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PSYCHIATRIC NEWS

"See" references appear in articles on pages 3, 4, 11, 15, 18, 19, 25, 26

Jeremy Lazarus, M.D. (left), is congratulated by John McIntyre, M.D., on his election as vice speaker of the AMA's House of Delegates. McIntyre is chair of the AMA Section Council on Psychiatry, and Lazarus is a former speaker of APA's Assembly.

Psychiatrist Wins AMA Leadership Post

Professional News

Psychiatrist Jeremy Lazarus, M.D., is on track to be a future president of the AMA.

BY KATE MULLIGAN

Jeremy Lazarus, M.D., won an upset victory at the June AMA meeting to gain one of the top positions in the association.

In his new role as vice speaker of the House of Delegates (HOD), Lazarus will assist the speaker in directing the HOD's activities and will also sit as a nonvoting member on the AMA Board of Trustees.

The House of Delegates is the AMA's policymaking body.

Lazarus told *Psychiatric News*, "This is an important victory for psychiatry because it shows the respect that our AMA colleagues have for our specialty. It also is a reminder of the value of our section council's long history of working within the AMA to put forth the issues that affect psychiatrists and their patients."

Lazarus said the AMA has been particularly helpful in supporting efforts to secure parity for mental health in private insurance and the Medicare program and about issues affecting scope of practice.

John McIntyre, M.D., APA's senior delegate to the AMA, told *Psychiatric News*, "This is the most important position within the AMA that a psychiatrist has ever held."

He added, "It was not an easy victory. Dr. Lazarus's opponent, Dr. John Fagg, a plastic surgeon from North Carolina, has a long and distinguished history within the AMA. Last December he was identified by many delegates as the clear front runner."

Lazarus's energy, enthusiasm, progressive message, and history of leadership in psychiatry and medicine were key factors to his success, according to McIntyre.

Alternate APA delegate Jeffrey Akaka, M.D., told *Psychiatric News*, "The size of the delegation and increased influence of psychiatry within the AMA were important to the victory. Each of us could turn to friends and allies in other section councils and state societies to make the case for Jeremy."

Delegate Carolyn Robinowitz, M.D., said, "This was an uphill battle that represents politics at its best. Our job was to help give delegates a chance to know Jeremy. He did the rest. His competence is apparent immediately."

Robinowitz is a member of the AMA Council on Scientific Affairs (CSA).

APA Medical Director James H. Scully Jr., M.D., told *Psychiatric News*, "Jeremy's victory was first a recognition by his colleagues of his capability as a leader in medicine and of the respect they have for him. That he is a psychiatrist and a leader in APA reaffirms the role of psychiatry as a medical specialty and shows continued reduction of stigma toward the field."

Lazarus is chair of APA's Council on Advocacy and Public Policy and has chaired APA's Investment Oversight Committee and the Ethics and Managed Care committees. He is a former speaker of APA's Assembly. In addition, he is president of the Colorado Medical Society and chair of the Colorado AMA delegation.

Lazarus said that being vice speaker of the House of Delegates will enhance his

please see ***AMA*** *on page 37*

Clinical & Research News

FDA Warns Of Suicide Risk With Paroxetine

Following the action taken by its British counterpart, the FDA warns physicians and the public that paroxetine should not be prescribed to children and adolescents.

BY JIM ROSACK

The U.S. Food and Drug Administration, following in the footsteps of its British counterpart, warned June 19 that the antidepressant paroxetine (Paxil) may be linked to "a possible increased rate" of self-harming behaviors, including suicidal behavior in children and adolescents. As a result, the FDA stated that the drug should not be prescribed to this population for the treatment of major depressive disorder (MDD).

The FDA statement said "three well-controlled trials in pediatric patients with MDD failed to show that the drug was more effective than placebo. The new safety information that is currently under review was derived from trials of Paxil in pediatric patients."

Paxil, the FDA noted, "is not currently approved for use in children and adolescents." The agency also noted that "[t]here is no evidence that Paxil is associated with an increased risk of suicidal thinking in adults."

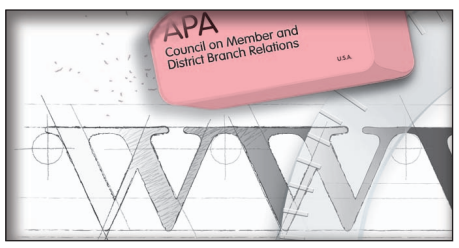
Both the FDA and the British regulatory agency stressed that Paxil should not be initiated as new treatment in any pediatric patients. In addition, Paxil should not be abruptly discontinued in any patient (pediatric or adult). Due to a known discontinuation syndrome associated with Paxil, the medication should be slowly tapered under close supervision by a physician.

Only a week before the FDA's action, the United Kingdom's Department of Health, acting on the recommendation of its Medicines and Healthcare Products Regulatory Agency (MHRA), issued on June 10 a warning to British physicians that was more strongly worded than the FDA warning. An

please see ***Suicide Risk*** *on page 37*

Coming Soon!

APA's Web site is now being redesigned and its content enhanced. It is expected to go live in the fall. See story on page 2.



APA President Explains Impact Of Ruling on Malpractice Insurer

The following is a message from APA President Marcia Goin, M.D., to update APA members on developments regarding the APA-endorsed Psychiatrists' Professional Liability Insurance Program.

In February 2002 the policy-issuing carrier for the APA-endorsed Psychiatrists' Professional Liability Insurance Program at that time, Legion Insurance Company, was downgraded by A.M. Best from A- (superior) to B (fair). A few months later, the commissioner of the Pennsylvania Insurance Department, which regulates Philadelphia-based Legion, petitioned the Commonwealth Court of Pennsylvania to place Legion in rehabilitation. Since the time that motion was granted, Legion has operated under the control of the department, which oversees its finances and maintains its day-to-day operations. As long as it remains in rehabilitation, Legion is responsible for claims brought against psychiatrists who are insured under policies it issued.

In late August 2002, however, the rehabilitator petitioned the court for an order of liquidation, and on June 26, 2003, Judge Mary H. Leavitt issued a ruling providing for issuance of such an order of liquidation. Although Legion currently remains in rehabilitation, it is anticipated that this will occur sometime after July 14, 2003. The order also granted the motion of Psychiatrists' Purchasing Group (PPG) to give psychiatrist policyholders direct access to the reinsurance purchased from Transatlantic Reinsurance Company for the Professional Liability Insurance Program. If this provision survives possible appeals, this would be very good news for many policyholders, particularly those who may now have access to the reinsurance funds to cover claims that might not otherwise be covered by state guarantee funds because of fund limits or exclusions. PPG is the sponsor of the Psychiatrists' Professional Liability Program and has provided educational and liaison services to insureds.

While it is possible that the decision of the court will be appealed and not immediately implemented, APA is in the process of reviewing the court's lengthy opinion to fully understand all aspects of the ruling. It is also working with its consultants and program personnel, particularly principals of PPG and PRMS, the administrator of the APA-endorsed program, to determine how the decision is likely to affect psychiatrists insured through the program who have malpractice claims against them and what steps they may need to take under the order.

As soon as we have additional information about any of these matters or whether an appeal has been filed, we will pass it along to you.

If you have specific questions about your policy or coverage, please contact PRMS by phone at (800) 245-3333 or by e-mail at update@prms.com. As we learn more, we will use the pages of* Psychiatric News *and other means as appropriate to keep you updated. Also, PRMS is likely to post updates on its Web site at <www.psychprogram.com>. ■

APA's Redesigned Web Site Will Be More Informative, User Friendly

The treasure trove of information available to members on APA's Web site will be easier to find and look far more attractive on the Association's improved Web site, which will go live this fall.

BY CATHERINE F. BROWN

It's been a long time coming, but months of hard work by APA's Council on Member and District Branch Relations and staff will pay off shortly when APA launches its totally revamped Web site this fall.

What members will find is a far more attractive, graphically oriented Web site with easy-to-navigate features—many of which are new—that will provide breaking news of interest to psychiatrists, information on the practice of psychiatry and advocacy, and programs that offer continuing medical education credit.

"We set out to create a site that is vibrant and easy to maneuver," said Michael Vergare, M.D., chair of the Council on Member and District Branch Relations and vibrant. "Members should be able to scan

please see ***Web Site*** *on page 36*

The "Suicide-Prevention Contract": A Dangerous Myth

BY MARCIA GOIN, M.D.

The "no-suicide" contract, where patients are asked to sign an agreement not to commit suicide, or in common parlance, "to contract," has become disconcertingly commonplace. A pseudo-legal agreement, it is alien to our best practices. Increasingly, clinicians refer to the need "to contract" with patients who they fear might harm themselves. It would be wonderful if contracts truly prevented such tragedies, but there are no reliable or valid data to confirm their effectiveness. Indeed, the use of such contracts flies in the face of clinical common sense and may in fact increase danger by providing psychiatrists with a false sense of security, thus decreasing their clinical vigilance.

Where did this begin? In 1973 Drye et al., in a suicide study published in the February 1973 *American Journal of Psychiatry*, developed a detailed questionnaire referred to as the "no-suicide decision." In future writings this evolved into the "no-suicide contract." The questionnaire was not designed as a contractual agreement, but rather as a vehicle to assess suicidal risk and make vital decisions about patient management. Patients were asked a series of questions regarding self-destructive thoughts and fantasies and then asked to consider the statement: "No matter what happens, I will not kill myself accidentally or on purpose at any time." If the patients could not fully agree, they were asked what modifications would make the statement acceptable. For example, could they accept a substitute of one hour, two weeks, and so on for the phrase "at any time"?

The investigators were enthusiastic about the use of this technique as a way of continuously monitoring, not controlling, the seriousness of a patient's suicide risk. The questionnaire assured that the clinician was continuously and methodically exploring the patient's thoughts and feelings and was a safeguard against any conscious or unconscious tendency for the psychiatrist to shy away from asking difficult questions. What originated as a guide to evaluation has dramatically and dangerously been transposed into a "contract" that some believe will control and/or prevent suicide.

The soon-to-be-published APA Guideline for the Management of Suicidal Behavior (see page 15) states the following about prediction: "We may know the risk factors, but knowledge of the risk factors will not permit the psychiatrist to predict when or if a specific patient will die by suicide." And in terms of a contract, it states, "The suicide-prevention contract, or 'no-harm contract,' is commonly used in clinical practice but should not be considered a substitute for a careful clinical assessment.

please see ***From the President*** *on page 38*

APA's Annual Meetings Department Working for You

BY JAMES H. SCULLY JR., M.D.

The 156th Annual Meeting of the American Psychiatric Association was held in San Francisco May 17 to 22. The total registration was 21,363 (compared with 19,887 in 2002), making this the largest annual meeting ever held. This total includes 6,607 members (19 percent of the APA membership), 10,272 nonmembers, 3,957 exhibitors, 353 members of the media, 6,570 international registrants (886 of whom were members), and 155 APA staff. From comments made by registrants throughout the week, we concluded that the 2003 annual meeting was a great success.

APA's Institute on Psychiatric Services will be held October 29 to November 2, in Boston (see pages 27 and 28). This is a small educational meeting held annually focusing on clinical and service programs, especially those that provide an array of services and clinical innovations to meet the needs of the most challenging patients.

The revenue generated from annual meetings is APA's second highest source of revenue, which is used to offset the costs of other APA projects.

The Annual Meetings Department (AMD) coordinates both the logistics and scientific programs of APA's annual meeting and the Institute on Psychiatric Services. AMD staff are responsible for coordinating all meeting logistics; publication printing; meeting publicity; registration; housing; busing; budgeting; contracts; vendor selection; ceremonial events (Opening Session and Convocation); staff coordination (including staff meetings and orientation); maintenance of historical databases, reports, and files; space assignments; site selection; and shipping.

AMD is also responsible for all logistical arrangements for governance meetings (Board of Trustees, Area Councils, Assembly, fall component meetings), and other APA meetings held throughout the year (committee meetings, Legislative Institute, and so on). Staff work closely with the Scientific Program Committees for both meetings by providing administrative support and meeting coordination.

The department is staffed by 19 employees, with an annual budget of $1.4 million. While the revenue generated from the meetings varies from year to year, the average total annual gross revenue for both meetings is approximately $14.8 million. The annual meeting alone nets anywhere from $2.5 million to $4.3 million a year.

Here's how we do it:

It starts with submissions to present a scientific session—an average of 1,750 for the annual meeting and 550 for the institute are processed each year. Many formats are offered—Advances in Research, Forums, Symposia, Industry-Supported Symposia, Lectures, Workshops, Scientific and Clinical Reports, Debates, Medical Updates, Review of Psychiatry Sessions, Caucuses, Innovative Programs, CME Courses, New Research Sessions, Clinical and Continuous Case Conferences, Distinguished Speakers, Research Advances in Medicine, Discussion Groups, Full-Day Sessions, Master Educator Clinical Consultations, Posters, Leadership and Career Development Seminars, Research Consultation With Series, and other invited and special sessions. Additionally, the department acquires and processes commercial support for symposia and various meeting activities.

Staff also prepare the program materials for 10 books for the annual meeting and five books for the institute, process more than 5,000 disclosure forms for both meetings, and coordinate audiotaping of 170 annual meeting sessions and 60 institute sessions.

Publicizing the meeting takes on a variety of forms—detailed information is posted on the APA Web site, advertisements and articles appear in our publications, and postcards and flyers are sent to all APA members, prospective members, medical students, and other mental health professionals.

With about 20,000 annual meeting attendees and 2,000 institute attendees, the registration process is monumental. AMD staff, along with temporary staff, enter data into the computer, confirm and acknowledge registrations and course enrollment, process monies and receipts, process cancellations and issue refunds, and prepare status reports.

Site visits are conducted prior to the meetings, and space assignments for the sessions are made. Staff secure buses, housing (up to 9,000 rooms on peak nights), audiovisual equipment, decorators, and all vendors needed to make the meeting successful.

On site, AMD staff manage the logistics for more than 600 scientific sessions, 160 allied meetings, and 225 component meetings; assist with registration; staff the Annual Meeting Office, where staff solve problems and provide membership support; check sessions to ensure program quality and compile statistical data; and manage the housing and shuttle bus services.

Following each meeting, staff prepare a critique for the purposes of implementing changes and enhancements for future meetings.

Final planning is under way for this fall's institute. APA's 2004 annual meeting will be held May 1 to 6 in New York. We look forward to your attendance at both of these important meetings.

Feel free to e-mail your questions and comments to me at medicaldirector@psych.org. ■

Mental Health Issues Reach Congressional Agenda

Several bills designed to address the mental health needs of children, adults, and the elderly are wending their way through Congress.

BY CHRISTINE LEHMANN

There has been a burst of legislative activity in Congress recently addressing the needs of children and adults with psychiatric problems.

The Senate bipartisan bill to reauthorize federal aid for special education passed the Senate Health, Education, Labor, and Pensions (HELP) Committee last month by a vote of 21-0. The bill, titled the Individuals With Disabilities Education Improvement Act of 2003 (IDEA), will move to the Senate floor for debate and a vote, although that may not occur until after Congress returns from its August recess.

