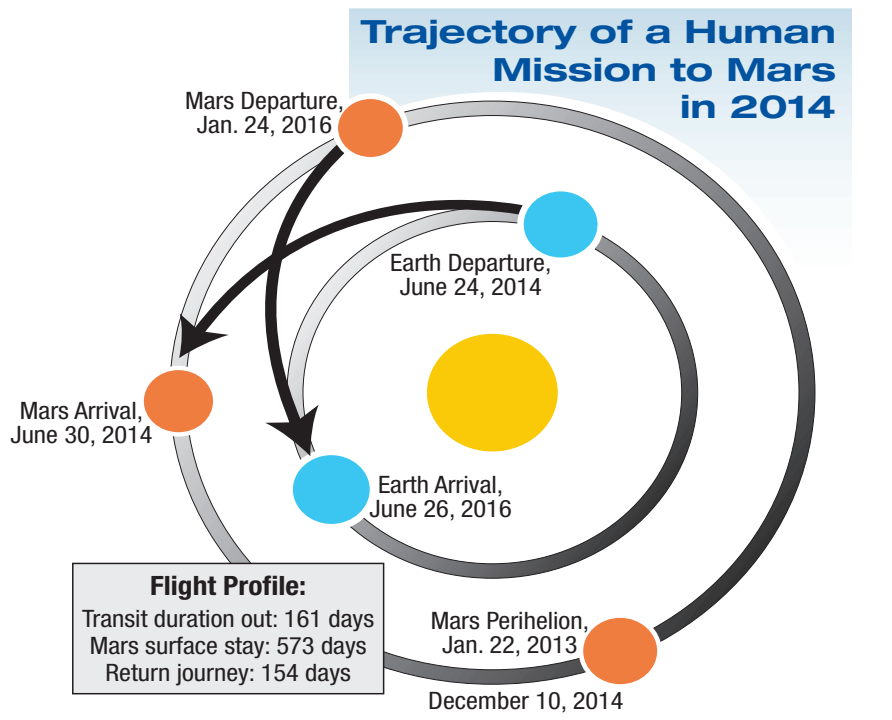
A manned Mars mission will take two-and-a-half or three years, however, and would undoubtedly present mental and physical health risks that shorter space missions do not. So NASA asked the Institute of Medicine to prepare a report to help it identify the mental and physical health risks that astronauts would be up against during such a mission. NASA also wanted advice on how to mitigate those risks. The Institute of Medicine's report, titled "Safe Passage: Astronaut Care for Exploration Missions," has now been published.

The three major health risks that astronauts will face on a long-term mission such as to Mars, the report stated, are exposure to radiation, bone loss, and mental/behavioral health problems. So, in the mental/behavioral health area, as in the radiation and bone-loss ones, it is important that NASA do three things before it sends astronauts on such a long-term mission, the report asserts.

One of these steps is to conduct research to better understand the risks involved. A second is to conduct research to learn how to protect astronauts from such risks. And the third is to put a health care system into place that can protect astronauts from those risks.

Here are several of the questions about mental/behavioral health risks that the report indicates should be answered:

- What would happen to a person's mental and behavioral health if he or she were cooped up with six or seven other individuals during a three-year period?
- What would living and working together in such close quarters over such an extended time do to group interactions? "Schisms, friction, withdrawal, competitiveness, scapegoating, and other maladaptive group behaviors are found among highly competent men and women working together in normal terrestrial settings," the report stated. "They can also be expected among astronaut crews."
- If mental and behavioral health problems arose among a flight crew, how could the ground crew intervene effectively, especially as it would take some 40 minutes for the flight crew to communicate with the ground crew and for the ground crew's response to get back to the flight crew?
- What sorts of mental/behavioral health supports would the flight crew need both from people back on earth and from each other?
- How could the mental and behavioral performance of the flight crew be monitored from earth?
- What kinds of tools might be developed so that flight-crew members could monitor their own moods and cognitive functioning?
- Finally, what kinds of mental health care might the astronauts need after returning to earth from such a long journey in space?



The above illustration depicts how a NASA trip to Mars and back in 2014 might take place. The illustration is adapted from one in the Institute of Medicine's report, "Safe Passage: Astronaut Care for Exploration Missions."

The Institute of Medicine is a private, nonprofit organization that provides health policy advice under a congressional charter granted to the National Academy of Sciences. NASA funded the preparation of the report.

The 318-page Institute of Medicine report, "Safe Passage: Astronaut Care for Exploration Missions," can be read online at <www.nap.edu/catalog/10218.html>. A summary of the mental/behavioral health recommendations contained in the report can be found in a box titled "Behavioral Health and Performance Research and Development Opportunities." This box can be read online at <http://books.nap.edu/books/0309075858/html/14.html>. ■

Mirin Advises on Space-Mission Risks

Who were the professionals who helped prepare the Institute of Medicine report for the National Aeronautics and Space Administration (NASA) on how to safeguard the mental and physical health of astronauts sent on long-term space missions?

They were physicians specializing in neurology, emergency medicine, gynecology, rehabilitation medicine, or other disciplines. They were former astronauts. They were scientists who have explored humans' mental and physical health needs in Antarctica and other harsh terrestrial environments. Among them were Douglas Powell, Ph.D., a clinical instructor in psychology at Harvard Medical School, and Joseph Brady, Ph.D., director of the Behavioral Biology Research Center at Johns Hopkins University—and APA Medical Director Steven Mirin, M.D.

The reason Mirin became involved in the report's development, he explained during a recent interview with *Psychiatric News,* is that he was serving on the Institute of Medicine's Board of Neuroscience and Behavioral Health. The board consists of both Institute of Medicine members and nonmembers who have expertise in the domains of neuroscience and mental and behavioral health and who are prepared to assist various Institute of Medicine committees when they need help in those arenas. Thus, Mirin served as a liaison from the Institute of Medicine Board on Neuroscience and Behavioral Health to the Institute of Medicine Committee on Creating a Vision for Space Medicine During Travel Beyond Earth Orbit. This was the committee that drafted the report.

Mirin said that he finds it very interesting that mental/behavioral health problems, along with bone loss and radiation exposure, are identified in the institute's report as the three major health risks that astronauts will face on their voyages into deep space. He also said that he anticipates that research to answer questions about these mental/behavioral health risks, as well as how to counter those risks, will be conducted not on space shuttle missions, which last one to two weeks, but rather on the International Space Station, where people stay for months at a time.

"We don't know exactly when NASA is planning to send a manned spacecraft to Mars," Mirin noted. "But I think NASA certainly anticipates sending spacecraft on extended missions not just to Mars, but to other destinations as well. So NASA's ability to plan and carry out long-range missions successfully really depends on developing both a research agenda and a health care system that can support the flight crews for those sorts of missions."

This report from the Institute of Medicine will be able to provide NASA with guidance in developing that research agenda and the necessary health care infrastructure, Mirin said.

Govt. Names Organizations That Can Accredit Methadone Programs

SAMHSA has approved four accrediting agencies to certify methadone treatment programs in meeting new federal requirements.

BY JIM ROSACK

Four organizations were chosen last month by the Substance Abuse and Mental Health Services Administration (SAMHSA) to accredit programs that use methadone to treat individuals with opiate abuse and dependency.

Along with the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation for Children and Family Services (COA), and the State of Washington Department of Social and Health Services Division of Alcohol and Substance Abuse will accredit methadone treatment programs for SAMHSA's Center for Substance Abuse Treatment (CSAT).

CSAT hopes that the move to accreditation, announced last year (*Psychiatric News*, March 2, 2001), will lead to improvements in the quality and oversight of opioid treatment programs that use either methadone or levo-alpha-acetyl-methadol (LAAM) to prevent relapse in addiction to heroin and other opiates.

"As a benchmark of quality," CSAT Director H. Westley Clark, M.D., J.D., M.P.H., said in a prepared statement released by the center, "accreditation indicates that an organization meets certain critical performance standards. This should enhance community confidence in opioid treatment and enhance the ability of treatment programs to access managed care contracts."

SAMHSA Administrator Charles G. Curie added that "accreditation of methadone treatment programs is a fundamental shift in the way we approach drug abuse treatment in our nation. Accreditation can help to reduce stigma and discrimination by moving drug abuse treatment into the mainstream of medicine. Just like treatment for other diseases,

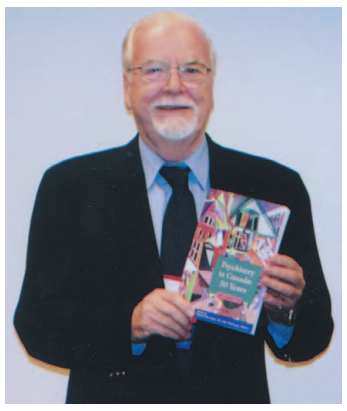
see ***Methadone*** *on page 32*

CPA Looks at Past, Future On Golden Anniversary

New organizations are born out of necessity, and the Canadian Psychiatric Association is no exception. It was formed in 1951 to give Canadian psychiatrists a voice in their country's evolving health care system.

BY CHRISTINE LEHMANN

The latter half of the 20th century saw the rapid transformation of psychiatry in Canada from ineffective to effective treatments, from provincial mental asylums to psychiatry units in general hospitals, and from minimal training standards for psychiatrists to a required five-year residency training program.



Quentin Rae-Grant, M.D., displays the new book he edited on 50 years of psychiatry in Canada.

The Canadian Psychiatric Association (CPA) played a key role in this transformation, which is chronicled in a new book, *Psychiatry in Canada: 50 Years*, edited by former CPA president Quentin Rae-Grant, M.D. The CPA released the book at its annual meeting in Montreal last November.

Many Canadian psychiatrists belonged to APA in the first part of the 20th century. But by the 1940s, a growing number of them were discussing the need for a separate national organization to represent their interests, Rae-Grant told *Psychiatric News*.

Robert Jones, Ewen Cameron, George Stevenson, Aldwyn Stokes, C.B. Farrar, Griffith McKerracher, and Charles Stogdill (all M.D.s) played important roles in founding the CPA. It was officially founded in 1951 with 143 charter members. Many of them later became CPA presidents.

The CPA emerged at a critical time in Canada. World War II had ended, and the federal government was particularly interested in meeting the mental health needs of veterans. It began providing grants to improve psychiatric services in provincial hospitals and started to consider various health insurance reforms.

In 1960, the Canadian government appointed a commission to study health care services. The CPA's Committee on Psychiatric Services was instrumental in developing recommendations on treating and preventing mental illness, which were presented to the federal commission and included in the commission's final report.

The CPA played an important role in advocating for the inclusion of psychiatric services in the historic Canada Health Act initiated in 1967, said Rae-Grant. "The legislation mandated universal health coverage and made no distinction between medical and psychiatric services," he said.

Because psychiatric services in general hospitals and private offices were fully covered for the first time, their use increased, according to Rae-Grant. More residents entered psychiatric training and began to practice in underserved areas.

However, the Canada Health Act did not cover psychiatric hospitals, which were funded by the provincial governments. They struggled to attract staff, but the deinstitutionalization movement in the 1960s and 1970s triggered their demise. Only a few of the provincial psychiatric hospitals remain open, with inpatient services largely being provided by psychiatric units in general hospitals, said Rae-Grant. Another important mandate for the CPA at that time was establishing training requirements. In the first part of the century, the only training requirement was that psychiatrists spend a year at a provincial psychiatric hospital, he said.

The Committee on Psychiatric Education, originally the Committee on Professional Standards, formed a critical alliance with the Royal College of Physicians and Surgeons of Canada, which certifies medical specialties, according to Rae-Grant. The first formal four-year training program was developed at McGill University in Montreal in the 1950s. By 1980, all 16 Canadian medical schools had departments of psychiatry with residency training programs.

Child and adolescent psychiatrists who were members of the CPA in the 1950s proposed subspecialty certification with additional training requirements. The CPA initially supported the separate certification recommendation but reconsidered because the specialty was so new. Instead, the CPA, with the approval of its Section on Child and Adolescent Psychiatry, proposed to the Royal College of Physicians and Surgeons that two years of optional training in child and adolescent psychiatry be allowed and counted toward the four-year training requirement. Training institutions would recognize the specialized training with the Diploma of Child and Adolescent Psychiatry.

In addition, the CPA recommended that all psychiatry residents be required to take six months of child and adolescent psychiatry training. The Royal College of Physicians and Surgeons approved all of the recommendations, said Rae-Grant.

Although the CPA Section on Child and Adolescent Psychiatry agreed to the two-year compromise in the 1950s, it has not dropped the issue of subspecialty certification.

Indeed, child and adolescent psychia-

*see **CPA** on page 31*

Cultural Consultation Service Bridges Mental Health Divide

Montreal is a city of many nationalities, with recent immigrants and political refugees from nearly every continent. A psychiatric consultation service now offers cultural and language expertise to improve their mental health care.

BY CHRISTINE LEHMANN

An Indian immigrant in Montreal attempts to commit suicide because she finds her home life unbearable. She is referred to the Cultural Consultation Service at the psychiatry department of Jewish General Hospital in Montreal, where she is matched with a psychologist from India who assesses social and cultural factors that could influence her diagnosis, prognosis, and treatment. She and family members are interviewed multiple times, and a treatment plan is drawn up for discussion with the referring clinician.

"The psychologist discovered a huge conflict between her husband and a son-in-law over family obligations related to their migration. The woman was distressed because she was not allowed to visit her grandchildren," explained psychiatrist Laurence Kirmayer, M.D., who developed and evaluated the cultural consultation service in 1999 with a federal grant. He directs the Cultural and Mental Health Research Unit at the Jewish General Hospital.

"Because the mental health professionals who had treated her before relied on her minimal English to communicate, their knowledge was superficial, and she was diagnosed with treatment-resistant depression," said Kirmayer at the Canadian Psychiatric Association (CPA) annual meeting in Montreal last November.

"By getting her husband and other family members to talk about the problem, we were able to suggest practical solutions including that family members in India act as mediators. Because the grandmother's burden was lifted, she became less suicidal," said Kirmayer, who is also professor and director of the Division of Social and Transcultural Psychiatry at McGill University in Montreal.

The Right Resources

The Indian woman's case is not atypical. Kirmayer found that about one-third of the 60 cultural consultations performed in 1999 and 2000 by the new service involved cases that had not been evaluated properly because the referring clinicians did not use interpreters or others knowledgeable about the individual's culture.

"We spent a lot of time finding the appropriate interpreter and doing a thorough evaluation with the patient and with immediate and extended family members. To provide a cultural context for the patient's and family members' comments, we match the patient's country of origin and ethnic, cultural, or religious background with a 'culture broker' from a similar background," said Kirmayer.