Lizbet Boroughs, an associate director of APA's Division of Government Relations, told *Psychiatric News*, "We were gratified that the full committee included language we proposed requiring schools to conduct behavioral assessments of children facing disciplinary actions to determine whether their behavior problems resulted from their disability."

However, APA remains concerned that children who bring illegal drugs or weapons to school will automatically be removed from school without having the behavioral assessment, said Boroughs.

Another positive provision requires the schools to determine whether a student's behavioral problems were a result of the failure of the child's individualized education plan to contain positive behavioral interventions and supports. Another provision provides funding to expand special support and interventions in schools to prevent student discipline problems, according to Boroughs.

These provisions were welcomed by APA, the American Academy of Child and Adolescent Psychiatry (AACAP), and Children and Adults With Attention Deficit Disorder (CHADD).

HELP Committee Chair Sen. Judd Gregg (R-N.H.) and ranking Democrat Sen. Edward Kennedy (D-Mass.) worked for months on drafting a compromise bill to avoid a repeat of partisan clashes that occurred during the 1997 IDEA reauthorization. The senators promised to address funding levels when the bill goes to the Senate floor.

APA, AACAP, and CHADD opposed the House version of the IDEA reauthorization bill (HR 1350), which passed in April by a vote of 251-171. The primary reasons were that the bill didn't contain the behavioral-assessment language and that, while parents could appeal a school's decision, the bill required them to prove that their child's behavioral problems were related to their disability, said Boroughs.

Protecting Immigrant Children

APA joined several groups, including AACAP, the Child Welfare League of America, and Physicians for Human Rights, in sending a letter to senators urging them to cosponsor the Unaccompanied Child Protection Act of 2003 (S 1129), introduced by Sen. Dianne Feinstein (D-Calif.) in May.

The letter stated, "S 1129. . . would ensure that each child is treated humanely while in federal custody, is placed in settings appropriate for their special circumstances, and is protected from those who might seek to further exploit them. In addition, S 1129 would provide an infrastructure for pro-bono legal representation of such children in their immigration proceedings that would help expedite the resolution to their immigration status, providing counsel at government expense only as a last resort."

The bill was prompted by a recent report by Amnesty International outlining poor conditions in detention centers where undocumented immigrant children are placed while in federal custody.

Preventing Child Abuse

Congress passed legislation last month to renew the 1996 Child Abuse Prevention and Treatment Act. President George W. Bush quickly signed S 342 into law (now Public Law 108-36).

The goal of the legislation is to provide funding to local communities for outreach programs designed to prevent child abuse and encourage adoptions. The bill authorized $200 million in grants for Fiscal 2004.

The conference report passed by both the Senate and House includes a provision requiring that health care providers involved in the delivery or care of infants affected by illegal substance abuse or withdrawal symptoms notify child protective services.

"I think this initiative will go a long way toward protecting children before they are subjected to abuse," said Rep. James Greenwood (R-Pa.) in *Congressional Quarterly Today* on June 18.

The conference report also includes a provision authorizing a new program to help children who witness domestic violence based on a bill introduced in 2001 by the late Sen. Paul Wellstone (D-Minn.) (*Psychiatric News*, November 2, 2001).

Child Mental Health Workforce

Sen. Jeff Bingaman (D-N.M.) introduced the Child Healthcare Crisis Relief Act (S 1223) last month to increase the number of child mental health care professionals in the workforce. The bill is the

please see ***MH Bills*** *on page 38*

House Bill Would Help Americans Build Psychological Resilience

A bill now before Congress is intended to help Americans cope with the psychological consequences of terrorism. The legislation calls for a federal interagency task force to coordinate public education and evidence-based programs to increase psychological resilience.

BY CHRISTINE LEHMANN

Studies of the health impact of the sarin gas attack in the Tokyo subway system in 1995 and the September 11, 2001, terrorist attacks in the United States suggest that in the event of a future terrorist attack, psychiatric casualties will outnumber physical casualties by 4 to 1.

Yet taking steps to build the public's psychological resilience has barely been on the public health system's radar screen and has been overlooked by the Department of Homeland Security in preparing for and responding to terrorist attacks, according to psychiatrist Michael Barnett, M.D., APA's 2002-03 Daniel X. Freedman Fellow in Rep. Patrick Kennedy's (D-R.I.) office. Terrorism is defined in the bill as a conventional, biological, chemical, or radiological attack on the United States.

Barnett helped develop the National Resilience Development Act of 2003 (HR 2370), which Kennedy introduced last month in the House of Representatives. The bill would require federal health agencies to coordinate their efforts with the goal of increasing the public's psychological resilience by integrating effective clinical interventions and educational programs into national terrorism preparedness, response, and recovery efforts.

To facilitate the coordination of federal efforts, the legislation calls for the creation of the Interagency Task Force on National Resilience. The secretary of the Department of Health and Human Services would head the task force, and its members would include the directors of the Centers for Disease Control and Prevention, National Institute of Mental Health, and Office of Public Health Emergency Preparedness; the administrators of the Substance Abuse and Mental Health Services and Health Resources and Services administrations; and the surgeon general of the United States.

"Most of these agencies and the surgeon general have already expressed interest in developing strategies to increase the public's psychological resilience in the event of a terrorist attack," Barnett told *Psychiatric News*.

The task force is also charged with consulting with the departments of Homeland Security, Defense, and Veterans Affairs; the American Red Cross; and national organizations of health care professionals to ensure that public communication strategies and interventions designed to build psychological resilience are integrated into national and local emergency response systems, according to the legislation.

"We recognize that there isn't a one-size-fits-all strategy to increasing psychological resilience at the local level because of cultural and other variations among local communities," said Barnett.

The legislation also calls for collaboration between state public health and mental health agencies in developing evidence-based interventions and educational programs to enhance psychological resilience. "The result should be better, more effective delivery of health care in the event of a disaster and more efficient collaboration with the interagency task force," said Barnett.

To fund these provisions, the bill would require the states to set aside 1 percent of the overall emergency preparedness funds they receive from the Department of Homeland Security to use for implementing efforts to build psychological resilience locally.

Barnett was doubtful that Congress would take up the legislation before next year since there is so little time left on the congressional calendar, and Congress is occupied with other pressing issues, such as a Medicare prescription-drug benefit.

"The bill takes a proactive approach to dealing with the psychological consequences of terrorism," he said. "We shouldn't wait until terrorism strikes again because we will be that much further behind."

The text of the National Resilience Development Act of 2003 can be accessed on the Web at <http://thomas.loc.gov> by searching on the bill number, HR 2370. ■

Lt. Col. Cameron Ritchie: "The public health training will enable me to evaluate the services I and others provide."

Ritchie commented to *Psychiatric News*, "I have considerable experience addressing psychiatric issues in combat units and a long-standing interest in disaster psychiatry. The public health training will enable me to evaluate the services I and others provide."

Ursano envisions numerous public health applications to psychiatry ranging from addressing depression and PTSD to somatic complaints regarding exposure to SARS or monkey pox.

For example, said Ritchie, the government has issued protective masks to emergency health workers and soldiers to wear in the event of a bioterrorist attack.

"When the U.S. entered the first Gulf War in 1991, I was a division psychiatrist at Camp Casey in South Korea," she said. "Soldiers were ordered to wear protective masks due to the threat of biological and chemical agents. It was hot, and some people felt panicky and claustrophobic. We used desensitization and relaxation exercises to help them adjust to wearing the masks, which seemed to work well."

Information about trauma and related issues is available at the Center for the Study of Traumatic Stress Web site at <www.usuhs.mil/psy/traumaticstress/center_body.htm>. ■

Fellowship Trains Psychiatrists For Post-Disaster Intervention

A unique fellowship combines public health training with research to inform clinical care and planning when disasters or other traumatic events strike.

BY CHRISTINE LEHMANN

As the nation prepares for possible terrorist and bioterrorist attacks, the need for public health strategies to deal with the psychiatric consequences of terrorism is clear, according to the Institute of Medicine (IOM).

One institution that is already trying to fill the void is the Uniformed Services University of the Health Sciences (USUHS) in Bethesda, Md. Last month USUHS, which is the U.S. military's medical school, launched a new fellowship—the Public Health and Preventive Psychiatry Fellowship—to train psychiatrists in public health strategies to prevent or reduce psychiatric symptoms including traumatic stress.

The fellowship was created by Robert Ursano, M.D., and Ann Norwood, M.D., of the department of psychiatry at USUHS. Ursano is a professor and chair of the department, and Norwood is an associate professor and associate chair.

"The nation needs more psychiatrists trained in public health to respond to terrorist and disaster events," Ursano told *Psychiatric News*. He is the past chair of APA's Committee on Psychiatric Dimensions of Disasters, and Norwood is the current chair.

Ursano is supervising the first fellow, Lt. Col. Cameron Ritchie, an Army psychiatrist. Ritchie's last position was program director for mental health policy and women's health issues in the Office of the Secretary of Defense/Health Affairs.

During the first year of the fellowship, the fellow earns a master's of public health degree at USUHS. The second year consists of a practicum at the USUHS Center for the Study of Traumatic Stress.

"Ritchie will participate in research activities, clinical assessments, and surveillance and learn how federal, state, and local health care organizations plan for disasters and terrorist events," said Ursano.

Ezra Susser, M.D., M.P.H., a professor of epidemiology and psychiatry and chair of epidemiology at the Mailman School of Public Health at Columbia University, commented in an interview with *Psychiatric News*, "This fellowship is unique in that it combines an M.P.H. with training in traumatic stress. Our school offers fellowships in public psychiatry, psychiatric epidemiology, and disaster psychiatry and a separate M.P.H. degree," said Susser.

Psychiatrists Take to the Air To Educate the Public

Ever yearn to educate the public about psychiatric issues but didn't know where to start? Psychiatrists with extensive broadcast experience share helpful hints.

BY CHRISTINE LEHMANN

Panelists at an APA annual meeting workshop on psychiatrists in the broadcast media sponsored by the APA Alliance included (from left) Bill Lichtenstein, Harvey Ruben, M.D., Linda Austin, M.D., Harry Croft, M.D., and JoEllen Fasanello. (Not pictured is Michael Blumenfield, M.D.)

Glamour, fame, fortune?—not exactly, but hosting a radio show is fun, rewarding, and a powerful way to educate the public.

Linda Austin, M.D., host of "What's on Your Mind," a public radio program broadcast in 13 states, said at APA's 2003 annual meeting in May, "Speaking on radio or television gives you an instant credibility with the public that is rare in other settings."

For example, Austin met a woman at a party who said that her talk on dementia and psychosis was helpful in understanding her grandfather and his belief that he was being infested by insects.

Austin was joined on the annual meeting panel by these psychiatrists:

- Harry Croft, M.D., former host of the local CBS radio program "Psych Talk" and the medical-minute series "The Mind Is Powerful Medicine" on CBS and ABC television stations in southwestern Texas.
- Michael Blumenfield, M.D., host of the local weekly radio show "Talking About Mental Health," and past chair of APA's Joint Commission on Public Affairs (JCPA).
- Harvey Ruben, M.D., former host of NBC Radio's "Talk Net," broadcast in every state and Puerto Rico; the immediate past president of the National Association of Medical Communicators (NAMC); and past chair of APA's JCPA.
- Bill Lichtenstein, executive producer of "The Infinite Mind," a weekly radio show broadcast in 30 states. Lichtenstein filled in for Frederick Goodwin, M.D., the show's host.

The workshop, titled "Using Radio to Combat Stigma and Improve the Image of Psychiatry," was sponsored by the APA Alliance. The APA Alliance is made up of spouses and partners of APA members and others who support and assist APA in working on behalf of mentally ill people and the profession of psychiatry. Ruben and Alliance President JoEllen Fasanello co-chaired the workshop.

Croft, too, experienced the phenomenon of "instant credibility" by appearing on a broadcast program. "A patient resisted my suggestion to take medication for a long time until she told me she heard a doctor on the radio telling a caller that the best thing for people with obsessive-compulsive disorder is therapy and medication. The doctor was me," he said.

To become known to the radio audience and show producers, panelists recommended arranging to be interviewed on radio or television or appearing as a guest on a radio or television show.

Croft suggested researching the show beforehand. "It's better not to discover on the air that the host is antagonistic to psychiatry. Remember that the host is in charge of the show, so don't argue with him or her," said Croft.

He also suggested sending the producer a thank-you note afterward expressing appreciation for being invited. "The producer will forward the note to the show's director and host, which increases your chances of being invited back."

The panelists each had some media exposure prior to becoming radio hosts.

Croft was interviewed often by local and national media on mental health topics and did "medical minutes" for local CBS and

please see ***Take to the Air*** *on page 38*

AMA Steers MDs Around Internet Prescribing Pitfalls

New guidelines from the AMA will help physicians navigate the often-complicated—and sometimes dangerous—world of online prescribing.

BY CHRISTINE LEHMANN

The American Medical Association adopted new guidelines on Internet prescribing last month in an effort to help physicians avoid potential disciplinary actions and malpractice problems.

"The AMA supports the use of this new technology to help physicians care for their patients," said AMA President-elect John Nelson, M.D., in a press release. "Physicians can refer to these new guidelines as they integrate online prescriptions into their practices while continuing to provide high-quality care."

The guidelines are intended to protect patients from substandard medical care and physicians from potential disciplinary actions by state medical boards and other regulatory agencies. Since 1998, 27 of the 70 medical boards nationwide have disciplined doctors for improperly prescribing medications online, according to the Federation of State Medical Boards.

The most important advice to physicians from the AMA is that they should not prescribe medications online without first obtaining a medical history from the patient and performing a physical examination. Moreover, physicians should be sure to have a license in the state or states where their patients reside.

To protect patient privacy, the AMA recommends that physicians use a secure network with password requirements and prescription encryption. Medem Inc., for example, has these features. Medem was founded in 1999 by some of the nation's leading medical societies, including the AMA and APA.

The AMA also identified these safeguards for physicians who prescribe online:

- Have adequate dialogue with each patient about treatment options, risks, and benefits.
- Follow up with the patient as appropriate.
- Maintain an updated medical record that is readily available to the patient and to his or her other health care professionals, subject to the patient's consent.
- Include the electronic prescription information in the patient's medical record.
- Routinely transmit identifying information including full name, practice address, and financial interests in any products prescribed.

The AMA "Guidance for Physicians on Internet Prescribing" is posted on the AMA's Web site at <www.ama-assn.org/ama/pub/category/10292.html>. ■

Foundation to Support Research Project On Barriers to Care

A $700,000 grant from the American Psychiatric Foundation will underwrite research that will identify strategies to increase access to care.

The American Psychiatric Foundation has awarded a five-year, $700,000 grant to APA's American Psychiatric Institute for Research and Education for a major research study that will examine barriers to accessing quality mental health care and identify strategies that can be implemented to overcome those barriers. The grant is the largest ever made by the foundation.