Most often, this was a psychiatrist, psychologist, psychiatric nurse, or social worker on the hospital staff or from the larger Montreal region who agreed to serve on the consultation service. "Ideally, the mental health professional served as the interpreter and culture broker. But if we could not find one who matched the patient's background, then we used professional interpreters and international medical graduates and members of the patient's ethnic/cultural community as culture brokers," said Kirmayer.

"They had to be familiar with the Canadian health care and mental health care system and not be alienated from their country of origin or ethnocultural background to be effective," Kirmayer noted.

A thorough evaluation often required multiple contacts with the patient and his or her family members.

New Issues Uncovered

"The increased communication and understanding of the patient often uncovered new issues that led to a different diagnosis and treatment plan," said Kirmayer. "We discussed our findings with the referring clinician, who usually agreed to revise the plan."

"Immigrant mother and child" was painted by Jaswant Guzder, M.D., director of the child psychiatry day treatment center at Jewish General Hospital in Montreal.

Most of the consultations done in 1999 and 2000 involved recent immigrants and refugees from Africa, Southeast Asia, and the Indian subcontinent. Some refugees from Kosovo were referred as well, said Kirmayer. The remaining cases were from Central and South America, Canadian citizens who had emigrated from Europe a few decades ago, aboriginal Canadians (First Nations and Inuit), and foreign students, Kirmayer said.

"But a disproportionate number of cases were from the same countries as our consultants. For example, we had a psy-

see ***Consultation*** *on page 27*

More Teens Using Ecstasy, But Increase Begins to Slow

Survey results show that some illicit drugs and cigarette smoking are now less popular among teens, but Ecstasy hasn't lost its appeal.

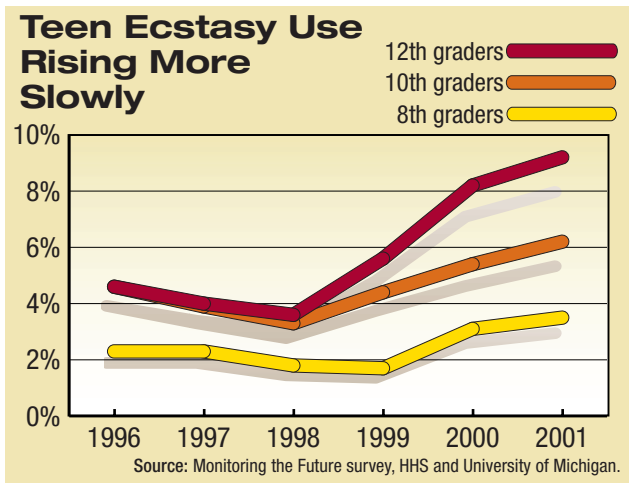
BY EVE KUPERSANIN

Despite evidence that Ecstasy can kill, teen use of the "club drug" is still on the rise, according to the Department of Health and Human Services' Monitoring the Future study.

The study, which included self-reported data from a representative sample of 44,000 students in grades eight, 10, and 12 in more than 400 schools across the nation, tracks major trends in the use of illicit drugs such as LSD, cocaine, heroin, and marijuana. In addition, researchers gather information on the smoking habits of youth. "Use" is defined as having taken the drug at least once in the past year.

The University of Michigan's Institute of Research, which conducts the study during each academic year, found that in 2001, 3.5 percent of eighth graders, 6.2 percent of 10th graders, and 9.2 percent of 12th graders had taken Ecstasy in the past year.

These numbers pose a striking contrast to data from 1998, when 1.8 percent of eighth graders and 3.3 and 3.6 percent of teens in 10th and 12th grades, respectively, used the drug. Although these percentages almost tripled between 1998 and 2000, the increase has been less drastic in the past year, according to study data.



Ecstasy use among eighth, 10th, and 12th graders reached new heights in 2001. Usage rates, however, are not rising as quickly as they once were.

Researchers postulate that perhaps the usage rates aren't growing as quickly because more teens are aware of the dangerous effects of the drug, which, according to research sponsored by the National Institute on Drug Abuse, can cause brain damage and even death.

Researchers asked 12th graders about their perceptions of risk for Ecstasy use, and those who deemed Ecstasy experimentation "a great risk" jumped by 8 percent last year, from 38 percent in 2000 to 46 percent in 2001.

Ecstasy was also easier to obtain in 2001 than in years past. While 40 percent of 12th graders said that they could get Ecstasy "fairly" or "very" easily in 1999, 62 percent said the same in 2001.

Lloyd Johnston, Ph.D., is the principal investigator of the Monitoring the Future study and the Distinguished Research Scientist at the University of Michigan. He told *Psychiatric News* that the increased use of Ecstasy may be due to its reaching communities that haven't encountered it before. "In these communities," he said, "there will be new users recruited even if use already has begun to decline in other communities that have had Ecstasy available for some time. [The decline in those communities is] due to the fact that young people generally are beginning to see it as more dangerous."

"We think that active efforts. . .to get the word out about the dangers of inhalants have paid off."

Although Ecstasy use is still on the rise, usage rates during the past year for other illicit drugs dropped in 2001, according to the Monitoring the Future study:

- Tenth graders are using crack and powder cocaine less. Use declined from 4.9 percent in 1999 to 3.6 percent in 2001.

- LSD use is also on the decline. Tenth graders, once again, showed the most significant decreases: 6.9 percent had used the drug in 1996, but only 4.1 percent did so in 2001. Johnston speculated that the drop was due to the rising popularity of Ecstasy.

- Although the decline in inhalant use reached statistical significance only for 12th graders, inhalant use, including solvents and aerosols, dropped for all three age groups. For 12th graders, use dropped from 5.9 percent in 2000 to 4.5 percent in 2001. Although Johnson said he is hesitant to attribute the decline in the use of certain drugs to antidrug campaigns, the exception he was willing to make was for the use of

see ***Ecstasy*** *on page 31*

WHO Joins Chorus of Concern Over Clinical Trials Bias

Declaring that the reliability of clinical drug trials is "suspect," a World Health Organization official has called for strict new rules governing industry-supported research.

BY JIM ROSACK

The director of Essential Drugs and Medicines Policy for the World Health Organization (WHO) recently said that the reliability of clinical trials is seriously threatened in three major ways: conflicts of interest on the part of investigators, inappropriate involvement of research sponsors in the design and management of trials, and publication bias in disseminating results.

The WHO official, Jonathan Quick, made the comments in an editorial titled "Maintaining the Integrity of the Clinical Evidence Base," in the December issue of the WHO's monthly *Bulletin*.

Quick cited recent studies showing that authors who supported the use of certain cardiovascular treatments "were significantly more likely to have a financial relationship with the drug's maker than those who did not [support the drug]." In addition, other studies have indicated that research funded by the manufacturer of a new medication is significantly more likely than independently funded research to support the safety and efficacy of the new medication.

Indeed, Quick cited one study in which independently funded research of cancer drugs was found to be seven times more likely to reach an unfavorable conclusion about the drugs than research funded by the maker of the drug being studied.

Recent studies have also documented the extent to which some drug companies allegedly go in order to produce desired results for a candidate drug. "Investigators may have little or no input into trial design, no access to the raw data, and limited participation in data interpretation," he stated. This may result in flawed design or invalid research practices such as "data dredging," he noted, which is repeated post-hoc analyses of data sets until positive results turn up.

One study Quick cited found that 35 percent of signed agreements between drug companies and university-based researchers had clauses allowing the sponsor to delete information prior to publication; 53 percent of those agreements allowed delay of publication, and some 30 percent allowed both.

"Most clinical research is still conducted to highly exacting standards of objectivity," Quick wrote. However, last fall, the concern was great enough that 13 leading medical journals jointly published an editorial clearly stating that "contracts should give the researchers a substantial say in trial design, access to the raw data, responsibility for data analysis and interpretation, and the right to publish."

Shifting Editorial Policy

The new editorial policy adopted by the *Lancet*, *Journal of the American Medical Association*, *New England Journal of Medicine*, and 10 other major medical publications sets out new editorial policies in which submitting authors are required to sign a statement verifying that their results and conclusions have not been influenced unduly by an industry sponsor.

APA's *American Journal of Psychiatry* and *Psychiatric Services*, as well as the journals published by American Psychiatric Publishing Inc. (APPI), are reviewing the new editorial policy to consider whether to adopt them, according to their editors.

"Objective research is the lifeblood of future treatments," APA President Richard Harding, M.D., told *Psychiatric News*. The editorial policies adopted by the 13 journals last fall are "an important step in bringing back into perspective the objectivity and the accountability of each individual physician researcher."

APA President-elect Paul Appelbaum, M.D., agreed. The editorial policy "seems to be a very important step to take in terms of helping to guarantee the objectivity of the data that are reported."

Both Harding and Appelbaum are hopeful that the editorial boards of the APA and APPI journals will give strong consideration to the policies written by the other journals.

Appelbaum said one of the goals of the new editorial policies is to "give researchers leverage with the pharmaceutical companies in terms of getting rid of such clauses." Appelbaum said that under the new policies, authors would be able to argue that research conducted under contracts with restrictive clauses would not be publishable in any of the major journals, so if the drug company wants results published, the contract would have to be free of any such clauses.

New Policies at WHO

The WHO is tightening its own rules for staff and expert advisers on conflicts of interest, and according to Quick, has established "firewall procedures between commercial interests and normative, regulatory, and research decisions."

Quick believes it is time for a declaration on the rights and obligations of clinical investigators and how to manage the entire clinical trials evidence base, similar to the Declaration of Helsinki that nearly 40 years ago sought to provide fundamental protections for human research subjects.

Such a declaration would stipulate, Quick wrote, that industry sponsors of clinical trials certify that specified rules were followed "to ensure the intellectual independence of investigators."

He also called for the development of a registry, accessible to third parties, that would include all details of clinical trials, as well as the enactment of legislation that would prohibit drug companies from taking legal action against investigators, except in cases of fraud.

"If clinical trials become a commercial venture in which self-interest overrules public interest, and desire overrules science," Quick concluded, "then the social contract that allows research on human subjects in return for medical advances is broken."

Quick's editorial in the December WHO* Bulletin *may be read online at <www.who.int/bulletin/>. ■

Editor in Chief Selected For *Academic Psychiatry*

Laura Weiss Roberts, M.D., of the University of New Mexico Health Sciences Center has been selected editor in chief of the journal *Academic Psychiatry*. This is the premier peer-reviewed scholarly journal dedicated to psychiatric education and professional development in the field of academic psychiatry.

"It is a great privilege to work with *Academic Psychiatry* in this leadership role," said Roberts. "The journal fills an important niche in the psychiatric and education literatures, and it has a strong tradition of mentoring through the authorship and publication process. I am utterly delighted, and I look forward to the good work ahead."

Roberts is an associate professor and vice chair of psychiatry and director of the Institute for Ethics Research, Education, and Policy at the University of New Mexico Health Sciences Center. Roberts came to the University of New Mexico in 1989 for her psychiatry residency from the University of Chicago, where she had previously completed her B.A., M.A., M.D. degrees and clinical ethics fellowship training. Roberts has served as a writer, peer reviewer, editorial assistant, guest editor, and assistant to the editor for *Academic Psychiatry* since 1994.

The Association for Academic Psychiatry and the American Association of Directors of Psychiatric Residency Training cosponsor *Academic Psychiatry*, which is published by American Psychiatric Publishing Inc. The journal was founded in 1977 as the *Journal of Psychiatric Education* and named *Academic Psychiatry* in 1989.

Laura Weiss Roberts, M.D.: "I am utterly delighted, and I look forward to the good work ahead."

Roberts has identified several goals for her work with the journal. Among these are continuing to serve as a venue for academic development and collaboration; fostering the value, standing, and contributions of the journal for medical education; increasing the journal's responsiveness to the field of psychiatry; advancing the scholarship and methods of psychiatric education; improving the mechanics of the publication process of the journal; and strengthening its financial base.

Academic Psychiatry ***can be accessed on the Web at <www.psychiatryonline.org>.*** ■

Academic Psychiatry Seeks Associate Editor

The governance board of *Academic Psychiatry* has announced a nationwide search for an associate editor for the journal to work with newly appointed Editor in Chief Laura Weiss Roberts, M.D. The Association for Academic Psychiatry and the American Association of Directors of Psychiatric Residency Training cosponsor the journal, published by American Psychiatric Publishing Inc.

Academic Psychiatry is a quarterly peer-reviewed scholarly journal devoted to psychiatric education and professional development in academic psychiatry.

Potential candidates must have a strong background in medical education and academic psychiatry and must demonstrate a clear commitment to collaborative professional work. Ideal candidates will also possess editorial experience and excellent writing skills.

Interested individuals should submit a letter of intent and a current curriculum vitae (original plus four copies) by April 10 to *Academic Psychiatry*, Attn: Associate Editor Search Committee, American Psychiatric Publishing Inc., 1400 K Street, N.W., Washington, D.C., 20005.

More information is available by calling Roberts at (505) 272-2223. ■

'Dear Abby' Gets Earful From People With Schizophrenia

People with schizophrenia share some of their innermost thoughts with a world-famous advice columnist.

BY EVE KUPERSANIN

"This is my admonition [to psychiatrists]," one person wrote to advice columnist Abigail van Buren, better known as "Dear Abby." "Make it known to your patients that you really care. As schizophrenics, we need all the caring that we can get."

This advice came from one of more than 500 letters sent to Dear Abby several years ago by people with schizophrenia and is now part of a booklet titled "Now That We Are Listening."

"We need to be told we are valuable human beings, lovable people with a capacity for love and giving of ourselves," wrote another person with schizophrenia. "Our own nightmarish thoughts drive our self-respect, self-love, and self-trust right out of us."

The project began several years ago, when the Group for the Advancement of Psychiatry's (GAP) Committee on Psychiatry and the Community approached Van Buren. They inquired if she would ask her readers with schizophrenia to write to her describing their experiences with psychiatrists and psychiatric treatment.

"When GAP asked me to help with the project, I was thrilled," said Van Buren's daughter, Jeanne Phillips, who now writes the column under the well-known pseudonym. In 1956 her mother, Pauline Phillips, wrote to the editor of the *San Francisco Chronicle* and told him that she could write a better advice column than the one that had been appearing in his newspaper. So began the career of Dear Abby. Phillips began helping her mother answer the onslaught of mail at the age of 14 to earn her allowance.