The project will include numerous elements, such as the development and implementation of a pilot study of treatment barriers, outcomes, and quality of care for adolescents with major depression. It is anticipated that the data collected from this pilot will lead to a federal government grant for a full-scale study on the same topic.

Additionally, the project will examine the barriers to and outcomes of treatment for adults with major depression. This phase of the research program is also expected to generate data for developing a full-scale study of adults with major depression in collaboration with primary care physicians, psychologists, and social workers.

The grant will also support the follow-up evaluation of the impact of parity on federal employees. The first part of this evaluation project was funded by the foundation in 2000. This next phase will look at how the management, financing, and pricing of mental health benefits affect treatment provision and access to care.

In the latter part of the five-year grant period, data related to the development of depression-screening and quality-improvement tools will be used to report on patterns and outcomes of treatment and how barriers to treatment affect outcomes of care. Tools developed during the examination of major depression in adolescents and adults earlier in the project will be used to feed back information to clinicians to enhance treatment adherence and retention and to collaborating organizations to support depression screening and quality-improvement efforts.

"This project will have a lasting impact on our profession and patients for many years to come," said Abram M. Hostetter, M.D., president of the foundation. "It would not have been possible without the financial support of our donors."

More information on the foundation is posted on its Web site at <www.PsychFoundation.org>. ■

Psychiatry Workforce Trends Point to Access Problems

A decade of managed care economies is having a negative impact on the psychiatric workforce.

BY KATE MULLIGAN

Psychiatrists are aging, increasingly in short supply, and spending less time per week with each patient. Joshua Wilk, Ph.D., a research scientist in APA's Office of Research, presented data at APA's 2003 annual meeting in San Francisco that support those commonly held views.

The presentation, titled "Current Status of the Psychiatry Workforce in the United States," was based on studies directed by Darrel A. Regier, M.D., M.P.H., director of APA's Office of Research and executive director of American Psychiatric Institute for Research and Education (APIRE).

Regier, Wilk, and their colleagues used AMA data from its master file of registered physicians, APIRE data about APA members, and a sample of non-APA members from the AMA masterfile.

The former data represent the universe of psychiatrists, but rely on self-designation. APIRE data provide information not otherwise available, but do not represent the universe of psychiatrists.

There were 40,867 clinically active psychiatrists in the United States in 2000, according to the AMA data. Regier defined "clinically active" as being in practice 35 hours or more a week.

The figure for 2000 represents a 41 percent increase since 1982, but the rate of increase is declining. From 1998 to 2000, the increase was less than 1 percent.

Since the number of people in the general population is growing at a greater rate than that of psychiatrists, the proportionate number of available hours for direct patient care decreased by 4 percent between 1989 and 1998.

Both the AMA and APA data show that the psychiatric workforce is aging. According to the AMA data, only 32 percent of psychiatrists were under the age of 45 in 2000, a reduction from 46 percent in 1990.

More than 60 percent of clinically trained APA members completed their professional degree more than 21 years ago.

Joshua Wilk, Ph.D.: "There is evidence that we might be reaching our limit in terms of access" to psychiatric care.

The researchers analyzed trends by comparing results from APIRE's 2002 National Survey of Psychiatric Practice (NSPP) with the 1988-89 Professional Activities Study (PAS).

Researchers mailed a self-administered questionnaire to 2,000 randomly selected psychiatrists listed in the AMA master file of physicians for the NSPP survey. The study sample size was 1,189.

In 1988 researchers mailed a self-administered questionnaire to all APA members (n=34,164) and in 1989 to all known non-APA members who were self-designated psychiatrists in the AMA list of physicians (n=10,091). The study sample size was 19,431.

Psychiatrists are seeing more patients each week and spending less time with each individual patient, according to a comparison between the two surveys.

In 1988-89, the mean number of patients per week each psychiatrist saw was 35. The respective figure for 2002 is 41.

Conversely, PAS data show that the mean number of minutes spent with each patient in 1988-89 was 55, as compared with 34 minutes for patients in 2002.

Wilk told the audience that a psychiatrist can earn approximately 57 percent more money for providing three medication-management visits than for providing one visit for outpatient psychotherapy with medication evaluation.

During the 13-year period, hospitals declined as a primary work setting for psychiatrists from 34 percent to 15 percent. Outpatient clinics/HMOs showed a corresponding rise from 10 percent to 28 percent.

Administrative activities in 2002 claimed an average of 20 percent of a psychiatrist's time, as compared with 12 percent in 1988-89, with a related decrease in time devoted to patient care from 67 percent to 60 percent.

Wilk said, "There is evidence that we might be reaching our limits in terms of providing access."

NSPP data show that only 54 percent of psychiatrists are accepting new patients who have insurance subject to managed care restrictions.

Sixty-five percent of psychiatrists are accepting patients covered by Medicare, and 68 percent will accept patients with non-managed care insurance. Seventy-nine percent will accept new self-pay patients. ■

Team Works the Streets Aiding Homeless Mentally Ill

A small group of psychiatrists and mental health professionals is attempting to make a difference in the lives of the thousands of people who call San Francisco's hilly streets and back alleys home.

BY JOAN AREHART-TREICHEL

Adam Nelson, M.D., a psychiatrist working for the Psychiatric Foundation of Northern California, is a big guy who goes around in a casual jacket and jeans and who "hangs out" with the less fortunate members of society.

Adam Nelson, M.D.: "I'm the only psychiatrist I know who does psychiatry by motorcycle."

"I'm the only psychiatrist I know who does psychiatry by motorcycle," he says.

Nelson is attempting to improve the lives of the homeless in a city long famous for its beauty and now, alas, also becoming infamous for its homeless problem—San Francisco.

San Francisco's homeless problem got national attention in May when it was the subject of a report on ABC's "World News Tonight." "San Francisco doesn't know how many homeless it has," declared anchor Peter Jennings. "Some say 8,000; others think as many as 14,000. It depends on who's counting."

Nelson puts the number at 6,000 to 12,000—but even that is a staggering number.

Working the Streets

Actually, Nelson is attempting to help San Francisco's homeless as part of a team effort called the Brinton Homeless Project. Other members of the team are psychologist Michael Barbee, Ph.D., social worker Sue Ferrer, and outreach worker Abby Lehrman.

The project was launched by the Psychiatric Foundation of Northern California and is being financed by it (see box). The mission of the project is to "provide psychiatric care and mental health services for those homeless persons in San Francisco who suffer from mental illness and have limited or no access to such services."

Thus, the project team's major activity is to work the streets—that is, try to make contact with people who are mentally ill and qualify for help under the terms of the project.

For example, Nelson may drive through some of San Francisco's rundown neighborhoods on his motorcycle and stop to chat with heroin users. Or Nelson and Lehrman, a silver-haired, husky-voiced woman who has been helping San Francisco's homeless for three decades, may cruise these neighborhoods in a car and halt from time to time to interact with street people.

The team then tries to sell homeless persons in poor mental health on the idea that they need help. "It's difficult to approach a homeless person and say, 'You know, you're mentally ill, and we're going to provide you with services,' " says Lehrman. "So we have little carrots—and one is that homeless people who are ill are eligible for Supplemental Security Income. So I've sort of got a reputation on the street, 'Oh, Abby, she'll get you SSI."

Then after that, Nelson explains, "We introduce them to the idea, 'Hey, you can actually see a psychiatrist; you can actually see somebody who can give you medicine, who will take away that paralyzing anxiety, that severe paranoia, those voices that won't leave you alone in the night."

Finally, potential patients are encouraged to drop in at any one of five established homeless centers where Nelson, Barbee, Ferrer, and Lehrman provide mentally ill homeless people with help. The centers are Caduceus Outreach, Continuum Day Services, Glide Health Clinic, Haight Ashbury Free Medical Clinic, and Mission Neighborhood Health Center.

Nelson, Barbee, Ferrer, and Lehrman cycle through each of these centers on a regular schedule. "We literally plop ourselves down in each of the facilities we work at, just occupy a little work space," Nelson explains. "Actually, my office is a little black bag that I tote around with me wherever I go."

They also use the record-keeping system in each center to make sure that other clinicians on site have access to information about the homeless individuals whom they have helped.

Challenges Small and Big

Not surprisingly, working with individuals who are both homeless and mentally ill is not the easiest task. Some of the challenges are small. For instance, Ferrer is a lively, young, unattached Latino-American who knows a lot of street people. "Sometimes when I'm on a date," she chuckles, "a homeless person who knows me will come up to say 'Hi.' I then introduce him to my date."

Other tests, however, are bigger. For example, Nelson's cell phone, a vital part of his operation, was appropriated by a homeless person. Thus, the team lives with the awareness that there is always a risk of being mugged or attacked by mentally unstable street people. In fact, an APA member attending the annual APA meeting in San Francisco in May was beset by a mentally unstable homeless person and seriously injured, although none of the Brinton Homeless Project team members has been attacked yet.

"The homeless population is not so much dysfunctional as unpredictable," explains Mel Blaustein, M.D., president of the Psychiatric Foundation of Northern California. "They can be paranoid, terrified, or whatnot. I'm amazed that Sue and Abby feel comfortable going out on the streets with them."

The Mission Neighborhood Health Center is one of the five homeless centers where Nelson and his colleagues tend to the mental health needs of San Francisco's homeless population.

People Get Help, Dignity

Thanks to the team's courage, street savvy, energy, and hard work, however, they have managed to help at least 300 homeless individuals since the project was launched in 1999. "Three hundred" may not sound like many in view of the enormous need: a third of San Francisco's homeless population—anywhere from 2,000 to 4,000 persons—is estimated to be seriously, persistently mentally ill; some 80 percent—anywhere from 5,000 to 10,000 persons—have mental health problems, substance abuse problems, or both. Nonetheless, helping 300 people is impressive considering the dearth of volunteers and resources.

One way that the team has helped these individuals is with a proper diagnosis of their mental illnesses. For instance, "One of the things that I have discovered in working with this population," Nelson says, "is that there is an incredibly high percentage of posttraumatic stress disorder, much higher than I expected. It's not just from living on the street, mind you, because living on the street is a traumatizing experience in itself. It's also from having been physically and/or sexually abused before the age of 14."

Take the case of "Delores." "She was in pain, a lot of distress, having nightmares about being sexually abused," says Nelson. "If anybody yelled within 20 yards of her, she would jump." Yet before Delores got help from Nelson and his team, that is, when she was in jail for a while, her posttraumatic stress disorder was not detected.

Another way that the team has helped these people is by giving them treatment. Sixty-two-year-old "Bill" is one example. A few years ago, Bill's wife and daughters left him; his health deteriorated, and he lost his job. He ended up on the streets, severely depressed. When the team connected with him, he got medication for his depression from Nelson and counseling from Ferrer.

The group is assisting these individuals in practical ways as well. For example, Lehrman helped Bill obtain Supplemental Security Income and rent a room in a building with a bathroom down the hall. "It's great having my own place," Bill tells *Psychiatric News*. "And with a TV, too," he adds proudly.

And last but not least, the team is helping these individuals "see themselves as participants in a bad situation rather than as perpetrators of their own difficulties," Nelson points out, "because, frankly, a lot are already blaming themselves, are already feeling bad." ■

DB, MH Advocate Join Forces

In 1993 the Northern California Psychiatric Society (an APA district branch) set up the Psychiatric Foundation of Northern California to seek tax-deductible contributions from society members and to use the money for various good works. The district branch saw the creation of the foundation as a way to impact the mental health care of the community.

Then in 1998 the foundation experienced some unexpected good news. San Francisco resident Mary Jane Brinton made a generous donation to it, with the promise of annual renewals and with the stipulation that the money be used to help mentally ill homeless people in San Francisco.

Brinton had been an activist with a local grass-roots group of religious leaders who had been advocating for homeless people for years. So when she had the wherewithal to do something financially for this population, this is how she decided that she wanted it to be used.

Brinton did not specify, however, *exactly* how she wanted her money to be used. So "there was an issue about what was the best thing to do," Mel Blaustein, M.D., president of the foundation, told *Psychiatric News.* Blaustein and the other foundation board members put their heads together and decided that the money could best be used to set up a project that would directly serve the needs of mentally ill homeless people.

They also decided that the most effective way to meet this goal would be via community homeless centers that were already established. This way, homeless people could receive mental health care in centers that already had good reputations and were trusted. Moreover, mental health services for the homeless could be linked with general medical services and social services for the homeless, and overhead costs could be kept to a minimum.

Thus, the Brinton Homeless Project was born in 1999, and Brinton has expressed her satisfaction with it through annual donations. Since then, the project has helped at least 300 homeless persons with mental health problems (see story).

The foundation is also gathering statistics about the population it serves so that it can demonstrate the value of the project and raise more money for it, Blaustein said.

The foundation may also use the data for advocacy purposes—that is, to provide information to legislators on the mental health needs of San Francisco's homeless population, Adam Nelson, M.D., the psychiatrist chosen by the foundation to lead the project, said in an interview.

"We have not yet found anybody else who has devoted so much exclusive time and energy and resources to the mental health of San Francisco's homeless as has the Psychiatric Foundation of Northern California," he said.

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(BLEED)
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Psychiatrists Run To Reduce Stigma

A team of psychiatrists and others concerned about the plight of mentally ill people participated in San Francisco's Bay to Breakers run in May to increase community awareness of mental illness and related issues.

BY MARK MORAN

APA members, their families, and affiliated organizations interested in mental health took to the streets to "walk the talk"—and run the talk—on behalf of treatment for mental illness and substance abuse at this year's annual meeting in San Francisco.

A 29-member team of psychiatrists, psychologists, and family members bearing the team name "Mental Health Matters!" participated in the famous Bay to Breakers run, which coincided with this year's annual meeting in San Francisco.

Seattle psychiatrist Ron Sterling, M.D., who helped organize the team, said it included members from California, Colorado, Georgia, Massachusetts, Maine, Minnesota, North Carolina, South Carolina, Texas, and Washington.

Paul Zarkowski, M.D., a psychiatrist from Seattle, was the first of the Mental Health Matters! Team to finish, with a time of 1:04:03. David Benedek, M.D., a psychiatrist from Clarksville, Md., finished second at 1:07:02.

Sterling told *Psychiatric News* that participation in runs and walks like the Bay to Breakers run is a vital way that psychiatrists can enhance their relationship with a community and demonstrate solidarity with others involved in advocacy for the mentally ill.

"Such runs and walks allow consumers, the general public, and all sorts of mental health professionals the opportunity to have face-to-face contact in a nonthreatening and fun environment," he said. "In a very real way, these types of events provide a potent form of desensitization for traditionally stigmatized issues. This is antistigma at its best. Runs like Bay to Breakers are great opportunities for psychiatrists and their friends to influence the community's comfort zone about mental health care."

Sterling cites a study by the Chicago Consortium for Stigma Research testing three ways for combating mental illness stigma: protest, education, and contact. Results showed that face-to-face contact between individuals with mental illness and the test subjects produced the best antistigma results and the most understanding.