"Anything that I can do to demystify and destigmatize mental illnesses and the attitudes that the public has about them is a boon to everybody," said Phillips, who was not surprised by the candid nature of many of the letters. "People are willing to tell Dear Abby things they wouldn't tell their doctor, and often do."

After the letters flooded in, GAP members compiled them in a 47-page booklet aimed at helping psychiatrists, mental health professionals, and policymakers be more attuned to the needs of people with schizophrenia. According to GAP member Stephen Goldfinger, M.D., the Committee on Psychiatry and the Community "wanted to give back to the consumers who were so willing to share their stories with us" and gain access to groups that normally do not think about community psychiatry issues.

Janssen Pharmaceutica funded the production and distribution of the booklet.

GAP committee member Richard Lamb, M.D., said that the letters were enlightening. "Many [people] described their experiences with treatment in graphic and meaningful ways. Some found that their psychiatrists were not so helpful, so they got help from other areas including the spiritual community, families, and friends."

For example, one person wrote, "The psychiatrists in the program engaged in the worst sort of mystification. I asked how, why, and will it happen again? No information was offered, no guidance, and no questions were encouraged. . . .The most pompous of the many pompous assured me that 'a little knowledge is a dangerous thing.' "

"People are willing to tell Dear Abby things they wouldn't tell their doctor, and often do."

Another person wrote, "After my first breakdown I saw Dr. X. . . . He cared little about me. He told me all about his family and patients and even answered his messages during my appointment."

Said Lamb in response to these and other letters, "We learned that we really must be sensitive to the feelings and concerns of people with schizophrenia."

Some of the letters showed that psychiatrists were, in fact, invaluable to their patients with schizophrenia. "I hooked up with a doctor who prescribed my medicines. She is my lifeline, a very, very, long rope," wrote one respondent. "Our work together has saved my life and turned it around altogether."

Last August, Dear Abby printed another letter, this time from the Committee on Psychiatry and the Community, responding to the many letters it had received and informing readers that the lessons learned were summarized in "Now That We Are Listening."

The committee said that although there were many inspirational letters about life-saving care, "we physicians were appalled at how often the treatment was perceived as impersonal, fragmented, and dehumanizing."

Since the August column appeared, almost 10,000 copies of the booklet have been distributed.

Copies of "Now That We Are Listening" can be obtained by writing to McKassen, Attn: Maria Harryn, 800 Business Center Drive, Suite 100, Horsham, Pa. 19044. ■

Analytic Theory, Not Practice Influenced by Neuroscience

Although advances in neuroscience are not going to change psychoanalysts' techniques, they *are* going to change analysts' theories, according to a Philadelphia psychiatrist-psychoanalyst.

BY JOAN AREHART-TREICHEL

Sydney Pulver, M.D., a clinical professor of psychiatry at the University of Pennsylvania and a training and supervising analyst at the Psychoanalytic Center of Philadelphia, is a man who likes sticking his neck out, ruffling things up.

For instance, he has grappled over the years with such contentious subjects as medical hypnosis, exorcism and demonic possession, and the dismay at finding oneself naked in dreams. Yes, indeed!

Thus, it should probably come as no surprise that he decided to deliver a plenary talk at the December meeting of the American Psychoanalytic Association in New York City that would roil his psychoanalyst colleagues. The title of his talk? "On the Astonishing Clinical Irrelevance of Neuroscience."

"The mind is my profession—of course I'm interested in the brain!," said Pulver as he warmed up his audience of several hundred analysts. They had gathered in the Grand Ballroom of the Waldorf Astoria Hotel, where the meeting was being held, to hear his address. But right now, Pulver declared, "we are in the midst of a great neuroscience bubble, a time of irrational exuberance (forgive me, Alan Greenspan)!"

Audience laughter followed.

"I want to leaven some of the overexpectation that tends to be stirred up by many of the papers about neuroscience that are appearing these days in the analytic literature. These papers often imply that neuroscience will in some way change our daily psychoanalytic technique, an implication that I feel strongly is unwarranted. [By technique I mean] the way we are with patients . . .our way of listening, our timing, our psychoanalytic attitude."

Pulver cited some of the papers that have attempted to document how neuroscience has changed analytic technique but in his view do not really make the case. He also provided an example from his own analytic experience to support his contention that neuroscience has not altered analytic technique.

"Many, if not most, of our patients have suffered traumatic episodes that play an important part in their psychopathology," he related. "For many years, I had approached such patients with the conception that the memory of these episodes had been repressed. One of my therapeutic goals was to help my patients recover those traumatic memories. It will be no surprise that some of those patients did recover those memories, and some didn't. My patients always realized, of course, what I was looking for. Those who did not clearly recover memories felt, as did I, that although in many ways the analysis was helpful, in this one aspect it had failed.

"[Then], in the past few decades, cognitive and neuroscientific description of. . . memory systems led me to realize that memory organization is much more complex than our topographical model implied. Many of the traumatic memories I was searching for were not coded explicitly and were unrecoverable as memories per se. As I appreciated this, I began conveying to patients that, while they might be able to remember these traumatic episodes, they might also gain access to them only through their less-direct appearance in dreams, bodily sensations, and fantasies. . . .

"My change in attitude changed the tone of some of my analyses, sometimes subtly but occasionally dramatically. Soon, however, I realized that this same ambivalence about traumatic memories was present within psychoanalysis itself, almost from the beginning, and certainly far earlier than any neuroscientific findings."

In short, Pulver stressed, neuroscience has not brought about any significant changes in analytic technique to date, and "I want to dampen any wild hope you may have had that neuroscience will revolutionize your way of working with patients."

Nonetheless, after arguing that neuroscience has not transformed analytic technique and will probably not do so in the future, Pulver cocked a provocative eyebrow and declared: "I turn now to the second major point of my paper: the astonishing 'relevance' of neuroscience to psychoanalytic theory." And to bolster this position—that neuroscience is changing analytic theory—he referred to neuroscience's influence on the theory of motivation.

Sydney Pulver, M.D: "We are in the midst of a great neuroscience bubble, a time of irrational exuberance."

Analysts' initial assumption about motivation, he explained, was that it arose from the id and was in some way either sexual or aggressive. This assumption was based upon Freud's drive theory. However, neuroscience has since shown that there are motivational systems in the brain for not just sexuality and aggression but some other drives as well, such as hunger, thirst, safety, maternal devotion, and social attachment. As a result, analysts are starting to integrate these findings into their own hypotheses, and a "few brave souls have even advanced comprehensive motivational theories based on these systems," Pulver said. "These attempts have not yet caught on, but we are moving in the right direction."

Still another way that neuroscience is impacting analytical theory, Pulver pointed out, is via its influence on concepts of the ego. Analysts used to view the ego as a rather abstract "hodge-podge of functions and processes," he said. But those functions and processes are now becoming much clearer, thanks to neuroscience research taking place in areas such as perception, planning, reasoning, learning, memory, self-awareness, and empathy. In fact, in 50 years or so, the term "ego" will be usurped by the term "executive system," Pulver suggested.

"Our topographic description of the mind, which we now crudely designate as 'conscious, preconscious, and unconscious,' " Pulver predicted, "will be refined to be congruent with the many different ways in which mental functioning relates to varieties of consciousness, an area now just beginning to be investigated by neuroscience."

Neuroscience, he said, is likewise hard at work in other areas pertinent to analytical theory. These include sleeping, dreaming, nonverbal communication, and mechanisms of therapeutic action. Advances in these areas, he anticipates, will also recast analytical theory.

What is crucial, he emphasized, is that analytical theories be kept congruent with neuroscience advances. "And we ought to be educating our psychoanalytic candidates about neuroscience," he added. "In fact, we are doing it at our institute in Philadelphia. Some sessions are being taught by analysts and neuroscientists simultaneously."

"So, while neuroscience is not going to help us with technique, it sure is going to tell us a lot about theory," Pulver concluded. To which his audience rose from their seats and gave him appreciative applause.

But had he converted them to his views on neuroscience and analysis? Some very possibly, but others not all. For one could be overheard saying as the applause receded in the spacious ballroom: "I disagree with Pulver's premise. If neuroscience influences our theory, it also has to influence our technique since our theory informs our technique." ■

Analysts Explore Roots of Prejudice And How It Can Be Contained

Prejudices often derive from fear, envy, or other negative emotions, according to some psychoanalysts. Although it may be difficult for people to get rid of prejudices, at least they can keep from acting on them.

BY JOAN AREHART-TREICHEL

For a few years now, Afaf Mahfouz, Ph.D., a Bethesda, Md., psychoanalyst, has been coming together with some other analysts at the December meetings of the American Psychoanalytic Association to probe the mental state of prejudice. "We have been struggling because we have been dealing with many contradictions and blind spots," she admitted during this past December's meeting.

Susan Lazar, M.D. (left), chats with Afaf Mahfouz, Ph.D., after a session on prejudice at the American Psychoanalytic Association meeting last December.

Nonetheless, she and the other analysts who have been brainstorming prejudice at these sessions believe that they are making some progress in better understanding it. Here are some of the insights that emerged at their latest session.

"Prejudice" means "prejudgment," according to the dictionary. And prejudices can be neutral or at least benign, Henri Parens, M.D., a Philadelphia psychiatrist-psychoanalyst noted. But more often than not, he said, prejudices are pejorative—that is, negative beliefs or feelings about other people.

And if prejudices are negative, one of the causes is often fear, session attendees tended to agree. For instance, sexism is a kind of prejudice, and it stems in psychoanalytic terms from men's fear that powerful women will castrate them, Beth Seelig, M.D., an Atlanta psychiatrist-psychoanalyst, asserted. Still another cause of negative prejudices is envy, session attendees indicated. And the envy that drives negative prejudices in turn often comes from the inability to have what another has, Harvey Rich, M.D., a psychiatrist-psychoanalyst from Washington, D.C., pointed out. Envy can also arise when people are conflicted about their own capabilities, Susan Lazar, M.D., a Bethesda, Md., psychiatrist-psychoanalyst, added.

Yet even negative prejudices that are born out of fear or envy or some other negative emotion become fully malignant only when people act on them, Parens indicated. For example, a negative prejudice becomes malevolent when someone shows hostility. Or a negative prejudice becomes vicious when it leads to a physical assault.

Can people rid themselves of their negative prejudices? Session attendees disagreed on this question. However, they appeared to agree that people can at least keep from acting on their negative prejudices.

One way to keep from acting on negative prejudices, Parens said, is to be aware of one's prejudices. "When we are aware of our prejudices, then we can quickly restrain ourselves," he explained.

Still another way to avoid acting on negative prejudices, he pointed out, is to be aware that prejudices are not fixed entities and, when fueled enough by fear, envy, or other negative emotions, can grow from sparks of dislike into flames of loathing and finally into conflagrations of hate.

Indeed, "resentment is a form of hate," and "resentment is the explosive element that dwells in all prejudice." This is the observation of Leon Wurmser, M.D., a Baltimore psychiatrist-psychoanalyst, who also attended the session. ■

How to Get the Most Out of Your PDA

BY FATIMAH A. TAHIL, M.D., M.P.H.

Recent advances in computer technology have redefined and simplified access to information. Today mobile technology has brought to the fore an ability to access virtually any information, anywhere, 24/7, at the mere tap of a fingertip. One such technology is the increasingly popular personal digital assistant (PDA) that utilizes the Palm OS platform. The thought that this palm-sized machine can redefine our self-image as better task organizers and time-efficient individuals is tempting, particularly in our world of demanding schedules. Indeed most of the psychiatry residents in my program have invested in the PDA, in the hope of fine-tuning our executive functions. In short, this is a machine that can help the trainee in psychiatry.

Not all of my colleagues, however, own a PDA, citing reasons such as cost and techno-illiteracy. Another concern has been that use of the PDA is like an eighth grader using a calculator: we ought to have the information in our head. The fact is, the amount of information for which we are individually responsible, from every drug-drug interaction to how each patient is billed by the clinic, has grown immensely in the past decades. No doubt we need to learn psychiatry, but for the information that is too much to memorize, we need these "assistants" that are "personally" tailored and "digital" to boot—the PDA.

I have found the value of this pocket-sized machine, primarily in its capacity to store and display a variety of information, be it references, lecture notes, or patient-based management data. While it may take some time to learn the magic of the PDA, it is important to appreciate the return on the investment. This article provides an overview of the uses of the PDA during residency training.

• Repository of reference materials: One can purchase, or download for free, many compacted versions of reference materials such as textbooks, handbooks, and databases containing laboratory values and specific medical specialty information. Also available are portable language translators, particularly worthwhile when human translators are not to be found in the wee hours of the morning.

The mobile, abbreviated version of the *DSM-IV* is worth its weight in gold for me, as is a handbook of psychiatry. Epocrates, which is a favorite with residents for handy information on today's prescribed drugs, is also used for checking drug-drug interactions. Many educators are advocating that we should not be expected to memorize drug-drug interactions, as we might get these constantly changing dyads wrong, and that it is far better patient care to be sure. The PDA is the right machine at the right time.

• Personal educational notebook: The memo function of the PDA enables the capture of the pearls of information handed down during our didactic classes, journal club, and grand rounds. These notes, retrievable anytime, anywhere, may be edited and reorganized at leisure.

Recording notes into the handheld using a stylus (or even a fingernail) is not difficult. The Grafitti system is mastered with practice, using Giraffe, a Palm OS game designed to transform you into a precise writer. Otherwise, an on-screen keyboard is available for tapping notes. Suggested alternatives for purchase are stick-on screen templates and various external keyboards designed for easier and faster text input.

• Updates in psychiatry: Keeping abreast of new paradigms in psychiatry is simple using the PDA. Imagine fast access to best-practice guidelines, leading-edge information, full-text journal articles, and abstracts. Download any document reader (such as the free Adobe Acrobat Reader) before selecting your reading materials.

• Patient-charting system: An essential add-on to your basic PDA is a database management program, which provides an organized structure for storage of multiple data elements. This is key to forming byte-sized patient medical charts. You can custom build, as I have, your own databases to keep track of patient information to which confidentiality can be responsibly secured by password. Data entry is simple, as is retrieval of information sought. If designing a patient database is challenging, opt for any of the prestructured patient-tracking applications on the Web.

• Daily planner/organizer: Originally designed for a paperless approach to appointments, meetings, and reminders, the PDA allows direct appointment scheduling of patients. For weekly therapy patients, a template of regular individualized appointments can be created in the date book. Other recurring activities such as grand rounds, supervision times, and staff meet-

see ***Residents' Forum*** *on page 20*

Dr. Tahil is a PGY-3 psychiatry resident at St. Luke's-Roosevelt Hospital Center in New York City. She holds master's degrees in medical informatics and public health.