"One could extrapolate such results to reliably conclude that the best way to bring about more understanding and less stigma related to the profession of psychiatry and psychiatrists is face-to-face contact," Sterling said. "That principle should almost be intuitive at this point in history. As psychiatrists, we have more of an opportunity than ever to assist in the destigmatization of mental illness and mental health care. Organizations such as NAMI and NMHA have paved the way for us. We can join them in their efforts. We don't even have to reinvent the wheel."

The "Mental Health Matters!" team participated in the Bay to Breakers run during APA's 2003 annual meeting as a show of force against the stigma of mental illness. Top photo: Team member Fred Martin Jr., finished the race with a time of 1:30:53. Bottom photo: From left are team members Nikki Campbell, Jana Carroll, Sarah Fetzer, Ron Sterling (team captain in blue mask), David Benedek, Alex Marie, Kristin Dean, and M.B. Lardizabal.

Sterling says the team is already planning future runs. Next year's annual meeting in New York City will coincide with a women's health run—the Revlon Run/Walk for Women—which may provide an opportunity for the "Mental Health Matters!" team, Sterling said.

He urges APA members and others to visit the Web site at <MentalHealthRun.org> for information on many types of mental health and substance abuse runs and walks.

"I invite all my colleagues and their friends to join such efforts everywhere they can," he said. "These are great opportunities for psychiatrists and their friends to influence the community's comfort zone about mental health care." ■

Broad Plans Outlined For APA's Fiscal Future

APA's Board of Trustees focus on the Association's long-term fiscal future and approve policies to make the Board's proceedings—and the Association's finances—more transparent.

BY MARK MORAN

"Transparency," the new watchword of organizations everywhere, was a theme of last month's meeting of APA's Board of Trustees as it focused its attention on the Association's finances and long-term fiscal future.

Trustees agreed to place financial information about the Association—including 990 tax-form returns, audited year-end financial statements, and summaries of current year financial information—on the APA Web site in the form of downloadable copy.

Trustees also adopted policies to increase reserve funds over the next several years, including a policy restricting spending of funds derived from the sale of APA's land at 1400 K Street, N.W., Washington, D.C., in the late 1990s.

Further, the Board will experiment in future meetings with a process by which all votes that are not unanimous will be recorded and published in the Board's minutes.

District branch (DB) presidents and the chair of the Committee on International Medical Graduates (IMGs)—invited to speak at this month's meeting—echoed the need for ongoing interaction between the central office and the DBs.

"Communication, communication, communication," said North Carolina Psychiatric Association President Diana Dell, M.D., when asked by the Board to say what DBs most needed from the central organization. She suggested that the central office might play a "franchising" role, providing technical support and assistance to district branches for day-to-day programs.

The president of the Pennsylvania Psychiatric Society, Roger Haskett, M.D., reported on the progress of a lawsuit against Magellan Behavioral Health, and Chowallur Chacko, M.D., chair of the Committee on International Medical Graduates, emphasized ongoing efforts to end discrimination against IMGs.

Haskett told Board members that the Pennsylvania district branch had closed two offices in the state—in Pittsburgh and Philadelphia—to focus resources on the branch's advocacy and lobbying efforts in the state capital in Harrisburg and on the legal action against Magellan.

Haskett joined Dell in saying that the district branch supports efforts at creating a centralized membership process.

Chacko said he believed discrimination against IMGs was subsiding. Further, he said that there are many more non-APA members among IMG psychiatrists practicing in the United States than there are members. He urged APA to form a body composed of members of the IMG and Membership committees to recruit IMGs into APA.

In other business, the Board approved the following:

- **Adding Philadelphia to the rotation schedule** as one of the future meeting locations of APA annual meetings. Previously approved cities are New Orleans, Atlanta, New York, Washington, D.C., Toronto, San Francisco, San Diego, and Honolulu.
- **Restoration of a check-off box to the APA dues invoice** and the addition of such a box to the membership application allowing members to exercise more readily their option to receive a free subscription to *Psychiatric Services* as a member benefit.
- **Elimination of the requirement for a letter of reference from an APA member** for members-in-training who are advancing to general membership and for new applicants applying for general membership.
- **Dues waivers, upon request, for member reservists** who are called to active military duty.
- **A position in support of somatic cell nuclear transfer research** and its federal funding, opposition to legislation banning such research, and support of a prohibition on human reproductive cloning.
- **The Practice Guideline** for the Assessment and Treatment of Patients With Suicidal Behaviors (see story below).
- **Position statements** on HIV infection; confidentiality, disclosure, and protection of others with regard to patients with HIV-AIDS; and on HIV and pregnant women.

Dianna Dell, M.D., president of the North Carolina Psychiatric Association, addresses the Board at its June meeting. She is joined by Chowallur Chacko, M.D. (left), chair of the Committee on International Medical Graduates, and Roger Haskett, M.D., president of the Pennsylvania Psychiatric Society.

In addition, APA Board members heard a presentation from pediatrician Fitzhugh Mullan, M.D., about the new National Health Museum to be located on the National Mall in Washington, D.C. The museum project, now seeking seed money, will be an interactive resource to inspire people of all ages to live healthier lives and consider careers in health and medicine. Mullan is vice chair of the project.

APA members can access the summary of Board actions at <www.psych.org/members/bot/bot.cfm> under "Members Corner." ■

Area 7 Trustee Al Vogel, M.D., reviews financial data with APA Treasurer Carol Bernstein, M.D.

APA's Newest Practice Guideline Addresses Suicide-Risk Issues

Psychiatrists will soon have a comprehensive guideline on assessing and treating suicidal patients. The guideline is based on studies and clinical consensus identifying the risk factors, protective factors, and best treatments for at-risk patients.

BY EVE BENDER

If only psychiatrists could have a crystal ball at their disposal when working with patients at risk for suicide. While that's an unfulfillable fantasy, psychiatrists now can, with APA's newest evidence-based practice guideline, fine-tune their ability to assess those who may be at risk for suicide and treat them.

APA's Practice Guideline for the Assessment and Treatment of Patients With Suicidal Behaviors was approved by APA's Assembly in May and by the Board of Trustees last month.

The guideline is divided into two major sections: Part A includes recommendations for the assessment and treatment of suicidal behaviors, and Part B provides an overview of suicide and reviews the literature upon which the recommendations in Part A are based.

"The majority of psychiatrists are involved in the evaluation of the risk of suicide in their patients," Douglas Jacobs, M.D., chair of the Workgroup on Suicidal Behaviors, told *Psychiatric News*. Jacobs is an associate professor of psychiatry at Harvard Medical School and founder and executive director of Screening for Mental Health Inc.

Members of the work group, which included suicide researchers such as Jacobs, collaborated with members of the Steering Committee on Practice Guidelines, a group of consultants, and APA staff to formulate the guideline.

"The new guideline will be of great help to psychiatrists in their daily work," said John McIntyre, M.D., chair of the Steering Committee on Practice Guidelines. "Suicide and suicidal behaviors cause severe personal, family, and social consequences and remain among the most challenging issues facing psychiatrists."

APA practice guidelines are published as supplements to the *American Journal of Psychiatry*. The guideline is expected to appear in the November issue and will simultaneously appear on APA's Web site with previously published practice guidelines.

The guideline will also be included in the APPI publication *2004 Compendium of Practice Guidelines*, which is slated for release in fall 2004.

Jacobs said that by reviewing the guidelines, psychiatrists will better understand the prevalence rates, risk factors, and protective factors for patients, as well as the psychotherapeutic and pharmacologic treatments for at-risk patients.

"They will also learn that certain risk factors for suicide are modifiable and some are what we call static—this is important to keep in mind when evaluating patients," he said.

In addition, the guideline provides psychiatrists with tips about how to elicit information about suicidal intent, how best to manage the risk of suicide in patients from a legal standpoint, and under what conditions it may be necessary for the psychiatrist to reveal confidential information about the patient to significant others to keep the patient safe.

Some of the risk factors for suicide, according to the guideline, are aggression, impulsiveness, hopelessness, and psychic anxiety.

The guideline notes that long-term maintenance treatment with lithium is associated with major reductions in both the risk of suicide and suicide attempts in patients with bipolar disorder, while the evidence supporting lowered suicide rates with antidepressants is inconclusive.

Clozapine has been found to reduce the rates of suicide attempts and perhaps even suicide in patients with schizophrenia and schizoaffective disorder.

The guideline cautions psychiatrists not to rely on a suicide-prevention contract (see page 3). By signing such a document, a patient agrees to contact his or her psychiatrist or other treatment team members before harming himself or herself.

"No studies have shown their effectiveness in reducing suicide," the guideline states of these contracts. "In fact," the guideline continues, "studies of suicide attempters and inpatient suicides have shown that a significant number had a contract in place at the time of their suicidal act."

Jacobs emphasized that the guideline does not serve as the "standard of care" for suicidal patients, but instead offers psychiatrists recommendations about evaluating and treating at-risk patients based on available evidence and clinical consensus. ■

APA Members Reveal Their Creative Side

Some of the many artists among the APA membership and their spouses exhibited their work at the 2003 annual meeting and took home ribbons.

BY ELISABETH C. SMALL, M.D.

More than 1,000 people came to view the wide diversity of works on display in the APA Art Association's exhibit at APA's 2003 annual meeting in San Francisco in May and helped to determine the prize winners in each category.

The Art Association has sponsored an exhibit at the annual meeting for 32 years as an occasion for APA members and their partners to show their creative productions and to discuss and share with colleagues and attendees the many ideas and insights derived from their work, ranging from ceramics to poetry.

Visitors—many of whom were international psychiatrists—expressed their thoughts concerning the value of having such an event at the annual meeting: "We retain humanity this way." "Art—always essential." "Inspiring! Healing! As usual, wonderful." "Enjoyed the show and some pearls of wisdom."

Votes cast by the exhibit visitors determined the ribbon winners in each of the categories. The awards were presented by outgoing APA President Paul Appelbaum, M.D.

Ceramics
First: "Judith," Astrid Rusquellas, M.D.

Crafts
First: "Mustang," Habib Nathan, M.D. **Second:** "Ceramic Glass Plate," Habib Nathan, M.D. **Third:** "Box," William A. Alvarez, M.D.

Fiber (Textile)
First: "Halloween Quilt," Joanne Loritz, M.D. **Second:** "Pink Fantasy," Cynthia Poe. **Third:** "Reflections," Julie Dehnel

Graphics
First: "Can't See the Forest for the Limbs," Richard O. Poe, M.D. **Second:** "Security," Richard O. Poe, M.D. **Third:** "Marine Major Jack I. (Ret.)," Wilma Rosen, M.D.

Painting—Oil
First: "Coach," Wilma Rosen, M.D. **Second:** "Rapproachment," Laurie McCormick, M.D. **Third:** "Fiesta," Manijeh Nathan

Painting—Mixed Media
First: "Homage to the City, I–Amsterdam," Astrid Rusquellas, M.D. **Second:** "The Fourth Horseman of the Apocalypse," Iliyan S. Ivanov, M.D. **Third:** "Axis of Evil II," William A. Alvarez, M.D.

Joanne Loritz, M.D., took first place in textiles for "Halloween Quilt."

Painting—Water Based
First: "Lighthouse," Ayodan Ugur, M.D. **Second:** "Homage to the City, II–Buenos Aires," Astrid Rusquellas, M.D. **Third:** "Muchos Cololos," Ana-Maria Osorios, M.D.

Painting—Acrylic
First: "Monster of War Rising," Gail M. Barton, M.D. **Second:** "Thoughts of Summer and Sunshine," Gail M. Barton, M.D. **Third:** "Near Rockland, ME," Carol Smith

Photography
First: "Deep in Thought," Victoria Kelly,

please see ***Art Exhibit*** *on page 36*

APA outgoing President Paul Appelbaum, M.D., prepares to announce the winners of the APA Art Association exhibit at APA's 2003 annual meeting. With him are Gail Barton, M.D., president of the APA Art Association, and Elisabeth Small, M.D., exhibit coordinator.

APA Honors Many Who Work For Better Mental Health Care

Psychiatrists, senators, journalists, and researchers are among those who were honored at APA's 2003 annual meeting in San Francisco in May for their dedication to psychiatry and mental health causes.

BY EVE BENDER

Each year APA honors a number of individuals who have worked to improve the lives of people with mental illness in many ways, such as clinical practice, research, or public policy or advocacy work.

These are the people and the awards they received in conjunction with APA's 2003 annual meeting in San Francisco in May, as listed in the program book of APA's 47th Convocation of Distinguished Fellows.

William C. Menninger Memorial Convocation Lecture: *Charles Krauthammer, M.D.*, best known for his syndicated column for the *Washington Post*.

Special Presidential Commendations: *Richard Bonnie, L.L.B.*, the John S. Battle Professor of Law, professor of psychiatric medicine, and director of the Institute of Law, Psychiatry, and Public Policy at the University of Virginia; *Jay B. Cutler, J.D.*, former director of APA's Division of Government Relations; *Jeremy A. Lazarus, M.D.*, a clinical professor of psychiatry at the University of Colorado Health Sciences Center and former speaker of the Assembly; *Julien Mendlewicz, M.D., Ph.D.*, a professor of psychiatry at the University of Brussels, chair of the department of psychiatry at Erasme Hospital in Brussels, and director of the Laboratory of Psychiatric Research at the Free University of Brussels; *Lucy D. Ozarin, M.D., M.P.H.*, a longtime volunteer in APA's Library who has worked meticulously to document the history of psychiatry; *John A. Talbott, M.D.*, a professor of psychiatry at the University of Maryland School of Medicine and editor of the APA journal *Psychiatric Services; Howard V. Zonana, M.D.*, a professor of psychiatry at Yale University and training director of Yale's Forensic Psychiatry Fellowship Program.

Distinguished Service Award: *Leon Eisenberg, M.D.*, the Maude and Lillian Presley Professor in Harvard Medical School's department of social medicine and professor emeritus of psychiatry; *Donald J. Scherl, M.D.*, a professor of psychiatry and former president of Downstate Medical Center and longtime chair of APA's Budget Committee.

Organizational Distinguished Service Award: *Association of Women Psychiatrists*, which was founded in 1983 by Alexandra Symonds, M.D.

APA/Lilly Resident Research Award: *David Dybdal, M.D., Ph.D.*, a psychiatry resident at Massachusetts General/McLean Hospital; *Almut Engelien, M.D.*, a psychiatry resident at Cornell University Medical Center, Payne Whitney Clinic; *Shahzad M. Hashmi, M.D.*, chief psychiatry resident at Howard University Hospital; *Laura Martin, M.D.*, a research fellow at the University of Colorado Health Sciences Center and Denver Veterans Affairs Medical Center; *Patrick Zirnheld, M.D.*, a research fellow at Indiana University School of Medicine.

Human Rights Award: *Sen. Pete V. Domenici* (R-N.M.) and *Sen. Paul D. Wellstone* (D.-Minn.), for their work in trying to attain insurance parity for mental health services.

Blanche F. Ittleson Award for Research in Child Psychiatry: *David A. Brent, M.D.*, academic chief of child and adolescent psychiatry at Western Psychiatric Institute and Clinic and a professor of psychiatry, pediatrics, and epidemiology at the University of Pittsburgh School of Medicine.

APIRE/Kempf Fund Award for Research Development in Psychobiological Psychiatry (mentor): *Donald C. Goff, M.D.*, an associate professor of psychiatry at Harvard Medical School, director of the Schizophrenia Program at Massachusetts General Hospital, and medical director of the Freedom Trail Clinic at the Erich Lindemann Mental Health Center.

APIRE/Kempf Fund Award for Research Development in Psychobiological Psychiatry (mentee): *Jennifer Lafayette, M.D.*, chief resident of the Acute Psychiatry Service at Massachusetts General Hospital.

Agnes Purcell McGavin Award for Prevention: *William R. Beardslee, M.D.*, psychiatrist in chief and chair of the department of psychiatry at Children's Hospital in Boston and the Gardner Monks Professor of Child Psychiatry at Harvard Medical School.

Agnes Purcell McGavin Award for Distinguished Career Achievement in Child and Adolescent Psychiatry: *Joel P. Zrull, M.D.*, professor emeritus of psychiatry and former chair of the department of psychiatry at the Medical College of Ohio.

Isaac Ray Award: *Robert I. Simon, M.D.*, a clinical professor of psychiatry and director of psychiatry and law at Georgetown University School of Medicine.

Jack Weinberg Memorial Award for Geriatric Psychiatry: *Dilip V. Jeste, M.D.*, Estelle and Edgar Levi Chair in Aging, a professor of psychiatry and neurosciences, and chief of the geriatric psychiatry division at the University of California, San Diego, and the VA San Diego Healthcare System.

Administrative Psychiatry Award Lecture: *C. Edward Coffee, M.D.*, vice president of behavioral health and the Kathleen and Earl Ward chair of psychiatry at the Henry Ford Health System, a professor of psychi-

please see ***Awards*** *on page 32*

JAMA Depression Issue Highlights Reasons for Concern

A large, new study provides another snapshot of depression in this country, confirming its commonality, severity, and costs as one of the most disabling disorders facing the nation.

BY JIM ROSACK

Depression is common, highly comorbid, causes significant functional impairment, and remains vastly undertreated, according to the authors of a large, new epidemiological study. These conclusions are certainly not earth-shattering news to psychiatrists, who predominantly take care of the sickest of the 14 million patients the new study says have battled depression in the last year.

What may be surprising, however, is that the study appeared in a special theme issue of the *Journal of the American Medical Association* rather than a specialty psychiatric journal.

Released on June 18, the theme issue featured a series of eight new papers, all exploring the issue of improving the recognition, diagnosis, and treatment of major depressive disorder.

"We publish two theme issues each year," noted *JAMA* Editor Catherine DeAngelis, M.D., a professor of pediatrics on leave of absence from Johns Hopkins University School of Medicine.

"And we only do them," DeAngelis explained to reporters at a press briefing, "on topics that are of real significance and special importance to the public health." Depression, she said, clearly fits those criteria.

JAMA Deputy Editor Richard Glass, M.D., a clinical professor of psychiatry at the University of Chicago, who continues to maintain a clinical practice, noted in his editorial in the issue, "The challenge for all physicians regarding depression is to learn to recognize it, in themselves as well as in their patients, and to surmount the obstacles against effective treatment."

New Epidemiological Findings

In the lead article in the *JAMA* theme issue, Ronald Kessler, Ph.D., a professor of health care policy at Harvard Medical School, and his colleagues report results from the National Comorbidity Survey Replication (NCS-R). The NCS-R surveyed more than 9,000 adults in a nationally representative sample between February 2001 and December 2002 to "update information on the prevalence, correlates, and clinical significance of *DSM-IV* disorders," the authors wrote, as well as to study patterns and correlates of treatment and treatment adequacy.

This report provides data on the NCS-R estimate of the prevalence of major depressive disorder, while future reports are expected to be released on other disorders. The researchers found that 16.2 percent of adults in the U.S.—representing over 32 million persons—have experienced a major depression at some time in their lives, and 6.6 percent of all U.S. adults—representing just over 14 million persons—have experienced depression within the 12 months preceding the survey.

"This survey represents the largest population sample of U.S. adults—representative of all 48 contiguous states—and includes a much broader range of ages, from 12 to 94 actually, than any prior study," said Kathleen Ries Merikangas, Ph.D., co-principal investigator with Kessler on the study and senior investigator and chief of the Section on Developmental Genetic Epidemiology at the National Institute of Mental Health. (Only data from subjects aged 18 and older were included in the final analysis.)

"We strictly adhered to *DSM-IV* criteria," Merikangas told reporters during the press briefing, "and, importantly, included clinical follow-up on a significant proportion of those originally surveyed in their homes."

The survey interviewed individuals in their homes using laptop computer–based editions of the World Health Organization's Composite International Diagnostic Interview (CIDI), enhanced to avoid an overdiagnosis of clinically nonsignificant depressive symptoms previously associated with the CIDI. The enhancements, the authors reported, "specifically probed for severity of dysphoria and anhedonia, by requiring clinically significant distress or impairment associated with these symptoms, and by asking separate questions about symptom duration (hours per day, days per week, and duration of depressive episodes)."

"For those individuals whose CIDI indicated major depression," Merikangas said, "a clinician followed up with them and conducted a full Structured Clinical Interview for *DSM-IV*." A corresponding group without major depression on the CIDI was also given the SCID as a control measure. The severity of the depression and the amount of disability involved were evaluated using the Quick Inventory of Depressive Symptomatology and the WHO Disability Assessment Schedule, as well as the Sheehan Disability Scale.

Significant Upward Trends

The survey revealed significant trends toward higher rates of depression in specific demographic groups.

Depression was most prevalent in younger individuals for both men and women, although women had significantly higher rates at all ages.

"We think these are real trends," Merikangas told reporters, "and not an artifact of either the reporting process or other methodology. And the trends are important. They really tell us, for example, where we need to focus our assessment and treatment efforts."

Lifetime prevalence of depression was significantly elevated not only in younger age groups, but in women who were classified as "other" with regard to employment, which Merikangas clarified generally meant they were unemployed. The 12-month prevalence rates were significantly higher in younger women—those 18 to 29 were three times as likely and those 30 to 44 were 1.8 times as likely as those age 60 and older to be depressed—and were more likely to be Hispanic, a homemaker, student, or unemployed; had never married; and did not finish high school. In addition, those living below the poverty level were 3.8 times as likely to be depressed compared with those who were financially stable (living at three times the poverty level or above).

The current study also confirmed reports that depression is highly comorbid. Nearly three-quarters of those with lifetime depression (72 percent) and two-thirds of those with depression in the previous 12 months (64 percent) also met criteria for at least one other *DSM-IV* disorder, most commonly an anxiety disorder, impulse control disorder, or substance abuse.

"We also confirmed that major depression involves clinically significant distress, role impairment, and high clinical severity and is persistent," Merikangas emphasized. "This disorder claims on average 16 weeks per year from people's lives on a recurring basis. Over their lifetime, that adds up to 10 years lost to this debilitating disorder."

The survey found that of those with depression in the previous 12 months, 97 percent reported at least some impairment, with 87 percent noting the impairment as "at least moderate," 59 percent as either severe or very severe, and 19 percent as very severe. Impairment was greatest in social roles and lesser in work roles, although those with depression in the previous 12 months reported an average of 35 days in the past year in which they were totally unable to work or carry out their normal activities (see article at top of facing page).

Treatment Improving, but Not Adequate

The survey also noted significant increases in the proportion of persons with depression in the previous 12 months who received treatment for their depression, compared with the findings of earlier studies. The original National Comorbidity Survey (NCS), conducted in 1990 to 1992, indicated that 36 percent of those with depression in the previous 12 months had received some form of treatment. In the current report of the NCS-R, more than half (57.3 percent) received some treatment in the preceding year, although only 42 percent of those received adequate treatment. "Minimally adequate treatment" was defined using APA's Practice Guideline for the Treatment of Patients With Major Depression and the Agency for Health Care Quality criteria and included either "a minimum of four visits with a physician for pharmacotherapy that included the use of an antidepressant or mood stabilizer for at least 30 days, or at least eight outpatient visits with any professional in the specialty mental health sector."

The specialty mental health sector was defined in the study as "inpatient treatment or outpatient treatment with a psychiatrist, psychologist, any other mental health professional, or a social worker or counselor in a mental health specialty setting or use of a hotline."

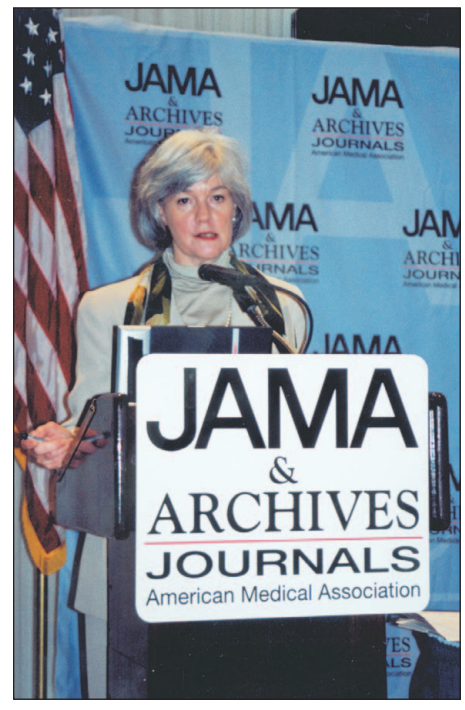
Merikangas noted that analysis of all of the data continues, and the researchers hope to further break down specific trends in how depression affects different groups of people.

"These results represent obvious advances as far as getting better information on disability and severity of mental disorder diagnoses," commented Darrel Regier, M.D., M.P.H., executive director of the American Psychiatric Institute for Research and Education and director of APA's Division of Research.

Regier, along with William Narrow, M.D., M.P.H., associate director for diagnosis and classification in APA's Division of Research, last year published revised prevalence estimates for psychiatric disorders, including depression. That report, which appeared in the February 2002 issue of *Archives of General Psychiatry*, established clinical significance of disorders in the community as a crucial factor in estimation of treatment needs (*Psychiatric News*, April 5, 2002).

Regier and Narrow aimed to reconcile earlier estimates of disorder prevalence from

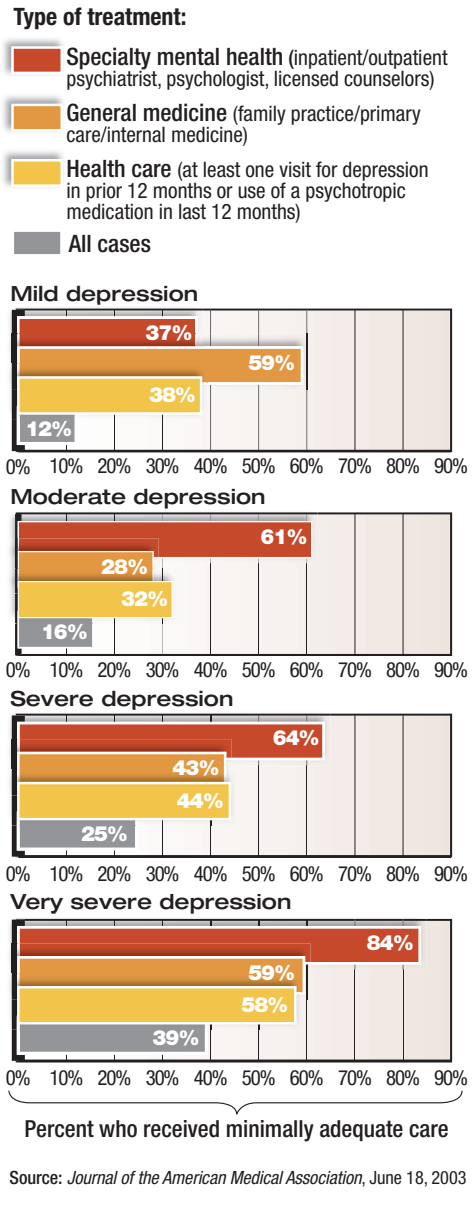
please see ***Depression*** *on facing page*



Kathleen Ries Merikangas, Ph.D.: "Patients with depression, on average, spend 16 weeks per year disabled by the disorder, adding up to 10 years of their lifetime lost."

Borderline Care

Most people who seek treatment for depression receive care that is inadequate. The chart shows the percentages of patients who receive minimally adequate treatment as defined by APA's practice guideline on depression.



Source: *Journal of the American Medical Association*, June 18, 2003

Depression Most Costly Illness for Employers

Employers across the country are losing an estimated $44 billion a year in lost productivity directly related to depression. And the vast majority of that loss is due to "presenteeism."

BY JIM ROSACK

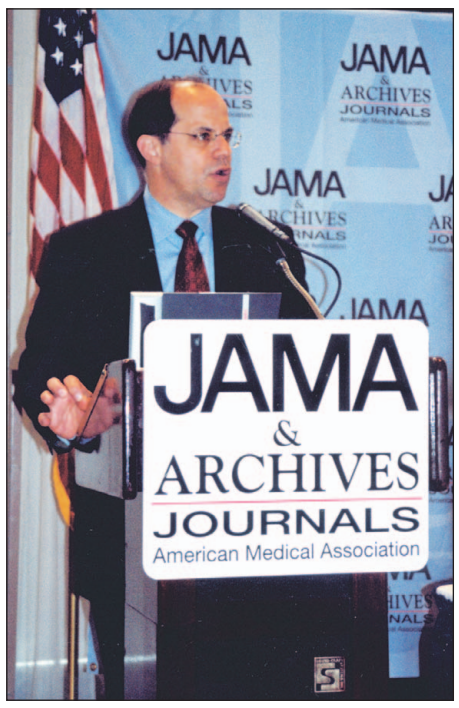
A new, nationally representative survey estimates that depression costs U.S. employers more than any other illness in terms of the lost productivity of their employees. According to results of the Depressive Disorders Study, (DDS) completed one year ago, workers with depression cost employers more than three times the amount associated with lost productivity from all other illness.

Results from the DDS, a subsurvey of the American Productivity Audit, were published in the June 18 *Journal of the American Medical Association*, a theme issue featuring eight articles on depression (see story on facing page).

The American Productivity Audit surveyed more than 30,000 employed individuals last summer to estimate the impact of various illnesses on labor costs, including work absences and reduced productivity on the job, in the U.S. workforce. The DDS and its related estimates are based on a nationally representative subsample of 3,351 of the larger group interviews.

"You cannot manage costs to employers without first measuring the impact of various illnesses," said Walter Stewart, Ph.D., M.P.H., a researcher with AdvancePCS Center for Work and Health in Hunt Valley, Md., at the time the survey was conducted. Stewart is now at the Outcomes Research Institute of Geisinger Health Systems in Danville, Pa. AdvancePCS conducted the American Productivity Audit and provided funding for the study, while Eli Lilly and Company provided funding for the DDS analysis.