Experts Disagree on Strategies To Reduce Medication Costs

While Congress and the Bush Administration argue about the best way to make prescription drugs affordable for the poor and elderly, Maine goes to the source and demands rebates from pharmaceutical manufacturers.

BY KATE MULLIGAN

Panelists at the keynote session, "Assess Options for Making Drugs More Affordable," of the Sixth Annual Congress on Medicaid and Medicare agreed on only one point: new ways must be found to make prescription drugs affordable.

According to the National Managed Health Care Congress (NMHCC), which sponsored the meeting last month in Washington, D.C., more than 40 states took steps last year to reduce escalating drug prices for the elderly, the uninsured, or Medicaid beneficiaries (*Psychiatric News*, January 18).

The panelists, who collectively represented state and federal governments and Congress, took sharply different positions about how to enable more people to benefit from the increased availability of effective prescription drugs.

Administration Pushes M+C

Jennifer Boulanger, acting director of health plans at the Centers for Medicaid and Medicare Services (CMS), said, "The administration is committed to a drug benefit in Medicare."

Boulanger described two approaches, which she called "short-term strategies," to increase access to drugs. Medicare+Choice (M+C), the Medicare managed care option, is "the fastest growing source for prescription drugs" and is also the basis for the administration's attempts to reform Medicare, according to Boulanger. She acknowledged, however, that the number of Medicare beneficiaries with access to an M+C program is declining and that benefits in those programs "particularly with respect to prescription drugs" are decreasing.

The second strategy is a Medicare-endorsed discount card program for prescription drugs. That program was announced last summer but has not yet been implemented. It would "use the organized purchasing power of millions of seniors and disabled Americans to move market share and lower the cost of prescription drugs," said Boulanger. She predicted that beneficiaries would get discounts averaging 10 percent to 13 percent on drugs through use of the card.

Senators Propose Legislation

Lisa Layman, senior policy advisor to Senator Bob Graham (D-Fla.), described provisions of the Medicare Prescription Drug Benefit Act (S 1135), which was introduced by Graham and 10 cosponsors last June and has been referred to the Senate Finance Committee.

In 1999, she noted, 75 percent of the M+C plans that offered drug benefits limited coverage to $1,000. S 1135 would offer a "standard prescription drug benefit as part of the Medicare program."

Medicare would contribute 50 percent of the cost of each prescription above the deductible of $250 and would also contribute 50 percent of the cost of premiums for most beneficiaries. After $4,000 in out-of-pocket expenditures, Medicare would pay any remaining expenses.

The program would be administered by the use of multiple competing pharmaceutical benefits managers (PBMs). Layman said, "We do not believe that the private sector should bear the insurance or the selection risk of a Medicare coverage benefit" because those companies might avoid signing up the beneficiaries most in need of prescription drugs. In a matter yet to be determined, the PBMs would be held accountable for the prices and mix of drugs and their skill at negotiating discounts and rebates.

Maine Demands Rebates

Panelist Kevin W. Concannon, commissioner of Maine's Department of Human Services, said, "States have been very passive for many, many years [concerning] the cost of prescription drugs," but change is coming about because of the increasing percentage of states' budgets allocated to those drugs.

Maine has two major initiatives concerning prescription drugs, both of which are under legal challenge by the Pharmaceutical Research and Manufacturers of America (PhRMA).

Healthy Maine Prescriptions is made possible through a Section 1115 Medicaid waiver that provides a single-purpose benefit extension. Through the program, any Maine resident is eligible for the Medicaid discount on prescription drugs as long as he or she has an income that does not exceed 300 percent of the poverty level. For example, a family of four with a monthly income of $4,413 is eligible for the program and receives a discount of approximately 25 percent on prescription drugs.

PhRMA filed suit, alleging that the Department of Health and Human Services (HHS) does not have the legal authority to grant a single-purpose Medicaid benefit extension. The legality of the program was upheld through several rulings and has been appealed by PhRMA to the United States Court of Appeals in the District of Columbia.

The second of the two programs, Maine R_x , was passed by the state legislature in May 2000, but implementation has been delayed by legal challenges.

Maine R_x authorizes Maine's commissioner of health services to negotiate rebates and discounts on prescription drugs for uninsured residents, establish maximum prices for prescription drugs if significant discounts and rebates are not negotiated by 2003, and require prior authorization under the Medicaid program if a prescription drug is not offered at lower prices.

According to the statute, a manufacturer or distributor of prescription drugs who charges an excessive price for prescription drugs or who restricts the supply of prescription drugs in the state may be assessed a civil penalty of up to $100,000 for each action.

In October 2000, PhRMA successfully challenged the program in the U.S. District Court for Maine based on constitutional grounds, including violations of the interstate commerce clause.

Maine appealed to the First Circuit Court of Appeals in Boston. The Court of Appeals ruled in the state's favor, saying that the program does not "regulate" the drug companies' interstate commerce and that the effect on the drug industry is not excessive in light of the benefits to be obtained.

PhRMA appealed the case to the U.S. Supreme Court, which asked for an opinion from the U.S. Solicitor General on the law's constitutionality. Concannon told *Psychiatric News* that he expects that opinion in the near future.

The text of S 1135 is posted at the Web site <thomas.loc.gov>. Various documents about the Maine initiatives are available at <www.state.me.us/dhs>. PhRMA's Web site is <www.phrma.org>. ■

N.Y. Consumers to Get Better Explanations When Coverage Denied

HMOs must provide specific medical reasons for denials of services, according to agreements negotiated by the New York state attorney general.

BY KATE MULLIGAN

Last October New York State Attorney General Eliot Spitzer announced a set of agreements that will enable consumers to challenge denial of coverage by health maintenance organizations (HMOs).

The agreements with six of the state's largest health insurance plans require HMOs to spell out the specific reasons for denying a treatment deemed "not medically necessary." Under current law, plans are required to disclose the reasons and clinical rationale they use to deny coverage, but have done so only in the most general terms, according to Spitzer. Consumers will now be told the specific medical findings on which the plans relied to support denials of service.

Seth Stein, J.D., executive director of the New York State Psychiatric Association, said, "The settlement is certainly a welcome development. We have been meeting with the attorney general and others for at least four years about problems related to denials of service. The kind of computer-generated responses doctors were receiving about reasons for denial made appeals very difficult."

The health plans are Aetna/U.S. HealthCare Inc./Prudential Health Plan of Hartford, Conn.; Excellus Health Plans Inc. of Rochester; Group Health Inc. of Manhattan; HIP Health Plan of Greater NY Inc.; Oxford Health Plans of Trumbull, Conn.; and Vytra Health Plans of Long Island Inc.

Staff of Spitzer's Health Care Bureau examined how HMOs authorized or denied care during the period from January 1, 1999, through June 30, 1999. This examination, said Spitzer in a press release, "revealed that these plans were refusing to pay for extended hospital stays and recommended treatment for anxiety, depression, and substance abuse, while offering nothing more than a generic phrase to justify the denial of such claims."

Some doctors treating addicted or suicidal patients were told that plans would no longer pay for the care they recommended at psychiatric hospitals because "the proposed service or treatment was not medically necessary."

The health plans have also agreed to:

- ensure that any company hired to conduct utilization review for a health plan complies with the terms of the agreement with the attorney general's office and with state laws;
- disclose to patients and their doctors that under the state's utilization review law, a plan's failure to meet the statutory deadlines for processing an appeal will result in an automatic reversal of the denial. When a plan does not meet the deadline, it must notify the consumer that the denial was reversed;
- comply with all the provisions for monitoring by the attorney general's Health Care Bureau, including maintaining complete and accurate records related to each denial; and,
- contribute $1 million to cover the costs of the attorney general's investigation.

Spitzer said his office will monitor HMOs for at least a two-year period to ensure that the plans comply with the terms of the agreement.

According to Donald Moy, J.D., general counsel of the Medical Society of the State of New York (MSSNY), the settlement will not affect the society's lawsuits against six managed care companies that together account for almost half of the managed care contracts controlling patient care in New York.

Those suits *(Psychiatric News*, October 19, 2001) charge the companies with "continual arbitrary denial of medically necessary care, capricious reductions in reimbursement claims, subjective downcoding and bundling of claims, as well as utilization of computer programs that deny claims based on arbitrary guidelines."

The MSSNY suit also cites "the failure of carriers to provide adequate staffing for the volume of claims being submitted and their failure to provide information to physicians about how claims decisions are made."

Moy told *Psychiatric News* that four of the six insurance companies have sued to shift the cases to federal courts and that no action on the merits of the cases is expected in the near future. He mentioned, however, a recent favorable ruling in Connecticut in which a state court had decided that medical societies have the right to sue insurance companies. ■

Parity: Where We've Been and Where We're Going

BY JAY B. CUTLER, J.D.

Photo: Marty LaVor

By now most APA members know that, in the closing hours of the first session of the 107th Congress, we came within two votes of a stunning victory in the long struggle to enact a meaningful federal mental health parity law for patients. The parity struggle offers important lobbying lessons that I want to share with you so we can work together even more effectively.

Last December, 18 House and Senate conferees on the Fiscal Year 2002 appropriations bill for Labor and Health and Human Services (HHS) met in a packed hearing room in the U.S. Capitol for an impassioned debate on mental health parity. With staff from APA's Division of Government Relations (DGR) and members of the APA-spearheaded allied Coalition for Fairness in Mental Illness Coverage in the room and lobbying until the last minute, conferee after conferee rose to speak in favor of the Domenici-Wellstone mental health parity amendment that was passed overwhelmingly by the Senate in October.

Unfortunately, when the vote came down to the wire, the House conferees—under intense pressure from the House GOP leadership—rejected the Senate amendment *(Psychiatric News*, January 18). The vote was 7 ayes to 10 nays, along strict party lines. Conferees subsequently approved a one-year extension of the limited 1996 Mental Health Parity Act. Most significantly, all our lobbying was not in vain. Rep. Ralph Regula (R-Ohio), chair of the House Labor-HHS Appropriations Subcommittee and the key House conference leader, having heard loudly and clearly from his grass-roots psychiatrists and working with us, issued a strongly worded statement included in the final conference agreement that the "conferees recognize the devastating impact of mental illnesses on Americans from every walk of life and the widespread bipartisan support of mental health parity legislation in both houses of Congress. The conferees strongly urge the committees of jurisdiction in the House and the Senate to convene early hearings and undertake swift consideration of legislation to extend and improve mental health parity protections during the second session of the 107th Congress."

Jay B. Cutler, J.D., is director of APA's Division of Government Relations.

Far From Failure

While it is frustrating to come so close, this was by no means a failure. Instead, we should focus on the tremendous progress we have achieved together in securing our ultimate objective of ending discrimination between health insurance coverage for psychiatric illness as contrasted to other medical illness. Here are just a few of the highlights of the successes we achieved jointly in 2001 with the extraordinary support and involvement of our local grass-roots APA members:

- 66 senators—two thirds of the Senate—sponsored the landmark Domenici-Wellstone parity bill, known as the Mental Health Equitable Treatment Act (S 543).
- 21 members of the Senate Health, Education, Labor, and Pensions Committee voted to approve S 543; not a single senator voted no.
- 66 senators sponsored the Domenici-Wellstone parity amendment that passed the Senate.
- Only a single senator spoke in opposition to the measure, which passed by overwhelming voice vote.
- 200 representatives sponsored the broader House parity bill, the Mental Health and Substance Abuse Parity Act (HR 162).
- 224 representatives—a majority of the House—signed a bipartisan letter supporting the Domenici-Wellstone amendment.
- All told, nearly 250 individual representatives expressed strong support for parity.
- An unprecedented number of editorials, op/ed pieces, letters, columns, and commentaries supporting parity appeared in newspapers across the country, including the *New York Times*, *Philadelphia Inquirer*, *Newsday*, *Business Week*, and *Boston Globe*, to name just a few.
- The strong report language increases pressure on House authorizers to take action on parity or else face another parity amendment in the 2003 spending bill.
- President Bush has pledged to work with Sen. Domenici on parity in 2002.

We can take tremendous satisfaction in the fact that our APA core message—that the case for parity is clear and compelling on the grounds of basic civil rights, scientific merit, and long-term cost savings—has been heard and largely accepted by public decision makers and opinion leaders.

Opposition to parity has essentially been reduced to two groups: the Church of Scientology (and those with similar antipsychiatric views), and big-business coalitions that generically oppose man-

see ***Capitol Comments*** *on facing page*

continued from facing page

dates. Even among business groups, opposition to parity relates more to perceived cost shifting than it does to disputes about the need for or efficacy of psychiatric treatment. It would, however, be a serious mistake to underestimate the cost concerns of business groups. These concerns are now being exploited by insurance industry associations who seek to deflect responsibility for the recent surge in health insurance premiums by blaming mandates—including mental health parity—and so-called "patients' rights" legislation.

The Challenge Ahead

What is our strategy for 2002? First and foremost, we must redouble our efforts to secure broad support in key House committees: Education and the Workforce, Ways and Means, and Energy and Commerce. We have already made a very good beginning, and your DGR staff has initiated meetings with key committee staff to explore the possibility of consensus in the House. Together, the grass roots and your staff will press for early hearings and legislative action.

Second, we must be prepared to respond to concerns about cost of coverage and the scope and efficacy of treatment. While we have certainly made the case for parity on ethical, scientific, and cost-benefit bases, the political reality is that House leaders are under heavy pressure from some sectors of their own constituencies to oppose parity in the context of double-digit health insurance cost increases and rising unemployment.

Third, we must build on the extraordinary grass-roots strategy that helped us move so far this year. Our dedication must be absolute, and the pressure—at the national and local levels—on recalcitrant representatives must be relentless.

Finally, we must redouble our work with local opinion leaders—reporters, editorial writers, local business groups, and local legislators—to make the case loud and clear to House leaders: support meaningful parity legislation NOW.

The main lesson of our struggle for parity is that success requires a coordinated, sustained national campaign that utilizes not only the national staff of mental health and patient groups and relentlessly engages the media, but also relies heavily on the active efforts of local grass-roots constituents. Again and again your DGR staff was told by Capitol Hill staff that they were hearing in unprecedented numbers from local constituents, prominent among them local psychiatrists with a clear message of support for parity, and that the local message was vitally important to their decision to support parity legislation in the Senate and House.