Stewart added, "We know that employers won't act on what they cannot measure." Unfortunately, he continued, "employers focus much more on how much they are paying for employee health care rather than on steps to make the health care plan more cost-effective."



Walter Stewart, Ph.D., M.P.H.: "The problem is, employers focus on how much they are paying for health care coverage, rather than asking is it cost-effective?"

DDS was necessary, Stewart emphasized, because previous estimates of the cost of depression in the U.S. workplace were based on data collected during the 1980s and included assumptions regarding prevalence, duration of depressive episodes, impact on work, and associated labor costs. Stewart wanted to fill in the real-world numbers to come up with a sound estimate of actual costs.

The overall data from the larger audit are based on the "Work and Health Interview," a five- to 15-minute telephone interview that includes questions in reference to only the previous two-week period and asks about occupation, a self-reported health assessment, the number of days of work missed in the previous two weeks, and how that affected the respondent's productivity on the job. Also, questions elicited information on income, quality of life, and any treatments obtained, as well as standard demographic details.

The DDS subset was composed of 733 individuals who completed the interview and screened positive for possible depression, along with 457 gender-matched individuals who screened negative for depression. During a follow-up interview, those individuals were then administered the PRIME-MD mood module and the Somatic Symptom Inventory and asked further questions regarding treatment.

Stewart reported at a *JAMA* press briefing in Washington, D.C., last month that 9.4 percent of the total sample was found to have a depressive disorder, with 3.4 percent meeting screening criteria for major depression, 2.4 percent for partial remission of major depression, and 3.6 percent for dysthymia. Depressive symptoms were more common in women and people with lower levels of education.

Twenty percent of the $44 billion cost of depression was accounted for by absenteeism, while 80 percent of the costs associated with depression, or $35.7 billion, was linked to "presenteeism"—that is, present on the job but with significantly reduced productivity.

This, Stewart noted, is a major finding that should be reinforced over and over with employers. They believe the employees are generally fine because the employees are on the job, Stewart noted; however, they do not realize the "hidden costs" of lost productivity due to lack of energy, lack of insight, lack of creativity or motivation—all items difficult to quantify. Those interviewed estimated that with depression, they lost an average of 5.6 hours a week of productivity, versus 1.5 hours a week for persons without depression.

In terms of treatment, the DDS found that about 25 percent of individuals with depression had received treatment and of those, the patients said that on a scale of treatment effectiveness self-reported by the subjects, from zero (doesn't work at all) to 10 (complete relief), the average rating was midline, at 5.6.

"Major depression may not be the most common illness, but is it probably the most costly," Stewart concluded. "And these numbers do not include short- and long-term disability. Most of these costs are invisible, but the average loss of 14 percent in productivity time is concentrated in a minority of workers who are depressed."

Major depression is an important target for employers and their health care plans, Stewart noted, because "it accounts for 50 percent of work-related costs, but may not be effectively and appropriately identified and treated. We need to improve that."

An abstract of "Cost of Lost Productive Work Time Among U.S. Workers With Depression" is posted on the Web at <http://jama.ama-assn.org/cgi/content/abstract/289/23/3135>. ■

Depression

continued from facing page

the Epidemiologic Catchment Area (ECA) Program and the original NCS. The ECA had estimated the prevalence of major depression in the previous 12 months for adults aged 18 to 54 at 5.4 percent, and the NCS estimate was 8.9 percent. The revised estimate, taking into account clinical significance criteria, placed the one-year prevalence of major depression at 4 percent.

While the current study's one-year rate of 6.6 percent is higher, Regier noted that each of the three studies employed different methodologies on different populations.

"It's hard to know what is really happening with these rates," Regier said, "without a clear understanding of the instrument changes and the age groups under consideration."

The theme issue of* JAMA *can be accessed on the Web at <www.jama.com> by clicking on "Past Issues" and selecting the June 18 issue. ■

Improving Depression Treatment Outcomes Requires More Precise Definitions

Having psychiatrists work with primary care physicians to improve their understanding of treatment outcomes for depression may increase patients' treatment compliance and, ultimately, remission rates.

BY JIM ROSACK

Those five elusive "Rs" of treatment—Response, Remission, Relapse, Recovery, and Recurrence—are benchmark treatment outcomes, yet their definitions remain uncertain and often misunderstood when clinicians try to apply them in the treatment of major depression.

That lack of precisely defined and clearly communicated treatment goals contributes to the high percentage of patients who receive inadequate treatment, said Martin Keller, M.D., a professor of psychiatry and human behavior at Brown University. In a "special communication" in the June 18 *Journal of the American Medical Association*, Keller explored current understandings of the optimal goal for depression treatment and what needs to occur to improve outcomes.

"I think the proportion of patients who need to be treated for depression and are not given the appropriate treatment for a sufficient time at a sufficient dose is still too high," Keller told *Psychiatric News*.

Another report in that same issue of *JAMA* indicates that less than half of those who pursued treatment for depression within the 12 months prior to the survey received minimally adequate treatment.

While the vast majority of clinical trials involving antidepressant medications, as well as psychotherapy interventions, have focused on "response," the definition of response has varied, Keller said. It is typically defined as more than a 50 percent decrease from baseline scores on a standardized scale, Keller wrote, but even a 50 percent reduction could leave a patient with significant symptoms.

"The important thing here," he said, "is that we have to strive to meet remission, not response, as the goal of treatment."

Wellness, Keller emphasized, must be determined by "evaluating a combination of three key domains: symptoms, functional status, and pathophysiological changes." But he continued, "At this point we are reliant on purely clinical factors as the outcome variables and what I would call remission—based on a state of no or very minimal symptoms and a return to normal functional status—is really what we should be aiming for in patients with depression."

Keller noted that studies have strongly indicated that patients achieving remission have a much better prognosis in the long term. But remission should be defined as a set endpoint on a depression scale, such as a score of 7 or less on the Hamilton 17-Item Depression Rating Scale or a score of 10 or less on the Montgomery-Asberg Depression Rating Scale. These scores have been shown to differentiate reliably those who do not have depression from those who have even mild depression.

Psychiatrists, Keller noted, know this. "None of what I am saying is earth shattering. But in the primary care world [where the vast majority of patients with depression are treated], these scales and specific scores are largely lost."

He continued, "There is a great deal of effort ongoing to help primary care physicians be more aware of and identify patients with depression." But efforts that reinforce the variety of available treatments and that help primary care physicians understand the importance of treatment outcomes are still needed.

"The outcome goals, unlike those for most other medical illnesses, are not based on laboratory values or diagnostic procedures, so in making the original diagnosis, you have to be sensitive to that and appreciate the difficulty of gauging improvement," he said.

"We have a variety of treatments that are efficacious, safe, and tolerable," Keller concluded. "They simply need to be used in a more rigorous and thorough way."

An abstract of Keller's "special communication" in the June 18* JAMA *is posted on the Web at <http://jama.ama-assn.org/cgi/content/abstract/289/23/3152>. ■

Depression in Pregnancy Often Goes Untreated

Depression doesn't always wait until the postpartum period to strike. According to a new study, women who have a history of depression are five times as likely to have a recurrence of symptoms during pregnancy.

BY EVE BENDER

Although pregnancy can be a time of joyful anticipation, research at the University of Michigan shows that 1 out of 5 expectant mothers experience symptoms of depression, and few are receiving help.

"We know that there are risks to the mother and infant that are associated with a failure to treat depression in pregnancy," said Sheila Marcus, M.D., principal investigator on the study and lead author of the article, "Depressive Symptoms Among Pregnant Women Screened in Obstetrics Settings," in the May 22 *Journal of Women's Health*.

Marcus is a clinical assistant professor of psychiatry at the University of Michigan Medical School and director of the Women's Mood Disorders Program at the University of Michigan Depression Center.

She and her colleagues screened 3,472 pregnant women at 10 obstetrics clinics in southeastern Michigan from 1999 to 2002. The researchers queried the women about history of depression, treatment for depression, use of alcohol, and employment status, for example.

To measure subjects' depressive symptoms, they used the Center for Epidemiologic Studies Depression Scale (CES-D), a standardized 20-item questionnaire.

After screening the women, the researchers found the following:

- Twenty percent of the sample, 689 women, screened positive for elevated depressive symptoms as measured by the CES-D.
- When researchers reinterviewed the women with elevated CES-D scores using the Structured Clinical Interview for *DSM-IV-TR*, they found most had minor depression or dysthymia, and about 20 percent met diagnostic criteria for major depressive disorder.
- Of the 689, just 13.8 percent, or 91, were receiving psychotherapy and/or medications for their depression.
- Twenty-eight percent of the total sample reported a lifetime history of major depression. Of this group, 42.6 percent had current symptoms of depression.
- Women who reported a history of major depression (958) were 4.9 times more likely than other subjects to have elevated CES-D scores during pregnancy.
- Risk factors associated with depressive symptoms during pregnancy include being unmarried, unemployed, and in poor overall health.
- Eighty-eight percent of those with a history of major depression had not received any treatment for their depression in the months before the study.

Marcus told *Psychiatric News* that significant changes in a pregnant woman's hormone levels can affect her levels of mood-regulating neurotransmitters, which may in turn result in depressive symptoms.

But mounting evidence shows that life's circumstances may also play an important role.

"Unemployment and the resulting financial circumstances or the lack of a family support system for an expectant mother may worsen the problem," she said.

It's difficult to know whether rates of depression among pregnant women are on the rise in America, Marcus added. One reason is that studies measuring depression in pregnant women over the past 10 to 20 years use different scales to measure different degrees of depression.

In general, rates of minor depression or depressive symptoms among pregnant women are usually higher than those of major depression.

It is possible, she acknowledged, that as certain risk factors for depression during pregnancy increase—being unmarried and poor, for example—the prevalence of pregnant women experiencing depressive symptoms will also increase.

One reason that screening pregnant women for symptoms of depression during pregnancy is so important, Marcus said, is that it may prevent future bouts with depression. "We know depression is recurrent," she said, and studies have found that "women with symptoms of depression during pregnancy are probably more likely to have full-blown postpartum depression."

Marcus and her colleagues are now following their cohort of pregnant women in Michigan to track the occurrence of postpartum depression in the sample.

Once a pregnant woman screens positive for depressive symptoms or major depression, then what?

"Assuming that the woman has only minor symptoms with a history that is relatively benign," Marcus said, "psychotherapy would probably be the best option."

Many physicians may be reluctant to prescribe antidepressants for major depression, said Marcus, because they fear that the medications will harm the fetus.

Although some drugs, such as lithium, have been associated with birth defects, the bulk of evidence, she said, "would suggest that there is no link between selective serotonin reuptake inhibitors (SSRIs) and tricyclic agents and congenital defects in newborns."

"We know there are risks associated with not treating depression in pregnancy, however," she said.

Nada Stotland, M.D., M.P.H., a professor of psychiatry and obstetrics and gynecology at Rush University in Chicago and APA representative to the American College of Obstetricians and Gynecologists, agreed.

"Few physicians are aware of the deleterious impact depression has on the progress and outcome of the pregnancy, a woman's ability to mother, and the well-being of her child after it is born," she said.

Although "no one can say for certain

please see ***Pregnancy*** *on page 30*

Form of Cognitive-Behavior Therapy Said Effective for OCD Patients

Three treatments that may help patients with obsessive-compulsive disorder are the SSRIs, clomipramine, and a cognitive behavior therapy called "exposure and ritual prevention therapy," two psychiatrists who specialize in the illness report.

BY JOAN AREHART-TREICHEL

There are those who fear their house is going to burn down unless they check and recheck the stove. And there are women who believe they are as depraved as serial killers because they think about harming their babies.

These are individuals with obsessive-compulsive disorder. And three different kinds of treatments may well help them, two psychiatrists who specialize in the disorder reported at APA's annual meeting in San Francisco in May at the symposium "New Research and Novel Therapeutic Strategies for OCD." The symposium focused on what the presenters judge as the top three most-effective treatments for people with this disorder.

The selective serotonin-reuptake inhibitors (SSRIs), of course, are one of the trio, Brian Fallon, M.D., an associate professor of psychiatry at Columbia University and a researcher on obsessive-compulsive disorder, pointed out. For instance, studies have found that 20 mg, 40 mg, or 60 mg daily of fluoxetine are more effective than a placebo in treating people with the disorder. The same for a 50 mg or a 200 mg daily dose of sertraline. In these trials, the SSRIs reduced obsessive-compulsive symptoms between 20 percent and 28 percent.

Another member of the trio, Fallon continued, is the potent serotonin and norepinephrine reuptake blocker clomipramine. Multicenter trials have found that it can reduce obsessive-compulsive symptoms 36 percent to 46 percent. However, "there are no dose-finding studies for clomipramine that I know of," he added, "so that we really can't say whether 150 mg is as good as 250 mg."

How do the SSRIs stack up against clomipramine in treating patients with obsessive-compulsive disorder? All double-blind trials that have compared clomipramine and the SSRIs have found them equally effective, Fallon said. Thus, "it is unlikely that clomipramine is more effective than the SSRIs," he concluded. Of course, he added, "that is not to say that there won't be individual patients for whom one SSRI is better than another, or for whom clomipramine works when none of the SSRIs works. And it is reported that maybe 15 percent to 20 percent of patients will improve when you switch to another one of these standard agents."

Finally, the third member of the trio—yet one with which psychiatrists may not be familiar—is a kind of cognitive-behavior therapy called exposure and ritual prevention (EXRP) therapy. So reported H. Blair Simpson, M.D., Ph.D., of the Anxiety Disorders Clinic of the New York State Psychiatric Institute.

At the start of EXRP therapy, Simpson explained, the therapist spends time building an alliance with the patient, reviewing the treatment rationale, constructing a hierarchy of the patient's feared situations or objects, then planning with the patient how and when to confront the feared situations or objects. The meat of the treatment is exposure sessions in which the therapist exposes the patient to situations or objects in progressive steps from those that generate moderate fear to high fear without the patient's engaging in rituals (compulsions) for protection. While at home, the patient also practices confronting the feared situations or objects without ritualizing.

A number of studies have indicated that EXRP therapy counters obsessive-compulsive disorder, Simpson said. One was a large collaborative study in which she participated with colleagues not just from her clinic but also from the Center for the Treatment and the Study of Anxiety in Philadelphia.

In this 12-week study, 122 subjects who had had obsessive-compulsive disorder on average for 16 years were randomly assigned to one of four treatment arms. The first group received a fixed daily dose of clomipramine up to 200 mg daily, and if a subject did not respond to 200 mg, then it could be increased up to 250 mg. (The average daily dose for the group was 235 mg.) The second group received EXRP therapy five times a week for three weeks plus two home visits. The third group got clomipramine plus EXRP therapy. (The average daily clomipramine dose for the group was 194 mg.) The fourth group was given a placebo instead of medication and did not receive EXRP therapy.

All the subjects were assessed every four weeks over the 12-week study using a variety of rating scales. Both clomipramine alone and EXRP alone were significantly superior to placebo in reducing obsessive-compulsive symptoms, Simpson and her team found. What's more, EXRP therapy was found to be superior to clomipramine in most analyses. However, EXRP therapy plus clomipramine, while superior to clomipramine alone, was not better than EXRP therapy alone.

These results thus suggest that EXRP therapy can help patients with obsessive-compulsive disorder, Simpson concluded. Still, it is no panacea, she admitted—for instance, it reduced symptoms 60 percent, but "60 percent isn't 100 percent." Also, she pointed out, "you need skilled therapists to deliver the therapy in a correct manner, and skilled therapists are in short supply."

Nonetheless, "I would advocate that every OCD patient you see should be told about medication and EXRP therapy," Simpson declared. "That is standard care and correct care." ■

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Controversy Continues to Grow Over *DSM's* GID Diagnosis

Is gender identity disorder a valid psychiatric diagnosis that merits a continued place in APA's diagnostic manual? Experts presented both sides of the controversial issue at an APA annual meeting symposium.

BY KEN HAUSMAN

The diagnosis of gender identity disorder (GID) is one of those handful of diagnoses that invoke passionate debate. With the fifth edition of APA's diagnostic manual *DSM-V* now in the early planning stage, its authors will have to confront the contentious issue of whether the manual should again include the diagnosis of GID.

An APA annual meeting symposium in San Francisco in May showed just how much heat the debate can generate.

Darryl Hill, Ph.D., an assistant professor of psychology at Concordia University in Montreal, cited the lack of any scientific reliability or validity studies supporting the GID diagnostic criteria listed in *DSM-IV* as part of his argument for removing the diagnosis from the manual of mental disorders.

Darryl Hill, Ph.D.: "Gender roles are not clearly dichotomous, like *DSM* suggests they are."

In fact, he insisted, GID is not a mental disorder at all. More than anything else, the criteria described reflect "the distress often experienced by parents" who have become "preoccupied with the negative aspects" of their son's or daughter's behavior as the child struggles to make sense of gender-related feelings, Hill maintained.

"Parents may inadvertently create" a problem in their children, he said, because they cannot come to grips with a child who does not easily fit into society's approved gender roles and expectations.

"Psychoeducational approaches" directed at parents would do their children much more good than bringing them to therapy for a phantom disorder, Hill stressed. He urged a "parent-centered approach" to psychoeducation that encourages parents to accept their children "just the way they are," even if the parents' inclination is to try to have the children's feelings and behaviors somehow shifted back to the mainstream. Educational programs need to concentrate on teaching parents ways to help them and in turn their children understand that children may be comfortable in "nonstereotypical" gender roles, but they are not "sick."

Little Evidence of Pathology

Hill maintained that there are no valid rationales for treating youngsters who fit *DSM*'s criteria for GID (see box on page 32).

"There is little evidence of pathology" in these children, he said. "Researchers have been able to identify only minor distress sources in specific domains." Much of that distress arises from socialization problems, that is, "getting along with and being accepted by other kids."

He continued, "Gender roles are not clearly dichotomous, like *DSM* suggests they are."

The most "probable outcome" in children who meet GID diagnostic criteria, Hill stated, is homosexuality, "which is, of course, not a pathological outcome."

Hill likened so-called treatments for GID to "reparative therapies," which major mental health and professional organizations, including APA, have labeled "unethical and harmful" attempts to change sexual orientation.

He also noted that the *DSM* criteria allow a GID diagnosis without the individual's having to meet the criterion of a "repeatedly stated desire to be, or insistence that he or she is, the other sex." Without this as a required factor, psychiatrists are left pathologizing nonconformist behaviors, he said.

If the *DSM-V* editors decide to keep GID in the manual, Hill wants them to include "tighter language" and "get rid of stereotypes and dichotomizing language." Also, if it remains, all five of the criteria under Section A must be required. Finally, he said, there should be "a moratorium on diagnosing and treating it" until research can show that it is a valid and treatable condition.

Keep Diagnosis, But Change It

Katherine Wilson, Ph.D., a founder of the San Diego-based organization GID Reform Advocates and former outreach director of the Gender Identity Center of Colorado, disagrees with Hill on the value of a diagnosis based on gender identity. She insisted that it should remain in *DSM*, but

please see ***GID Diagnosis*** *on page 32*

Turkey Facing Dramatic Increase in Suicides

There was an upward trend in suicide attempts in Turkey from 1998 through 2001—especially by Turkish women in 2000 and 2001. Whether this trend is continuing remains to be seen.

BY JOAN AREHART-TREICHEL

Back in 2000, the *New York Times* reported that a young Turkish woman had thrown herself from the roof of a building after her father forbade her to work and beat her for wearing a tight skirt.

This incident may have been far from isolated, a study by two Turkish psychiatrists published in the June *Canadian Journal of Psychiatry* suggests. The study found a 94 percent increase in suicide attempts in Turkey from 1998 through 2001, and an especially sharp increase in suicide attempts during 2000 and 2001 by Turkish women.

Since 1962 Turkey has collected and published rates of completed suicides. However, no official records have been kept of suicide attempts. So in 1998, Halise Devrimci-Ozguven, M.D., an attending psychiatrist at Ankara University School of Medicine, and Isik Sayil, M.D., a professor of psychiatry there, decided to conduct a study to assess the rates of attempted suicides in Turkey.

The researchers decided to focus on Mamak, a district of Ankara, which is Turkey's capital and second-largest city. Some parts of Mamak are included in the old city, but most is newly settled. With many immigrants living there, it is fast becoming one of Ankara's most diverse districts, mirroring, to some extent, the cultural diversity of Turkey as a whole.

Mamak has 22 Ministry of Health primary care units and two general hospitals. Between 1998 and 2001, the researchers screened all admissions to these facilities for attempted suicides. During these years they also checked Mamak police records for attempted suicides to make sure that they didn't miss any reported cases.

The researchers found that there had been 737 suicide attempts during the four-year study period—514 by women and 223 by men, with a female-male ratio of 2.3. Women aged 15 to 19 were found to have been at the highest risk, followed by women aged 20 to 24.

The investigators also discovered that there had been a 94 percent increase in suicide attempts during the study period, and an especially sharp increase in suicide attempts by women during 2000 and 2001 (see chart). They speculated that that upward trend in suicide attempts "may be related to the intense economic difficulties, increasing unemployment, and rapid social change" experienced by the Turkish people, and especially by young Turkish women, during the past few years. For instance, the moral values of Western society have influenced social life in Turkey more during the past decade than ever before.

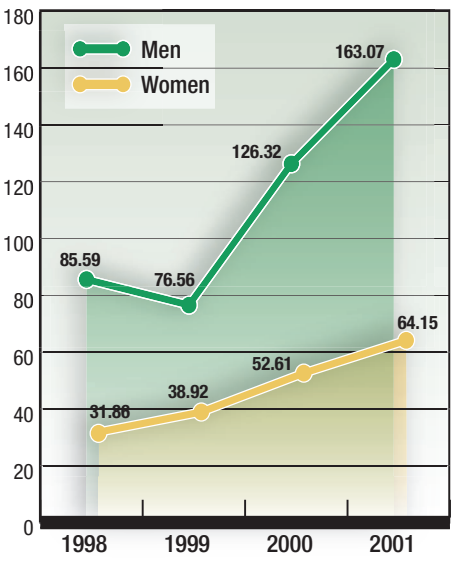
Whether the number of suicide attempts by Turks, and especially young Turkish women, has continued on an upward trajectory since 2001 remains to be seen. However, "we are continuing to collect data in our catchment area for monitoring suicidal behavior," Devrimci-Özguvén told *Psychiatric News*. "Besides, we are planning to monitor suicidal behavior in other catchment areas in Turkey as well."

She added, "Our results will be used for [developing] the national guidelines for suicide prevention in Turkey. In addition, we hope that this kind of research will be helpful for professionals in their practice with suicidal patients."

The study, "Suicide Attempts in Turkey: Results of the WHO-EURO Multicenter Study on Suicidal Behavior," is posted on the Web at <www.cpa-apc.org/Publications/CJP/current/ozguven.asp>. ■

Suicide Attempts On Rise in Turkey

Rates of suicide attempts have climbed for both sexes, though more dramatically in men. The graph shows mean suicide attempt rates for people over 15 years of age, per 100,000 people, for the period 1998 to 2001.



Source: *Canadian Journal of Psychiatry*, June 2003.

Clinical Care, Service Issues Focus of Fall Institute

APA's fall meeting highlights clinical innovations and high-quality services to meet the needs of individuals who suffer from serious mental illness, substance abuse, and other psychiatric problems.

BY RICHARD BALON, M.D.

While APA's 2003 annual meeting in the glorious city of San Francisco is probably not far from your mind, it is time to look ahead and include the Institute on Psychiatric Services in another great city—Boston—in your fall CME plans. The institute will offer another excellent educational experience for all its participants.

A trip to the cradle of higher education is not only just what you need but will also enjoy this fall. Make arrangements now to travel to Boston for the institute, which will be held October 29 to November 2 at the Marriott Boston Copley Place.

The institute is a smaller, more intimate meeting that offers an opportunity to expand your clinical knowledge while you catch up with colleagues and make new friends. The institute's manageable size and flexible schedule also allow you to reach your educational goals while enjoying sightseeing, cultural institutions, and culinary delights of the great city of Boston.

This year's theme is "Access to Integrated Mental Health Care." Our rich program reflects the clinical and service delivery issues we face in diverse communities. I hope you will share my excitement about this meeting.

Twenty-eight international, national, and local experts from various disciplines will offer interesting and stimulating lectures. Several prestigious APA awards will be given during the institute, followed by the awardees' lectures: Frederick Sierles, M.D., the recipient of the APA/NIMH Vestermark Award, will present the lecture "Why Many More Women Must Become Chairs, Deans, and Chief Academic Officers in Medical Schools"; Marvin Herz, M.D., the recipient of APA's Alexander Gralnick Award for Research in Schizophrenia, "Early Intervention in Different Phases of Schizophrenia"; Sir Michael Rutter, M.D., the recipient of APA's Marmor Award, "Using Epidemiology to Test Causal Hypotheses"; C. Edward Coffey, M.D., the recipient of the APA/APAA Administrative Psychiatry Award, "Pursuing Perfection in Depression Care"; and Abraham Twerski, the recipient of APA's Oskar Pfister Award, will try to answer the question, "Is There a Place for Spirituality in Therapy?"

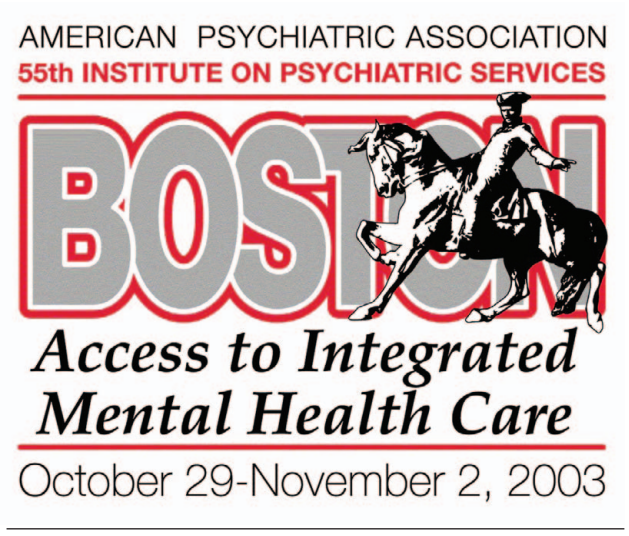
Other topics by expert lecturers include a wide variety of issues such as "Alcoholics Anonymous, Cult or Cure? A 60-Year Follow-Up of 200 Community Residents With Alcohol Dependency" by George Vaillant, M.D.; "Behavioral Complications of HIV Infection" by Francisco Fernandez, M.D.; "Psychotherapy and Psychopharmacology: Split Treatment Issues" by Michelle Riba, M.D.; "The Assessment and Treatment of Psychological Trauma" by Bessel van der Kolk, M.D.; "The Psychodynamics of Medicating" by Harold Eist, M.D.; "The Limbic Lobe in Relation to Psychosis" by Francine Benes, M.D., Ph.D.; "Diagnosis and Treatment of Antisocial Personality Disorder" by Glen Gabbard, M.D.; "What's New in Treating Patients With Borderline Personality Disorder?" by John Gunderson, M.D.; and many others.

Lecturers also include the popular National Public Radio ("All Things Considered") commentator Elissa Ely, M.D. The clinical consultations sessions will be led by such experts as Stephen Goldfinger, M.D., Joel Feiner, M.D., Kenneth Duckworth, M.D., and Ronald Diamond, M.D. There will be numerous workshops, innovative programs, industry-supported symposia, and poster sessions presenting the best work submitted by APA members and their colleagues.

I believe that besides mental health professionals taking care of severely mentally ill people, this meeting is attractive and of special benefit for residents and medical students. They will be able to join with psychiatrists and mental health professionals in several discussion groups and the clinical consultations to discuss clinical issues and the challenges of service delivery. They can also participate in special programs and get-togethers just for residents and fellows.

I hope that you will understand my pride in this meeting and my enthusiasm about the excellent program that the institute's Scientific Program Committee prepared for you. Please join us and continue the tradition of supporting community work and education at this wonderful fall meeting. ■

Dr. Balon is chair of the Scientific Program Committee of the Institute on Psychiatric Services.



Several Controversial Areas to Be Addressed in Medical Update Series

Boston is one of this country's leading storehouses of medical expertise. That expertise will be shared in the medical update lecture series at APA's 2003 institute.

BY JAMES M. ELLISON, M.D.

Boston, the location of this year's Institute on Psychiatric Services, is famous for its many historical sites, its thriving culture, its venerable academic institutions, its diverse cuisine, its indefatigable sporting teams and loyal fans, and of course its wealth of medical expertise.

With three top medical schools and a plethora of highly regarded teaching hospitals, Boston is one of the world leaders in medical teaching, research, and patient care. Given this medical culture, the institute's medical update lecture series for 2003 will include outstanding speakers and topics of practical interest to mental health clinicians.

Chronic fatigue and immune dysfunction syndrome (CFIDS; also known as chronic fatigue syndrome) is the topic of the first session, which will be led by Anthony L. Komaroff, M.D., on Wednesday, October 29, at 1:30 p.m. CFIDS affects the central nervous system, hypothalamic-pituitary-adrenal axis, and immune system, producing symptoms easily mistaken for disorders of mood or anxiety.

Komaroff, a professor of medicine at Harvard Medical School, editor in chief and publisher for Harvard Health Publications, and senior physician at Brigham and Women's Hospital, is an award-winning investigator of this disorder. He will help meeting participants understand current ideas about the pathophysiology and treatment of CFIDS, including psychiatric aspects of the disease and conflicting recommendations regarding the appropriateness and effectiveness of antidepressant treatment.

The preventive value of hormone replacement therapy for postmenopausal women has recently been questioned as a result of new data from the Women's Health Initiative study. These data and the larger controversy will be reviewed by JoAnn E. Manson M.D., Dr.P.H., on Thursday, Oc-

please see ***Medical Updates*** *on page 28*

Dr. Ellison is president of the Massachusetts Psychiatric Society.