Bluntly, the struggle for parity literally cannot be won without your personal dedication. We are on the verge of a tremendous victory for our patients and our members. We at APA are deeply grateful for your outstanding efforts throughout 2001, and we look forward to working with you again in 2002 as we move ever closer to our ultimate goal of ending discrimination against our patients. ■

FDA Orders Liver Warning On Nefazodone Labels

The FDA's MedWatch program issues a new "black box" warning for nefazodone. The new patient insert must warn about the potential of the drug to cause liver failure.

BY JIM ROSACK

The Food and Drug Administration (FDA) last month issued a "black box" warning of the potential for the combined serotonin/norepinephrine reuptake inhibitor nefazodone (Serzone), to cause severe and possibly irreversible liver failure, leading to transplant or death.

Nefazodone maker Bristol-Myers Squibb was ordered to revise the labeling of the antidepressant and produce a new patient information packet to be dispensed with each prescription. FDA said Bristol-Myers Squibb cooperated fully with its request in the development of the new warning text and patient information.

The FDA's MedWatch program lists the risk of "life-threatening" liver failure at "about one case of liver failure resulting in death or transplant per 250,000-300,000 patient years of Serzone treatment."

However, a bolded statement that FDA has required to be added to the approved drug labeling warns that "this represents a rate of about 3-4 times the estimated background rate of liver failure. This rate is an underestimate because of underreporting, and the true risk could be considerably greater than this."

The new warning is based on postmarketing experience with more than 7 million patients in the United States.

Physicians are warned in the new labeling to advise patients of the signs and symptoms of liver dysfunction—jaundice, anorexia, malaise, gastrointestinal discomfort. Patients should immediately discontinue nefazodone if symptoms suggestive of liver problems develop. In addition, the drug will now be listed as contraindicated in patients with active liver disease or in those with a history of previous nefazodone-induced liver dysfunction.

According to the FDA, periodic serum testing of liver enzymes (the transaminases AST and ALT) has not been proven to prevent serious liver injury; however, experts agree that early detection of drug-induced hepatic injury and immediate withdrawal of the suspected drug enhance the likelihood of recovery.

Patients who develop an elevated serum transaminase level greater than three times

see ***Nefazodone*** *on page 25*

ADHD + Conduct Disorder May Signal Trouble Ahead

Are children who have ADHD likely to grow up to become criminals? A small study suggests they do not unless they also have conduct disorder.

BY JOAN AREHART-TREICHEL

Small children who don't mind their parents, who throw temper tantrums, and who are all charged up physically may be headed down the path to criminal behavior, a British study suggested recently (*Psychiatric News*, December 7, 2001).

But how about somewhat older youngsters who are simply maddening dervishes of activity? Are they too on track for becoming criminals later in life?

Probably not, unless their behaviors are also accompanied by a conduct disorder, suggests a study reported by German scientists in the October *Journal of the American Academy of Child and Adolescent Psychiatry*.

Several investigations in the past have implied that having attention-deficit/hyperactivity disorder (ADHD) in childhood increases the risk of engaging in antisocial behaviors in adulthood. But these studies really didn't look into whether the risk was due to having ADHD alone or to having ADHD combined with conduct disorder. So Sabine Herpertz, M.D., an assistant professor of psychiatry at Aachen University in Germany, and colleagues decided to undertake a study to see whether they could solve this riddle.

They selected for their subjects 21 psychologically healthy boys, 21 boys with ADHD alone, and 26 boys with ADHD combined with conduct disorder. All the boys were between 8 and 13 years of age. All ADHD subjects met *DSM-IV* criteria for that disorder. All subjects with ADHD and conduct disorder (ADHD-CD) met *DSM-IV* criteria for both disorders.

Involuntary Responses

They decided to use as their yardsticks of which boys were at risk of becoming future criminals certain involuntary psychophysiological responses that antisocial adults—and particularly adults who show fearlessness, lack of remorse, selfishness, and other enduring personality traits of habitual offenders—are known to display in reaction to acoustical stimuli.

Three of the responses were abnormally low skin-conductance reactions to attention-getting acoustical stimuli; abnormally low skin-conductance reactions to aversive, startling acoustical stimuli; and abnormally quick skin-conductance habituation to aversive, startling acoustical stimuli.

To assess subjects' reactions, the investigators seated all three groups of their subjects comfortably in a lab. First they measured the amplitude—that is, extent—of subjects' skin-conductance reactions to attention-getting acoustical stimuli. They then compared the results from all three subject groups.

The ADHD-CD subjects, they found, showed significantly less extensive skin-conductance reactions to the stimuli than did the ADHD subjects and the controls.

Next, the researchers measured the amplitude of the subjects' skin-conductance reactions to aversive, startling acoustical stimuli and compared the results from the three study groups. The extent of the responses by ADHD-CD subjects, they found, was significantly lower than that of ADHD subjects and also lower, although not significantly so, than that of controls.

Finally, the scientists measured, via skin-conductance reactions, how quickly subjects got used to aversive, startling acoustical stimuli and again compared results from the three groups. The ADHD-CD subjects got used to the stimuli significantly earlier than the ADHD subjects and controls did, the investigators found.

Taking these results together, Herpertz and her team concluded in their study report, "Boys with ADHD plus CD showed a psychophysiological-response pattern that is very similar to that reported from studies with psychopathic antisocial personalities."

Timothy Brewerton, M.D., a professor of psychiatry and behavioral sciences at the Medical University of South Carolina and a member of the APA Council on Children, Adolescents, and Their Families, told *Psychiatric News* that he thought the study is an important one "because it helps to dispel the commonly held belief that attention-deficit/hyperactivity disorder itself leads to delinquency."

Psychophysiological Predictors?

Psychiatric News also asked Adrian Raine, Ph.D., a professor of psychology at the University of Southern California and an internationally recognized authority on the psychophysiology of criminals, to assess the study results. "The findings make good sense within the wider context of what is known about the psychophysiological activity in antisocial groups," he said. "The fact that the hyperactive-only group does not show psychophysiological markers for antisocial behavior supports the importance of distinguishing between hyperactive children with and without comorbid antisocial behavior.

"The fact that hyperactive children with conduct disorder show psychophysiological characteristics of antisocial and psychopathic adult individuals," he continued, "is also supportive of [the] position that hyperactive children comorbid for conduct disorder may be 'fledgling psychopaths.' Nevertheless, due care must clearly be taken in extrapolating from these psychophysiological findings to the clinical practice of predicting who will and will not develop problem behavior. An important future question," he added, is "whether psychophysiological measures will be capable of predicting problem behavior in later adolescence and early adulthood."

Indeed, Herpertz and her colleagues agreed with Raine on this last point. "Further research should include longitudinal studies testing whether psychophysiological responses increase our ability to predict outcome of boys with extroversive disorders," they wrote in their study report. Herpetz told *Psychiatric News* that she and her colleagues will now be undertaking such a study.

The study by Herpertz and her team was funded by the Interdisciplinary Center for Clinical Research of the Medical Faculty, RWTH Aachen, Germany, and the German Society for the Advancement of Scientific Research.

An abstract of the study report, "Psychophysiological Responses in ADHD Boys With and Without Conduct Disorder: Implications for Adult Antisocial Behavior," can be accessed on the Web at <www.jaacap.com> by typing the article title in the "Quick Search" box. ■

ADHD May Have Given Ancient Man A Survival Edge, Researchers Believe

A gene variant implicated in ADHD is a lot younger, evolutionarily speaking, than other variants of the same gene, a new study suggests.

BY JOAN AREHART-TREICHEL

Having attention-deficit/hyperactivity disorder (ADHD) is not usually thought of as providing an advantage in our society. But suppose some of the characteristics of ADHD were found in human ancestors. Could hyperactivity or shifting attention help a hunter survive in a world of mastodons and saber-tooth tigers?

This scenario is more than sheer fantasy, thanks to new findings from Robert Moyzis, Ph.D., a professor of biological chemistry at the University of California at Irvine, and his colleagues. The findings are reported in the January 8 online edition of the *Proceedings of the National Academy of Sciences*.

In the past several years, evidence has been mounting that a deficiency in the neurotransmitter dopamine may underlie ADHD (*Psychiatric News*, March 16, 2001). There has also been reason to believe that a particular variant of a gene called the DRD4 gene, which makes brain receptors for dopamine, may play a causal role in ADHD. For instance, about half of all youngsters with ADHD have this particular gene variant. Moyzis and his coworkers wanted to find out when this particular gene version might have arrived in the human gene pool compared with other variants of the same gene.

They analyzed genetic material from 600 individuals throughout the world for the presence of the DRD4 gene. They found 56 different variations of the gene, including the one implicated in ADHD. They then determined, via gene-recombination techniques, that the gene version implicated in ADHD is probably much younger from an evolutionary viewpoint than the other variants are. That is, they hypothesized that it probably arose as a spontaneous mutation as recently as 10,000 to 40,000 years ago.

When this version popped up, they suspected, it might have provided those humans possessing it with some evolutionary advantage over other humans who did not have it—say, being able to spring quickly to spear a mastodon. After all, around the time that the gene variant putatively made its debut, mastodons were roaming North America.

The study by Moyzis and his team was financed by grants from the U.S. Department of Energy and the National Institute of Mental Health.

An abstract of the study, "Evidence of Positive Selection Acting at the Human Dopamine Receptor D4 Gene Locus," can be read online at <www.pnas.org/cgi/content/short/99/1/309. ■

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ings may be entered with start- and end-date specifications on a daily, weekly, monthly, or even yearly basis. Keep track of on-call days, precious vacation days, and APA annual meeting dates by easily generating a list for display using the find feature.

The alarm feature is an added bonus for those of us who frequently lose track of time. With more than 20 alarm preference selections, you can assign a sound to discern various meetings or reminders. Needless to say, some of these alarms are excellent wake-up calls, especially when on-call at the hospital.

• **Personalized white and yellow pages:** There is nothing like keeping a list of pagers and hospital staff's telephone and page numbers in the address feature. Bypassing the hospital operator at 3 a.m. saves time when the need arises for an urgent consult.

A clever feature within this directory is the virtual business card. If you wish to enhance your networking encounters at psychiatric conferences and meetings, create your own personal card through the preferences option in the address directory. Beam it to another PDA owner and consider yourself in the loop.

Since acquiring my PDA, it has inadvertently become my inseparable transition object, an integral part of my psyche. In an age where saving time is an asset, and exact knowledge is both power and safety, the PDA is essential in molding task-efficient residents. If we are to obtain administrative support for PDAs and PDA enhancements at the psychiatry training program and departmental levels, we will have to demonstrate that PDAs are "not hype, but help" to us in education and patient care. ■

Errata

The printed version of the booklet that accompanied the 2002 ballot incorrectly listed the date that Anita Everett, M.D., joined APA as 1968. The correct date is 1986. The date was correct in *Psychiatric News* and on the APA Web site and the online ballots. APA regrets the error.

In the December 7, 2001, issue, it was incorrectly stated in the article "Residents Must Be Taught to Teach, Training Directors Say" that the Residency Review Committee (RRC) is a part of the American Board of Psychiatry and Neurology. The RRC is a part of the Accreditation Council for Graduate Medical Education. ■

Latinos' Belief Systems Can Shape Analytic Process

When Latinos who adhere to the religion of Santeria or to the spiritual belief system of Spiritualism receive psychotherapy, their beliefs may influence the psychotherapeutic process.

BY JOAN AREHART-TREICHEL

Although most Latinos in the United States are Catholic or Protestant, a number also ascribe to two spiritual beliefs called Santeria and Spiritualism. When Latinos who hold such beliefs receive psychotherapy, it can influence the psychotherapeutic process.

So reported two social workers of Latino descent at the December meeting of the American Psychoanalytic Association in New York City, during a session on the interface of psychotherapy with Santeria and Spiritualism. They were Annecy Baez, Ph.D., an assistant professor of social work at New York University, and David Hernandez, an assistant executive director of St. Christopher's Inc. in New York City.

Santeria is based on the ancient West-African religion called Ifa, Baez and Hernandez explained. The Voodoo religion is also an offshoot of Ifa. Ifa and its derivatives are still practiced by some 100 million people worldwide. Ifa and its variants include a vast, colorful pantheon of gods and rituals for spiritual progress, divination, and healing; it also has a vibrant musicality based on drumming and chanting. Santeria priests are believed to be capable of curing illnesses, securing employment, attracting a lover, destroying enemies, or otherwise solving human problems.

Spiritualism, in contrast, is a spiritual belief system based on the belief in spirits, Baez and Hernandez continued. It originated with a Frenchman named Allen Kardec during the 1850s. Each person is supposed to have guardian angels who guide him or her through life. However, each person is also supposed to encounter evil spirits during life's journey. So Spiritualism priests are used to communicate with both helpful and harmful spirits to find out what rituals might make them happy. Such rituals often consist of prayer, group-healing sessions, and personal cleansing through herbal baths.

In Spiritualism, as in Santeria, mental and physical illnesses are attributed to spiritual illness, biological illness, or both, Baez and Hernandez said. Both Spiritualism and Santeria stress the importance of harmony and balance in one's life.

Education and socioeconomic level do not seem to have much influence on whether Latinos ascribe to Santeria or Spiritualism, Hernandez pointed out.

Beliefs Fall Along Continuum

There are also different levels of belief in Santeria and Spiritualism, he added. For instance, on Level One can be found Latinos who consider such beliefs unfounded and also Evangelical Latinos who consider such beliefs consorting with the devil. On Level Two can be found Latinos who do not personally adhere to Santeria and Spiritualism, but who nonetheless respect such beliefs. On Level Three can be found Latinos who are Catholic, but who may also have an altar at home to some Santeria deity. On Level Four are Latinos who attend Santeria ceremonies with drumming and dancing. "Their dancing is sort of like the Electric Slide," Hernandez explained, "with participants repeating the same steps to honor a deity." And on Level Five can be found those Latinos who are such fervent adherents of Santeria and Spiritualism that they have been initiated into having a patron deity.

Also of note, Hernandez added, Latinos can fluctuate between these different levels of belief in Santeria and Spiritualism depending on how much stress is present in their lives at a particular time. In other words, Hernandez said, "There is a spectrum of belief that goes from virtually no belief to fervent devotion, and a person can move along that spectrum depending on unemployment, illness in the family, infidelity of a spouse, or another stressor."

Thus, considering that a number of Latinos adhere to Santeria and Spiritualism, at least during stressful periods of their lives, it is not so surprising that such beliefs can sometimes impact psychotherapy with them, Baez and Hernandez indicated.

For instance, a Latino patient in psychotherapy might attribute his job loss to a rational cause, say a company downsizing, while at the same time suspecting his wife of seeing another man because of malevolent spirits, Hernandez said.

And if the latter is the case, Hernandez continued, the patient might want to not only talk with his therapist about his suspicions that his wife is being unfaithful, but also visit a Santeria priest to find out whether his wife is truly seeing another man because of bad spirits. If the Santeria priest says that his wife is being unfaithful because of bad spirits, the patient may then decide to make an offering to the Santeria deity Oshun. This deity is supposed to help people resolve marital problems.

David Hernandez says that stress can influence levels of belief in Santeria and Spiritualism. Annecy Baez, Ph.D. (above right), grew up in the Dominican Republic, where both traditional African and Asian beliefs were interspersed with Catholicism. Maya Peris, M.D. (below right), participated in the session on Latino folk beliefs.

Still another example of how beliefs in Santeria and Spiritualism can influence psychotherapy, Baez said, is when believers enter religious trances. For instance, Baez had contact with a Latino family who had been personally affected by the September 11 attacks on the New York City World Trade Center and who also believed in Santeria and Spiritualism. The mother started talking to her nephew, who had been killed in the tragedy. Baez realized that the woman was not delusional, but had entered a religious trance and needed spiritual support rather than being admitted to the hospital on suspicions that she had schizophrenia.

Baez, in fact, has had contact with Latinos who have schizophrenia, yet who also adhere to Santeria and Spiritualism beliefs. She has helped such individuals learn to distinguish the symptoms of a pending psychotic crisis from the signs of an approaching religious trance.

Some Suggestions

So how can psychotherapists handle Latinos' beliefs in Santeria and Spiritualism so that the beliefs facilitate, rather than impede, the psychotherapeutic process? Baez and Hernandez gave a few suggestions:

- Therapists should let patients bring up the subject of Santeria and Spiritualism, not broach it themselves. All Latinos do not hold such beliefs, and Evangelical Latinos find such beliefs anathema.
- If patients bring the subject up, therapists should let them know that they are somewhat familiar with such beliefs. As a result, patients will feel more comfortable with them and will feel that they have a common point of departure. Also, the information that the patients divulge about their beliefs may prove useful in psychotherapy.
- Therapists should respect patients' Santeria and Spiritualism beliefs since, as Hernandez stressed, "nobody who practices any of these things thinks there is anything 'folksy' about it."
- Finally, therapists should not be afraid that Santeria and Spiritualism practitioners are going to try to lure patients away from them. A number are quite knowledgeable about mental illness and usually try to get mentally troubled clients to seek conventional medical help. ■

Falling in Love: Is It All Flowers, Chocolate, and Oxytocin?

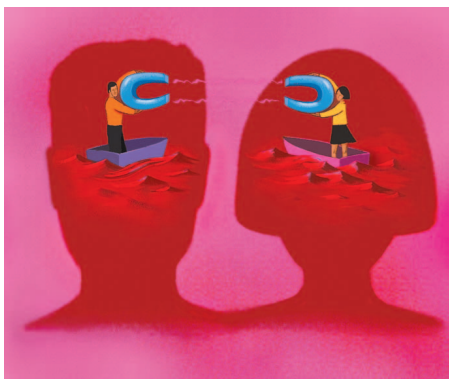
A Yale psychiatrist will be studying a psychological phenomenon of great interest to many people—the state of falling in love.

BY JOAN AREHART-TREICHEL

When February rolls around, many people's thoughts turn to Valentine's Day and romantic love. They get all warm and mellow inside and crank up production of hugs and kisses.

Yet Linda Mayes, M.D., an associate professor of child psychiatry at Yale University, has an interest in romantic love that extends far beyond Valentine's Day. She announced it at the December meeting of the American Psychoanalytic Association in New York City. She is planning to study a psychological-physiological phenomenon that scientists have scarcely heeded up to now. It is the state of falling in love.

She and a colleague will be recruiting Yale University students in romantic relationships for their study. They will then ask the students questions about their mental states during the periods when they fell in love, in hopes of gaining some insights into the process. For instance, they will be asking subjects: "What did you find especially attractive about your romantic partners?"



Mayes said that she suspects that falling in love might be akin to an obsessive-compulsive state because when young people fall in love, they are excessively preoccupied with each other.

If falling in love is similar to an obsessive-compulsive state, it may well be due to a rise in the hormone oxytocin, she believes. One reason why she suspects that this is the case is because oxytocin is known to underlie pair bonding and parenting. Another reason is that women prone to obsessions and compulsions are especially likely to engage in them during pregnancy and after delivery—times when oxytocin levels in their bodies are high.

Up to now, Mayes has been studying negative psychological-physiological arousal states in young people. For instance, she has found that youngsters who were exposed to cocaine in the womb tend to be emotionally labile and anxious, and she thinks it may hark back to cocaine's distorting norepinephrine and serotonin levels in their brains when they were fetuses. Indeed, cocaine is known to influence norepinephrine and serotonin levels in the brain, and norepinephrine and serotonin in turn are known to be involved in the regulation of negative arousal states.

However, the positive psychological-physiological arousal state of falling in love may differ dramatically from the negative psychological-physiological arousal states that she has studied so far, Mayes hypothesized. ■

Don't Underestimate Dangerousness Of Female Stalkers, Study Urges

Although men are more notorious for stalking than are women, women stalkers can be just as dangerous.

BY JOAN AREHART-TREICHEL

There are far fewer female stalkers than male ones—only 12 percent to 13 percent of all stalkers, by some counts. But how do female stalkers compare with their male counterparts? Are they just as predatory and dangerous?

The answer is yes, according to three authorities—Paul Mullen, M.D., a professor of forensic psychiatry at Monash University in Clayton, Victoria, Australia, and Rosemary Purcell and Michele Pathe, also of Monash University (*Psychiatric News*, June 15, 2001). They reported their results in the December *American Journal of Psychiatry*.

Mullen and his coworkers decided to obtain subjects for their study from a community forensic mental health clinic that specializes in the assessment and management of both stalkers and the stalked. Referrals to the clinic come mostly through the courts, community correctional services, the police, and medical practitioners.

Mullen and his colleagues defined stalking for the purpose of their study as persistent (duration of at least four weeks) and repeated (10 or more) attempts to intrude on or communicate with a victim who perceived the behavior as unwelcome and fear provoking. This was an intentionally conservative definition.

Mullen and his team selected 190 stalkers from the clinic who met their definition—150 males and 40 females. They then gathered demographic, psychiatric, and stalking-behavior information for the subjects and compared it on the basis of gender.

The male and female stalkers did not differ in terms of age, the researchers found; the mean age for both was 37 or 38 years. Nor did the two groups of stalkers differ in marital status, employment status, or diagnostic profiles—many in both groups had delusional disorders, personality disorders, morbid infatuations, and so forth. (Male and female stalkers also tended to use similar methods of harassment, except that female stalkers favored the phone, and male stalkers physical pursuit.)

Contrary to popular assumption, the female stalkers were no less likely than their male counterparts to threaten their victims or to attack their person or property. For instance, one female stalker damaged the sports car of her victim, her former fiancé. Another painted obscene messages on the fence of her victim's home. Nine of the 40 female stalkers assaulted their victims, and the nature of the assaults did not differ much from that of the male stalkers, except that the women did not commit any sexual assaults.

"There is no reason to presume that the impact of being stalked by a female would be any less devastating than that of a man," Mullen and his coworkers wrote in their report.

In contrast, the investigators discovered, there were some differences between the male and female stalkers—for one, choice of victim. With only two exceptions, the female stalkers focused on those with whom they had professional contact, especially psychiatrists, psychologists, and family physicians, although teachers and legal professionals were occasional targets. Male stalkers, in contrast, pursued a broad range of victims—not just professionals, but prior intimate partners, acquaintances, or strangers. Moreover, whereas female stalkers were just as likely to pursue women as men, male stalkers were more inclined to pursue women.

Finally, both the females and males engaged in stalking because they felt rebuffed, wanted to take revenge, or thought that stalking would help them get a date. But significantly more female stalkers wanted to establish an intimate, loving relationship with the person they pursued.

The study was financed by a postgraduate award to Purcell from the federal government of Australia.

The report, "A Study of Women Who Stalk," is posted on the Web at <ajp.psychiatryonline.org> under the December 2001 issue. ■

Budget

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treatment and community supports for nonviolent criminal offenders with severe mental illnesses, research and treatment of youth with posttraumatic stress disorder, the development of model suicide-prevention programs, mental health counseling of public safety workers, and mental health education and services to senior citizens.

- **The Children's Mental Health Program,** which grants funding to states to provide community-based services to children with serious emotional disorders.
- **The Youth Violence Prevention Program,** which funds state efforts to reduce school-based violence through early intervention and treatment.

Congress approved a 5 percent increase for the Center for Substance Abuse Treatment within SAMHSA, for a total FY 2002 budget of $2.017 billion. The Center for Substance Abuse Prevention had a budget increase of 13 percent, for a budget of $198 million. ■

Rejection of Rehab Facility Costs Small Town Big Bucks

A federal jury assesses damages against a small Maryland town that said "not in our backyard" to a psychiatric rehabilitation center that tried to buy a building in the town's small downtown area.

BY KEN HAUSMAN

A small Maryland town is facing the prospect of paying big monetary damages to a facility that provides rehabilitation programs for people with mental disabilities and to one of its clients.

Leonardtown, Md., population 1,475, is the county seat of mostly rural St. Mary's County. The town council refused to grant an occupancy permit to the Pathways Psychosocial Support Center, which wanted to relocate its rehabilitation facilities from a rural setting to a building that was for sale within the town's borders.

After it was thwarted several times by the council and the town's zoning board, directors of the Pathways center turned to the courts to affirm their belief that the Leonardtown governmental bodies had acted illegally in preventing them from opening the rehabilitation facility.

The battle lines were drawn in 1997 when Pathways began looking for a building in Leonardtown so that its clients would have more rehabilitation options, such as education and employment opportunities, than were available in the rural setting where the facility was then located. The center serves approximately 35 to 40 clients daily. (It also has a residential rehabilitation program, but that was going to remain at the original site.)

Center officials found a suitable building in a section of downtown Leonardtown that was being revitalized, an area in which property purchasers qualified for state financial assistance under Maryland's Neighborhood Revitalization Project. The catch, however, was that the funding was contingent on a purchaser's getting the backing of the town council.

Pathways originally had that approval. Two months later, however, council member Daniel Muchow brought the issue back to the council. He indicated he was troubled by having a facility that would bring many mentally ill people downtown. Several citizens agreed and protested at a council meeting the council's endorsement of Pathways' move to Leonardtown.

The council then voted to rescind its endorsement, which caused Pathways to lose the opportunity to buy the building with the state grant.

Pathways then turned its sights on another available building in Leonardtown's small downtown area, which the center planned to buy with private funds borrowed from a bank. The town council quickly indicated it would not approve an occupancy permit. The reasons it gave, according to Pathways attorney Beth Pepper, were first a concern about lack of adequate parking and then one based on a zoning issue—that a rehabilitation facility such as Pathways was not a legitimate use in an area zoned for commercial enterprises.

Pathways then had to turn to the zoning board, which agreed that the proposed use was not in compliance with zoning regulations, though medical offices were allowed to operate in the same area. As a result Pathways ended its loan agreement with the bank and lost the chance to buy the second building.

The case eventually went to trial, with Pathways and one of its clients, Clarissa Edwards, charging that the council and Muchow violated the Americans With Disabilities Act by discriminating against people with mental illness.

Before it could get its case before a jury, however, Pathways had to convince a federal court that it had standing to sue under the Americans With Disabilities Act. Leonardtown officials contended that only an individual has the right to sue for violations of that federal law. The court decided in the center's favor, ruling that Pathways was, in fact, entitled to sue, because the injuries and discrimination it was alleging were a direct result of its association with individuals who have a mental disability.

On December 18 a jury at the U.S. District Court for the District of Maryland found in favor of the plaintiffs and ordered the town of Leonardtown and Muchow to pay monetary damages. The town is to pay Pathways $540,916 in compensatory damages, primarily for losing the opportunities to purchase the two buildings. Edwards is to receive $20,000 in compensatory damages from the town. In addition, the jury ordered Muchow to pay Pathways $1 in compensatory damages and $5,000 in punitive damages. He is to pay Edwards $1 in compensatory and $15,000 in punitive damages.

Pathways and Edwards have also petitioned the district court judge for injunctive relief, Pepper said, which would stop the town from excluding Pathways from opening a rehabilitation facility in the downtown area—assuming it can find another building.

The saga is not over yet, however. The town's attorney, Daniel Karp, has indicated that Leonardtown will probably file an appeal. Leonardtown "does not, individually or collectively, discriminate against the mentally ill," he told the *Washington Post.*

So it will be a long time, if ever, before Pathways sees any of the damage award.

And it is still searching for a new facility, but its executive director is pessimistic about finding a suitable one. "We continue to look at the possibility of moving some of our operations to Leonardtown," Gerald McGloin, told *Psychiatric News.* "But it's been four and a half years since we first attempted to move, and since that time most of the suitable buildings in the commercial district have been purchased or rented."

Pepper told *Psychiatric News* that the verdict is "very significant in that it is one of the first involving the NIMBY [not in my backyard] syndrome that resulted in a jury verdict. The jury clearly found stereotypes about the mentally ill unacceptable and went a long way toward expressing the importance of welcoming people with mental disabilities into its community."

[*Pathways, et al. v. Town of Leonardtown, et al.*, U.S. District Court for the District of Maryland, No. DKC 99-1362] ■

More on Privacy Rule

Q. What is the difference between a "consent" and an "authorization" under the HIPAA's privacy rule?

A. The privacy rule under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) refers to both "consents" and "authorizations" with regard to releasing protected information. Although in common practice these terms are frequently used interchangeably, under the privacy rule they are distinct and separate concepts with clear definitions and requirements.

Patient "consents" permit the release of protected information for the purposes of treatment, payment, and health care operations *only*. "Treatment, payment, or health care operations" include the following activities:

- Payment
- Utilization review
- Peer review
- Quality assurance
- Continuity of care (disclosures to "providers," health care facilities, and others for treatment purposes)

Physicians are allowed to refuse services/treatment, except in emergency situations, if a patient refuses to sign a consent form for the physician to use and disclose protected health information for treatment, payment, or health care operations.

Consents must be in writing, and a patient has the right to revoke an existing consent in writing.

The privacy rule authorizes the release of information for treatment, payment, or health care operations without consents only in limited situations, as specified in the privacy rule.

Patient "authorizations" are required for all other disclosures; in other words, for all disclosures made for purposes other than treatment, payment, or health care operations. For example, an authorization is needed when a patient requests records to be released to his or her attorney. Unlike consents, physicians cannot condition services/treatment on the receipt of an authorization form from the patient. Patient authorizations must be in writing and in specific terms. Patients can revoke authorizations in writing.

The privacy rule also requires that physicians obtain patient authorization, with additional, specified elements when patient information is to be used for the physician's own uses and disclosures. For example, additional elements (such as any remuneration that the provider will receive) must be included in an authorization prior to the provider's disclosing protected health information to a pharmaceutical company.

Protecting confidential patient information is familiar territory for psychiatrists. Liability for releasing certain kinds of information without proper authorization or consent (that is, breaching confidentiality) already exists under state and federal laws. Ideally, psychiatrists should already be requiring patients to authorize, or consent to, the release of confidential information for all purposes, including for treatment and payment.

However, under the privacy rule, psychiatrists will be required to use specific documents designated as "consents" and "authorizations." Fortunately, the rule explicitly lists the necessary elements for both consent and authorization forms. Furthermore, the Department of Health and Human Services has indicated that it will provide additional guidance on drafting consent and authorization forms in the future.

There are several resources available from the Psychiatrists' Program for APA members to learn more about HIPAA and specifically how the privacy rule affects psychiatrists.

Online Education at <www.apa-plip.com>

- "HIPAA Help" provides HIPAA facts and figures such as a comprehensive HIPAA diagram and a listing of important HIPAA-related resources. Also available is a copy of "How to Handle HIPAA Hype," reprinted from APA's P*sychiatric Practice and Managed Care* (volume 7, number 2).
- "HIPAA in the News" gives advisories and updates.
- "HIPAA—You Asked For It" is a 15-minute presentation explaining the major events that culminated in the creation of HIPAA's privacy rule. It was written by PRMS Risk Management Consultant Donna Vanderpool, J.D., M.B.A. (This document is available at the Online Education Center for program participants only.)
- "An Overview of HIPAA's Privacy Rule," also written by Vanderpool, is a 36-minute presentation explaining the basic requirements of the privacy rule. It also offers downloadable handouts and a checklist to assist you in complying with the privacy rule. (This program is available at the Online Education Center for program participants only.)

Seminars

Professional Risk Management Services will present a series of one-day seminars titled "What Mental Health Professionals Need to Know About HIPAA's Privacy Rule." The seminar will include information on special protections for psychotherapy notes, the new federal patient rights, disclosure of patient information pursuant to the privacy rule, and compliance requirements. The seminars are scheduled as follows:

- **March 22:** The Conference Center at Sheppard Pratt, Baltimore/Towson, Md.
- **April 26:** Batterymarch Conference Center, Boston
- **June 28:** JPMorgan Chase Conference Center, New York City

More information on the seminars is available by calling Cynthia Smith at (800) 245-3333, ext. 347, or visiting <www.prms.com> on the Web. More information on joining the Psychiatrists' Program, the APA-endorsed Professional Liability Insurance Program, is available by calling PRMS at (800) 245-3333, ext. 389, or visiting its Web site at <www.apa-plip.com>. ■

This column is provided as a service to the membership by the Psychiatrists' Purchasing Group Inc., operator of the APA-endorsed Professional Liability Program. Send your questions to Pnews@psych.org.

Systems

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fell 7 percent, when adjusted for inflation, between 1990 and 1997, according to the report.

Not surprisingly, mental health is not a high priority for many states. In 2001, only seven states ranked mental health as a top priority, and 17 states ranked it among their top three priorities, according to the National Conference of State Legislatures.

More Reliance on Medicaid

States are also relying on the Medicaid program to fund more of their mental health budgets because the federal government provides a matching contribution, according to Koyanagi. "The problem is that Medicaid doesn't cover people with serious mental illnesses who are homeless or earning a living just above the poverty line but don't have health insurance. Without a Medicaid card, these people often can't get access to mental health services," said Koyanagi.

Although low-income people with severe mental disorders are eligible for Medicare as disabled persons, their medications are not covered, and their psychiatric treatment is reimbursed only up to 50 percent, said Gudeman.

Without accessible community mental health services, more people with serious mental illnesses show up in hospital emergency rooms or other crisis facilities, which in the long-term is more costly, according to Bernstein.

Shift in Funding

Howard Goldman, M.D., director of mental health policy studies and a professor of psychiatry at the University of Maryland School of Medicine, told *Psychiatric News* that despite the overall decline in mental health funding, states have shifted more of their funds towards community mental health services in the last decade.

Goldman, who is also a project director at the National Association of State Mental Health Program Directors Research Institute, referred to a 1999 report showing that state mental health agencies in Fiscal Year (FY) 1997 spent $9 billion, or 56 percent of their total expenditures, on community-based mental health services, which was up 31 percent from FY 1993. State psychiatric hospital inpatient spending in FY 1997 represented 41 percent of the total state mental health agency expenditures, according to the report.

In addition, several state mental health authorities have shown interest in improving the quality of mental health care by partnering with academic centers to develop and implement evidence-based services, said Goldman.

Evidence-Based Practices

Examples of evidence-based practices are assertive community treatment (ACT) programs and supportive employment, according to Goldman. The first ACT program was founded in the late 1970s in Madison, Wis., and relies on a multidisciplinary team of usually 10 to 12 professionals to provide a comprehensive array of services to people with serious mental illness in the community, Goldman explained. Because of the intensity of services, ACT programs typically have small caseloads, making them more cost-effective, according to Goldman.

Bernstein, the executive director of Bazelon, commented that evidence-based practices are important, but do not reach or work for everyone who relies on the public mental health system.

Educating Lawmakers

The Bazelon Center plans to urge state legislators to reform the system and adopt a model law its staff developed. The law would entitle people with serious mental illnesses to receive comprehensive mental health services and supportive services to assist their recovery, integrate into the community, and foster economic self-sufficiency, said Bernstein.

Koyanagi, the main author of another new Bazelon report, *Recovery in the Community: Funding Mental Health Rehabilitative Approaches under Medicaid*, said that 49 states and the District of Columbia now cover community-based psychiatric rehabilitation services under Medicaid, and slightly fewer states cover case management services, although these services are not mandated by Medicaid law.

"Most states cover basic psychiatric rehabilitation skills such as going to the grocery store that enable people with mental illnesses to function independently. But fewer states cover supportive services that enable people with serious mental illnesses to be employed and live independently, and even fewer cover critical services such as peer support and integrated services for co-occurring mental illness and addiction disorders," said Koyanagi.

"State laws also fall short because they allow the provision of mental health services to be subject to existing resources. We hope that if state legislatures adopt the model law, they will back it up with the appropriate resources," said Bernstein.

The reports "Disintegrating Systems: The State of States' Public Mental Health Systems" and "Recovery in the Community: Funding Mental Health Rehabilitative Approaches Under Medicaid" can be ordered online from the Bazelon Center at <www.bazelon.org/pubs.html>. There is a $4 fee per report plus $2 for postage and handling. ■

clinical & research news

Nefazodone

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the upper limit of normal while on nefazodone should be immediately taken off the drug and should be considered at increased risk for recurrent liver failure if the drug is reintroduced.

Physicians are strongly encouraged to report any serious adverse events to the FDA's MedWatch program by phone at (800) FDA-1088, by fax at (800) FDA-0178, or on the Web at <www.fda.gov/medwatch>.

The warning letter to health care practitioners and the complete revised labeling are posted on the Web at <www.fda.gov/medwatch/SAFETY/2002/safety02.htm#serzon>. ■

Philadelphia

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rent practices in substance abuse prevention and treatment, and diversity issues. Charles G. Curie, M.A., A.C.S.W, the recently appointed administrator of SAMHSA, will present a forum addressing the leadership challenges in mental health and substance abuse.

As part of the SAMHSA "track," Mary Jeanne Kreek, M.D., will give a lecture in the Frontiers of Science series on the neurophysiology of opioids. If you have never heard Dr. Kreek speak, I urge you to attend.

There will be four other "must-attend" Frontiers of Science lectures this year. Gerald Fischbach, M.D., dean of the Columbia University College of Physicians and Surgeons, will present "Neuroscience in the New Millennium," addressing issues of stem cell research and other 21st-century technology. Richard Mayeux, M.D., will present his stellar research on Alzheimer's disease (hint, wear a helmet when bicycle riding). Ira Byock, M.D., a well-known palliative care expert, will speak on "Dying Well: Beyond Symptoms and Suffering, Human Development at the End-of-Life." Many of you have seen the articles in the news media and in the *New England Journal of Medicine* about the research on implantable left ventricular assist devices. We are most fortunate to have the opportunity to hear from an outstanding cardiac surgeon, Eric Rose, M.D., the lead author of this research.

The 21st century brings with it remarkable challenges and expectations for advances in the diagnosis and treatment of psychiatric disorders. Sadly, the 21st century has also brought with it tragedy that we could not imagine. In keeping with Dr. Harding's theme, and in response to the events of last September, the annual meeting will present several sessions on issues related to realities and myths regarding violence, terrorism, and PTSD.

John Monahan, M.D., will give the Guttmacher Award lecture, presenting the MacArthur Study of Mental Disorders and Violence. Lenore Terr, M.D., will give the Marmor Award lecture on "Terror, Horror, and Fright: Past and Current Perspectives." Philip Zimbardo, M.D., will talk about "Evil in the World and Terror in Our Nation," and Samuel Klagsbrun, M.D., will present a forum on evil. Elio Frattaroli, M.D., will discuss the meaning of psychiatry after September 11. Randall Marshall, M.D., will present the mental health community response to the disaster in New York City, and Frederic Kass, M.D., will talk about the innovative collaboration between Columbia University (and the many New York City mental health professionals who volunteered to participate in this program) and the New York Police Department. Jerrold Post, M.D., will share his clinical expertise in a forum titled "Killing in the Name of God: Osama bin Laden and Radical Islam."

How do we aid in the response to terrorism? Ronnie Stangler, M.D., will present the forum "PSYOP: Psychological Operations in the War Against Terrorism." Rachel Yehuda, M.D., an international figure in research on the impact of trauma, will be available in a special "meet the authors" session on the "Treatment of Trauma Survivors: Theory vs. Practice."

There are many remarkable award lectures that will require planning if you wish to get a seat. Let me mention a few worth jotting down today. Don't miss any of the lectures in the Distinguished Psychiatrist Lecture Series. More information on these will appear in a later issue. Also, David Satcher, M.D., who will receive the Patient Advocacy Award, will discuss the findings and implications of his Surgeon General's report on mental health. Benedetto Saraceno, M.D., will fly to the United States to deliver the International Lecture and discuss the global implications of the "World Health Report 2001 on Mental Health." James Comer, M.D., who will receive the Benjamin Rush Award, will speak on "Problems Facing Inner-City School Educators and the Role of Psychiatry in Addressing Them."

A special treat will be the lecture by Sidney Lumet, the internationally acclaimed director of motion pictures, television programs, and stage productions, noted for his psychological dramas.

Each year the Convocation of Fellows features a special speaker. This year is no exception. We are most privileged that Rodger McFarlane will give the William C. Menninger Memorial Lecture on "Psychiatry and the Medical Consumer Movement." He is the former executive director of the Gay Men's Health Crisis and Broadway Cares/Equity Fights AIDS. He is also the author of the best-selling book *The Complete Bedside Companion.* Please note that the starting time of the Convocation is 6 p.m. this year.

The Master Educator Clinical Consultation sessions are limited in attendance to 30 people. You will find a broad range of topics including psychotherapy, treatment of addicted women, adult learning disabilities, the impact of childhood parental loss, integration of the bio- , psycho- , and social domains in child/adolescent clinical work, and the doctor-patient relationship in pharmacotherapy.

The other small-group format at the annual meeting is the discussion groups. We are starting a new feature this year: "Meet the Authors," where APPI authors will discuss topics from their books. Stuart Yudofsky, M.D., will discuss neuropsychiatry; Glen Gabbard, M.D., will speak on psychodynamic psychotherapy, and Rachel Yehuda, M.D., will talk about the treatment of trauma survivors. I am very excited about this collaboration between APPI and the annual meeting and expect these to be dynamic sessions.

I realize that no matter how hard I try to include everything, many wonderful sessions will surprise you when you review the entire program in the next issue of *Psychiatric News.* However, I anticipate that this brief review of annual meeting sessions will whet your appetite and stir you to register for what I expect to be a most memorable annual meeting.

More information on APA's annual meeting, including registration and housing forms, can be accessed on APA's Web site at <www.psych.org> by clicking on the annual meeting logo. ■

Consultation

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chologist from India who spoke five languages, which led to a number of Indians being referred to us," said Kirmayer.

Refugees were often referred for consultations to clarify the meaning of their behaviors or diagnoses. Many had been persecuted and tortured because of their political views, ethnicity, or religion and were seeking political asylum in Canada.

"Some of our consultants knew about specific groups' political and ethnic conflicts, which helped to validate the refugee's story and filled in gaps the refugee could not remember because of being dissociative. The referring clinician sometimes tended to assume the stories were fabricated as a convenient way to enter Canada," said Kirmayer.

Another important skill was understanding the family structure in the patient's country of origin and cultural views on marriage, divorce, and gender roles, according to Kirmayer.

Cultural Biases Challenged

"Occasionally, we had to challenge our cultural biases, such as assuming that arranged marriages are a recipe for misery, although there is no evidence to support that view," said Kirmayer.

Consultants also needed to understand the impact of migration on families. Often there was a loss of extended family and communal supports, changes in social status and gender roles, and intergenerational conflicts, said Kirmayer.

Tensions in the clinician-patient relationship were another reason for consultation referrals. "The patient who, for example, came from a country where physicians were authority figures did not feel comfortable with a physician who expected a dialogue," said Kirmayer. The consultants try to bridge the gap by explaining to the patient and clinician how their styles and expectations differ.

Clinicians' View of Program

The referring clinicians who were surveyed about the service gave it high marks for increasing their knowledge of social, cultural, religious, or psychiatric aspects of patient care and improved treatment, according to Kirmayer.

What they liked least was they couldn't transfer the patient's care to the consultation service, said Kirmayer.

"We designed our cultural services to be time limited so the consultants could take on new cases. For example, in 1999 and 2000 we received 102 consultation requests regarding individuals from 42 countries who spoke 27 languages. We were able to triage half of them by telephone, including giving advice and directing the clinician to other resources," said Kirmayer.

Since the research grant ended in 2000, Jewish General Hospital has hired psychiatrist Eric Jarvis, M.D., to direct the cultural consultation service.

But funding remains a critical issue. "Although the Canadian Medicare program pays for the clinician's services, it doesn't cover the services of nonmedical culture brokers," said Kirmayer.

He is encouraged that the Minister of Health recently created a multicultural advisory committee to identify ways to improve delivery of health care services.

Kirmayer would like to see the cultural consultation service replicated in other cities. He also recommended that psychiatrists and mental health professionals be trained to work with interpreters and culture brokers starting in residency and graduate programs.

"We also need to use clinicians' cultural background and language skills in consultations."

The evaluation report on the cultural consultation service, clinical resources, and information about the annual Summer Program in Social and Cultural Psychiatry at McGill University, which offers research and clinical training, are available at <www.mcgill.ca/psychiatry/ccs/eng/>. ■

'Universal Care' System Inevitable

An article in the December 21, 2001, issue, "Medicare's Managed Care Option Falls Short of Promise," shows once more that managed care only manages the care of the managed care companies' money.

Managed care corporations of all types are giving sick people and their true caretakers (health professionals) more and more of less and less as they protect their profits.

"Corporatized" medicine is also giving America every evil predicted for "socialized" medicine, only worse. Corporations' overhead plus profits siphon into their pockets 14 percent to 30 percent of the $1.2 trillion (and rising) spent yearly on health care. No matter how high that $1.2 trillion goes, billions of dollars will always be there for the corporations. That's because they will keep both the amount of care they provide and the pay of health professionals low.

The American people will finally get fed up and end the managed care profiteering party with its headaches, heartaches, and wasted time, energy, and money and its (often fatal) assault on sick people and administrative assaults on the health care "providers."

A universal care system (traditional Medicare type) with control of premiums and prices is inevitable and long overdue. The "market system" is a demonstrated failure. Worse, it is a profiteering ripoff.

LAWSON H. BOWLING, M.D.
Marietta,Ga.

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.

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Depression

continued from page 1

burgh and co-author of the study, said that although the growth in treatment for depression is good news overall, the quality of this treatment is still in question.

"We don't know if these cases are longitudinal contacts—whether people are being treated over the long term effectively," said Pincus, who is also director of the RAND Corporation's health program in Pittsburgh and former director of APA's Office of Research.

He noted that primary care doctors are probably handling the bulk of the depression cases.

Pincus noted that the study arose out of a national program sponsored by the Robert Wood Johnson Foundation called Depression in Primary Care: Linking Clinical and System Strategies *(Psychiatric News*, September 7, 2001).

"In this program, we are trying to break down some of the barriers to effective depression treatment in primary care," said Pincus, who directs the program.

What is behind this dramatic shift in the number of people seeking help for depression? "The availability of antidepressant medications with fewer distressing side effects commonly weighs in on the decision to seek treatment," said Olfson, referring to the introduction of fluoxetine in late 1987. This drug was followed by the development of other selective serotonin reuptake inhibitors (SSRIs), which boasted fewer harmful and bothersome side effects and which posed less danger of overdose than the older tricyclic antidepressants previously used to combat depression.

Depression Awareness

Olfson and his co-authors also noted that antistigma and education campaigns directed at the health care industry and the public made it easier for people to seek help for depression.

One such major public health and antistigma campaign noted by the study authors was the National Institute of Mental Health's Depression, Awareness, Recognition, and Treatment (DART) program, launched in 1988.

The program targeted three groups for depression education: primary care clinicians, mental health clinicians, and the general public. It sought to increase knowledge of the symptoms of depression and the availability of effective treatments.

Darrel Regier, M.D., M.P.H., executive director of the American Psychiatric Institute for Research and Education, served as director of the Division of Clinical Research for the DART program. He told *Psychiatric News* that the program sponsored public service announcements, awards presentations, and celebrity appearances that included actor Rod Steiger, humorist Art Buchwald, and the Harlem Globetrotters, for instance. DART was folded into a depression outreach program at NIMH in the mid-1990s.

In addition, an article published by Regier and colleagues in the November 1988 issue of the *American Journal of Psychiatry* established the scientific basis for the treatment of depression and lent extra credibility to the education and antistigma efforts of the DART program.

The article showed that depression is a treatable and common condition, and that most people seeking help for depression turn to their primary care doctors first.

Another well-known public education program of the early 1990s seeking to raise awareness of depression was the National Mental Health Association's Campaign for America's Mental Health, which was sponsored by Eli Lilly and Co. It was begun in 1992.

Study authors also noted the widespread influence of National Depression Screening Day (NDSD), first launched in 1991 and conducted by Screening for Mental Health Inc. By the end of the second data collection in 1997, NDSD had established 2,800 screening sites in the U.S. and Canada, according to the report.

Olfson and his colleagues linked these national depression education and antistigma programs to increased public acceptance of medication intervention, as reflected in opinion polls.

For instance, findings from a 1986 Roper poll showed that only 12 percent of respondents were willing to take medication for depression and that 78 percent of people would be willing to live with the depression until it passed. An ABC News poll conducted in April 2000, however, found that 28 percent of adults would be "willing to take antidepressants for depression over an extended period even though they were informed that safety studies had not been conducted on long-term use of these medications."

Long Road Ahead

Paul J. Fink, M.D., a former APA president and currently chair of APA's Task Force on Psychiatric Aspects of Violence, has long been involved with protecting patients' rights and the destigmatization of mental illness for years. He maintained a cautionary perspective of the study findings.

"I think the increase in people being treated for depression is fabulous," Fink said. "However, there are still millions of people who are afraid to seek treatment for depression and other mental illnesses due to stigma." These people, he noted, may quit treatment and stop taking medications prescribed to them because "they are afraid to be on a mind-altering drug, even if this drug could save their lives."

Although the study results are good news, "psychiatrists should not be complacent," warned Fink, who said that so much stigma still surrounds mental illness that it is hard to measure.

One reason to stay vigilant is to guard against future stigma, according to Fink. "New generations of people are seriously and negatively affected by all of the antipsychiatry hype, which makes it harder and harder to sustain the concept that there is value in what we [as psychiatrists] do."

Future antistigma efforts should continue to guide people to depression screening, evaluation, and high-quality treatment. "Good treatment is destigmatizing," said Fink, "and with it, people with depression can live good lives."

An abstract of the study, "National Trends in the Outpatient Treatment of Depression," is posted on the Web at <http://jama.ama-assn.org/issues/v287n2/abs/joc11356.html>. ■

CPA

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trists, forensic psychiatrists, and geriatric psychiatrists have been advocating since the 1990s for subspecialty certification by the Royal College, which the CPA supports, said Rae-Grant.

The CPA was instrumental in getting psychiatry included in the Royal College's maintenance-of-certification program. Beginning last year, certified psychiatrists are required to take 400 hours of continuing professional development (CPD) over five years, according to Rae-Grant.

The CPA was approved by the Royal College in 1999 to accredit programs for psychiatric CPD sponsored by other medical organizations. The CPA also hosts accredited programs at its annual and international meetings that are supported by the pharmaceutical industry but meet the CPA's strict standards, according to Dawn Haworth, director of corporate affairs for the CPA.

The CPA maintained close ties with APA, and Cameron, who served as CPA president from 1958 to 1959 previously served as president of APA for the 1952-1953 term.

It is a longstanding tradition that the presidents of the two associations attend each other's annual meeting. APA has also long maintained district branches for Canadian psychiatrists.

Many Canadian psychiatrists also belong to the Canadian Medical Association, which has had a section on psychiatry since 1945. The CPA became an affiliate of the CMA in 1960 and has a delegate on the CMA General Council. The CPA also forged relationships with organizations representing people with mental illness, including the Canadian Mental Health Association, Schizophrenia Society of Canada, Mood Disorders Society of Canada, and National Network for Mental Health. Because stigma remains a barrier to psychiatric treatment, the CPA collaborated with these organizations to launch the first Mental Illness Awareness Week in Canada in 1991, said Rae-Grant.

These five groups formed the Canadian Alliance on Mental Illness and Mental Health in 1998 to advocate in a unified voice for improved treatment, education, and research. The alliance issued a national action plan on mental health in 2000 aimed at reducing stigma, developing a national research agenda including a national database on mental illness and mental health, and proposing national policies to improve psychiatric services, especially to underserved areas, according to the CPA (*Psychiatric News*, Oct. 15, 1999).

The Canadian government has historically underfunded mental health research, according to Rae-Grant. A national workgroup co-chaired by alliance chair Sylvia Geist, M.D., and Donald Addington, M.D., chair of the CPA Scientific and Research Committee, proposed a new Canadian Institute on Mental Illness and Mental Health Research in 2000.

The government launched the Canadian Institutes of Health Research last June, and an interim council recommended that one of the new research institutes be devoted to mental health, addictions, and the brain. The alliance was successful in getting several psychiatrists appointed to the research institute's advisory board, according to the CPA.

Outgoing CPA President Michael Myers, M.D., told *Psychiatric News* that he plans to remain involved in efforts to identify and overcome stigma, which was the theme of his presidency and a goal of the mental health alliances's national action plan.

"Suicide prevention was a major topic of the CPA's 2001 annual meeting [*Psychiatric News*, January 18] and must be linked to efforts to reduce stigma and improve treatment of mental illnesses.

"I plan to pursue forging an alliance between the CPA and the Canadian Association of Suicide Prevention to discuss the need for a national suicide prevention action plan," said Myers.

Myers, a corresponding member of the APA Committee on Physician Health, Illness, and Impairment, recently formed the CPA Section on Physician Health and plans to facilitate collaboration between the two committees.

The anniversary book* Psychiatry in Canada: 50 Years *is summarized on the CPA Web site at <www.cpa-apc.org/anniversary.asp> and can be ordered online for $16 (Canadian). ■

Ecstasy

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inhalants. "We think that the active efforts of the Partnership for a Drug-Free America and other organizations to get the word out about the dangers of inhalants have paid off," he said. He noted that in 1996 adolescents surveyed around the time of an ad campaign warning about the dangers of inhalant use perceived that the risk of such behavior was greater than did adolescents surveyed at other times.

• For each grade level on the aggregate, the percentage who used any illicit drug during the prior year was lower than peak usage found several years ago. However, only the percentages for eighth graders are notable. Usage rates for that group dropped from 23.6 percent in 1996 to 19.5 percent in 2000 and 2001. The other two grades did not show any change between 2000 and 2001 either. The plateau is due to the fact that usage rates for marijuana, which is the most commonly used illicit drug, remained steady this year.

• For all student groups, marijuana use remained about the same in 2001 as in 2000. Rates were especially high for 12th graders, for whom peak usage occurred in 1997, when 38.5 percent of 12th graders used marijuana. In 2001 the usage rate was 37 percent.

• The percentage of teens who smoke cigarettes is declining. Between 1996 and 2001, smoking among eighth graders fell from 21 percent to 12 percent, and among 10th graders from 30 percent to 21 percent.

More information about the Monitoring the Future study can be obtained at <www.monitoringthefuture.org>. ■

Methadone

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physicians and other health care professionals will make decisions based on standards that emphasize best-care practices for patients."

The final approval of the four accrediting agencies follows recommendations made in 1997 by a National Institutes of Health consensus panel, which concluded that the existing federal and state regulations limited the ability of physicians to provide methadone treatment to patients and recommended the move away from regulatory oversight to accreditation in an effort to improve the quality of care. The change is also consistent with a report by the Institute of Medicine in 1995, which stressed the need to readjust the balance among regulations, clinical practice guidelines, and quality assurance systems.

Under the regulations authorizing the new accreditation process, treatment programs must apply for certification to one of the four approved accrediting agencies no later than March 4, so that accreditation is achieved no later than May 19, 2003.

CSAT, Clark said, is providing technical assistance to help treatment programs meet the new federal regulations and the accreditation standards. Each of the four accrediting agencies will provide technical assistance to programs seeking certification through their agency.

Questions regarding technical assistance with meeting the new accreditation standards can be directed to a toll-free CSAT helpline at (800) 839-6120. Other information about the new federal regulations is available toll free from CSAT at (866) 463-6687. ■

Antidepressants

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tory of prior response to medications, and presence of comorbid psychiatric and/or general medical conditions.

Most of the strong preference indicated in the survey may be coming from multiple anecdotal accounts within various physician practices, Petersen believes. The majority of the physicians attending the review course surveyed, he noted, were private practice physicians who "often may not have access to or the time necessary to go through the case reports and studies that are so widely known in academic and research circles."

In addition, Petersen noted, most believe that side-effect profiles for SSRIs are much more favorable than for the older TCAs or MAOIs.

Influential Side Effects

The remaining questions in the survey asked respondents about particular side effects commonly associated with antidepressants.

The majority of physicians responding to the survey believed mirtazapine (Remeron) was most likely to cause weight gain. Fluoxetine (Prozac) was considered most likely to cause sexual dysfunction (57 percent), followed by paroxetine (Paxil) (26 percent.)

When asked which antidepressant was most likely to cause a discontinuation syndrome, 48 percent responded paroxetine, and 29 percent said venlafaxine (Effexor).

More than half of those responding said fluoxetine causes agitation, while 26 percent cited bupropion (Wellbutrin).

Petersen noted that these results are a bit of a "mixed bag" with respect to matching the empirical evidence. Two of the respondents' beliefs are backed up by research—the belief that mirtazapine is the most likely to cause weight gain and that paroxetine is more likely to cause a discontinuation syndrome.

However, he said, research has not distinguished fluoxetine in particular as likely to cause sexual dysfunction, although there is empirical evidence that SSRIs in general are more likely to be associated with this side effect. As for agitation, Petersen noted, a review of empirical literature found that no single antidepressant type is most likely to produce this side effect.

Science Not Supreme

Petersen and his coauthors suggested that "scientific knowledge (empirical evidence) is not the only factor to consider when faced with the decision of what to prescribe a patient." They believe that the prescriber relies on at least four sources of data: accepted scientific knowledge, patient context, own experience, and situational context.

"Prescribing practices are influenced in many ways," Petersen told *Psychiatric News*, "by economics, by HMO or formulary restrictions, certainly by efficacy, but perhaps most by side effects and situational context. And I think marketing and detailing play a role. You don't hear these prescribers talking a lot about [older tricyclics] in this survey."

Petersen stressed that future surveys should gather information at the level of the individual agent for all questions and should gather more detailed information about respondents' characteristics.

An abstract of "A Survey of Prescribing Practices in the Treatment of Depression" is available on the Web through <www.sciencedirect.com>. ■