Register Now!

A copy of the preliminary program booklet, which includes registration, housing, and air travel information, can be obtained by calling the APA Answer Center at (888) 357-7924 or by clicking on the IPS logo on APA's Web site at <www.psych.org>.

Register in one of three ways:

- Register online by going to the Web site <www.psych.org/sched_events/ips03/registration/regindex.cfm> and click on "Register Online."
- Download a registration form at <www.psych.org/sched_events/ips03/registration/regindex.cfm> and mail or fax the completed form to APA.
- Use the registration form found in the preliminary program booklet and mail or fax the completed form to APA.

Save on fees by registering before September 29.

Colonial history comes alive with the sounds of the fife and the beat of the drum. Boston's prominent place in American history is celebrated by reenactors.

Photos curtesy of Boston USA! and Fay Foto

This monument commemorates the 1775 Battle of Bunker Hill.

apa institute

A Prescription for Fun In Beantown This Fall

Whether you come to Boston by land or by sea, just be sure to come! APA's 2003 Institute on Psychiatric Services is being held in one of America's most historic and culturally rich cities at the perfect time of year.

BY JAMES M. ELLISON, M.D.

Photos courtesy of Boston USA! and Fay Foto

Boston is a treasure trove of historical sites, cultural resources, and other tourism experiences—many of which you will be able to visit when you are in town for APA's 2003 Institute on Psychiatric Services from October 29 to November 2. The institute will be held at the Marriott Copley Place Hotel, located in Boston's Back Bay area.

Because Boston is compact and easily traversed, you can see plenty during a brief visit. How will you make the most of your free time here? It depends on what you enjoy. While some of us may look forward to visiting Boston's historical sites, others will prefer to find a live jazz or blues club or investigate the many bookstores. Still others may be waiting to sample the fine, multicultural restaurants or explore shopping opportunities.

For the multidimensionally oriented among us, at right in tabular form is a list of suggestions that take into account a variety of interests. Take a look at the recommendations and see where they lead you.

More information is available from the Greater Boston Convention and Visitors Center on theater, music, and dance events, nightlife, historical sites, and anything else that this article didn't cover by calling (888) SEE-BOSTON. ■

Dr. Ellison is president of the Massachusetts Psychiatric Society.

***Family Fun* magazine named Boston the top destination for families in the Northeast because of its rich history and family-friendly sites to visit, such as the Paul Revere House, the U.S.S. Constitution, and the Museum of Science.**

I. If you like...	II. And...	Then you should prescribe for yourself:

AMERICAN PSYCHIATRIC ASSOCIATION
58th INSTITUTE ON PSYCHIATRIC SERVICES
BOSTON
Access to Integrated Mental Health Care
October 29-November 2, 2003

Nature and outdoor activities	Having fun!	• **Boston Public Gardens:** Walk through these beautiful gardens and take a ride on a swan boat. • **Boston Harbor:** Take a harbor cruise or go on a three-hour whale watch. **Contact:** Boston Harbor Cruises at (617) 227-4321; buy tickets online at <www.bostonharborcruises.com/>.
Baseball	The Red Sox!	• **A tour of Fenway Park:** Tours depart from Gate D on Yawkey Way each hour, seven days a week from 9 a.m. to 4 p.m. or until three hours before game time, whichever is earlier. **Cost:** $9 for adults, $8 for seniors, and $7 for children 14 and younger. **Contact:** (617) 236-6666 or e-mail tours@redsox.com.
Shopping	A little walking!	• **Filenes Basement:** This is the original and still-famous Boston site for bargain shopping, located at Downtown Crossing on Summer Street. The earlier you arrive, the more bargains you will find! Also, Macy's, Marshalls, Tellos, and many other department stores are located nearby. Downtown Crossing is a pleasant stroll from Copley Square. • **Newbury Street:** Original boutiques, cafes, and art galleries with lots of original flair can be found here. Check out the new Kidder-Smith Gallery at 131 Newbury Street, for example, to view the work of cutting-edge artists. • **Copley Place and the Prudential Mall:** Peruse boutiques and department stores, including Saks and Neiman Marcus.
Museums	Visual stimulation!	• **The Museum of Fine Art:** This Huntington Avenue museum displays a huge permanent collection and special exhibitions that could easily occupy all your free time while in Boston. • **The Museum of Science:** Outstanding exhibits for adults and an engaging play area for children can be found here. It is located on Route 28, not far from Massachusetts General Hospital. • **The Isabella Stewart Gardner Museum:** Named for its founder, this museum houses an eclectic collection of fine and decorative art in a stunning 15th-century Venetian-style palace. It is located at 280 The Fenway. Call (617) 566-1401 for scheduled concerts featuring jazz and Latino as well as classical music.
Tours	Ducks or trolleys?	• **Boston Duck Tours:** See Boston by land and by sea in an amphibious vehicle that begins an 80-minute tour of the city on land and then chugs onto the Charles River! **Cost:** $23 for adults, $11 for children 3 to 11. **Where:** Tours meets outside the Prudential Center and Museum of Science. **Contact:** (617) 723-3825 or info@BostonDuckTours.com • **Old Towne Trolley Tours:** Tour Boston at your pace seven days a week from 9 a.m. **Cost:** $31.50 for two-day adult pass, children under 12 free. **Where:** Boston Marriott Copley Hotel stop. **Contact:** Buy tickets online at <www.historictours.com/boston/>.
Fine restaurants	Sitting, talking, and eating	• Too many great restaurants to list here, but check out the Boston Dining Guide online at <http://boston.diningguide.net/> for ideas.
Local history	Stretching your legs!	• **The Freedom Trail:** This trail offers an excellent walking tour of the city. One of its highlights is the Paul Revere house, in the North End (Boston's Italian district). While in the area, enjoy a cup of Italian coffee at Café Vittorio and a cannoli at Mike's Pastry or Modern Pastry. **Who:** Boston by Foot Guided Tours **Where:** Tours meet in front of Faneuil Hall, at the statue of Samuel Adams on Congress Street. **When:** Daily at 10 a.m. **Cost:** $9 for adults, $6 for children 6 to 12 **How long:** 90 minutes **Contact:** (617) 367-3766 • **Beacon Hill Tour:** Tour the State House and Louisburg Square and view rare examples of the work of Charles Bulfinch, who also designed the nearby State House and many of the older buildings in Boston. **Who:** Boston by Foot Guided Tours **Where:** Meet your guide in front of the State House steps on Beacon Street across from The Common. **When:** Monday through Friday at 5:30 p.m., Saturday at 10 a.m., Sunday at 2 p.m. **Cost:** $9 for adults, $6 for children 6 to 12 **How long:** 90 minutes **Contact:** (617) 367-3766 • **There are also tours of** Victorian Back Bay, the South End, Boston by Little Feet (the Freedom Trail tour in a version designed for children), and Boston Underground. **Contact:** (617) 367-3766

Medical Updates

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tober 30, from 1:30 p.m. to 3 p.m.

Manson is chief of the Division of Preventive Medicine at Brigham and Women's Hospital in Boston and the Elizabeth F. Brigham Professor in Women's Health at Harvard Medical School. She is known for her expertise as an epidemiologic investigator and for her interests in preventive medicine and women's health. She was also voted one of the "top docs for women" in a 2001 *Boston Magazine* poll.

Later that day, from 3:30 p.m. to 5 p.m., Ronald E. Kleinman, M.D., will make a presentation on the health risks of obesity. Kleinman is a professor of pediatrics at Harvard Medical School, associate chief of the department of pediatrics at Massachusetts General Hospital, and division chief of pediatric gastroenterology and nutrition. He is an outstanding teacher, is board certified in both pediatric gastroenterology and pediatric nutrition, and serves on the staff of Massachusetts General Hospital. His investigations of nutrition have addressed not only medical but also behavioral and emotional consequences of hunger and of complementary feeding.

The final speaker in the medical update series, Peter M. Wolsko, M.D., will discuss alternative and complementary medicine on Friday, October 31, from 10 a.m. to 11:30 a.m. Many clinicians are surprised to learn that patients in the United States make more visits to providers of alternative and complementary medicine services than to traditional primary care physicians.

Wolsko is an instructor in medicine at Harvard Medical School and serves on the staff of the Harvard Medical School Osher Institute and Division for Research and Education in Complementary and Integrative Medical Therapies. He will explore the growing popularity of alternative treatment approaches and their interfaces with conventional medical practices.

All of the medical update talks will take place on the third floor of the Marriott Copley Place Hotel. Sessions will include a 60-minute lecture and 30-minute discussion with the audience. ■

ASTRA ZENECA SEROQUEL (AKATHISIA)
P4C

Residents Should Make Joining APA One of Their New Experiences

BY ANGELA HARPER, M.D.

This is my first column as your member-in-training (MIT) representative to the Board of Trustees. I am a general psychiatry resident at the University of South Carolina in Columbia. I spent the last year on the Board as a nonvoting member and "learning the ropes" from last year's MIT trustee, Dr. Susan Padrino.

My background is somewhat unusual. Prior to medical school, I worked for six years as an office manager for a psychiatrist and three social workers. This experience allowed me to gain a great deal of understanding regarding managed care issues, scope-of-practice concerns, and the stigmatization of mental illness—knowledge that I hope will be useful as I serve the next year as your MIT trustee.

As I write this column, I am completing the last two weeks of my third year of residency and looking forward to beginning the last year of my general psychiatry training. While I am about to finish, hundreds of others across the country are just beginning their residency. To these new doctors, I extend a warm welcome to the field of psychiatry and to APA.

I remember the first year of training as being one of multiple "firsts." I still remember my first patient who passed away in internal medicine, my first night on call as I faced a very psychotic and agitated patient, and the first time that I had to commit a patient. I also remember how excited I was to begin the practice of being a psychiatrist and joining a residency program with wonderful colleagues and faculty from whom I have learned a great deal. Perhaps the highlight of my intern year was attending my first APA annual meeting in New Orleans. Walking into the convention center was overwhelming and inspiring. I felt as though I was a part of something that was in the midst of a time of growth and excitement. Experiencing the collegiality, attending lectures, and meeting some of the experts and leaders in our field served to reinforce, once again, my decision to pursue psychiatry as a career.

I know that interns beginning their training this month will have their own "firsts" that will stay with them throughout their career. I hope that you will all come to feel, as I have, that APA is part of your professional identity and that your membership is something that you value.

Obviously, there are multiple financial benefits to being an APA member-in-training. We receive a discount on textbooks and annual meeting registration. Multiple travel scholarships are available to MITs to attend the annual meeting and the Institute on Psychiatric Services. Dues at the national level are waived during your first year of membership and cost $80 thereafter. (Some district branches also waive first-year dues.) This nominal fee pays for APA publications that would cost hundreds of dollars if purchased without membership.

Freebies and financial benefits are wonderful, but the most important thing that APA can provide you with is a sense of community with other professionals in your field. Serving this last year on the Board of Trustees has proven to me that this organization has our best interests at heart. APA devotes a tremendous amount of effort to working for insurance parity, protecting us from scope-of-practice challenges, and diligently hammering away at the stigmatization that our patients and profession face each day. Our profession would be quite different were it not for the efforts of APA. I hope that each of you, whether you are just starting your training or are about to finish, considers how you too can make a difference, whether your involvement is at the local, state, or national level.

Best of luck to each of you as we begin a new year of training, and I look forward to serving you on the Board of Trustees this year. If you have any questions or concerns or if you are interested in writing an article for the Residents' Forum, please contact me by e-mail at a_d_harper@yahoo.com. ■

Dr. Harper is APA's member-in-training trustee.

Resolving Conflicts

Every year more than 900 new residents enter psychiatry residency programs; about 600 are U.S. graduates from all 50 states, and more than 300 are non-U.S. graduates from all over the world.

These residents work together on a daily basis for four years. For different reasons, they may experience conflicts among each other, and every resident has a way of dealing with such conflicts. However, using several methods of conflict resolution is confusing and time consuming. Thus, I would like to propose to my fellow residents the use of a three-step conflict resolution process that I have found to work very well. I call it the "OCD" guidelines:

First, whenever there is a conflict between two residents, the residents should talk to each **O**ther. If the conflict is not resolved, then they should talk to the **C**hief resident. If the conflict is still not resolved, talk to the program **D**irector.

Using this approach, my fellow residents and I have found that most conflicts are resolved at step one or two and that the process is time efficient and creates a good working atmosphere.

Reviewing these OCD guidelines with new residents during their program orientation will give them a uniform method to resolve conflicts and spells out the program's expectations that they will use it.

I think these steps will come naturally to many residents, but clearly describing and reinforcing them are beneficial. Moreover, practicing these guidelines will help the professional growth of the residents and increase the cohesion among them.

MOHAMED RAMADAN, M.D.
Wichita, Kan.

Focus on Public Psychiatry

Thank you for the focus on public psychiatry issues in many of the recent issues of *Psychiatric News*. I am especially appreciative of articles like "New Wave of Homeless Requires Creative Psychiatric Intervention" and "APA Helps DBs respond to Growing Medicaid Crisis" in the June 6 issue. These help to increase awareness and knowledge of our members so that they can become better informed advocates for their patients. This is a great service to our profession and to our patients. Thank you.

ANITA EVERETT, M.D.
Richmond, Va.

Dr. Everett is the inspector general for mental health in the Office of the Governor of Virginia.

In Defense of Analysis

We write to protest the highly disparaging comments concerning psychoanalysis in the letter by Drs. David Brody and Michael Serby ("Off the Couch") in the June 8 issue. Most of their criticisms are clearly unwarranted. For example, "Psychoanalysis," they say, "is simply not effective for addressing the treatment of patients with most psychiatric disorders." Starting with Sigmund Freud, psychoanalysts have never claimed that psychoanalysis can meet the treatment needs of most psychiatrically disordered patients.

As nonpsychoanalysts, we can attest to the remarkable ameliorative (indeed, curative in many cases) effect that psychoanalytic treatment has had on many patients who have failed to respond to a variety of nonpsychoanalytic psychiatric interventions.

ABRAHAM L. HALPERN, M.D.
MARILYN L. HALPERN, PH.D.
Mamaroneck, N.Y.

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,* APA, Suite 1825, 1000 Wilson Boulevard, Arlington, Va. 22209; fax: (703) 907-1094; 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.

APA Member Brings Message to Kennedy

APA Member **Timothy Mueller, M.D.** (right), of Providence, R.I., recently met with Rep. **Patrick Kennedy** (D-R.I) on Capitol Hill to discuss various bills that Kennedy is supporting on behalf of people with mental illness: Kennedy is the lead Democratic sponsor of the House version of the Sen. Paul Wellstone Mental Health Equitable Treatment Act of 2003 and is working to increase the federal budget for the National Institute of Mental Health. Kennedy also recently reintroduced, along with Rep. Steny Hoyer (D-Md.), the Positive Aging Act, which AAGP members helped to draft. The bill would provide federal funding mechanisms to promote collaborative, integrated mental health initiatives for seniors within the primary care setting. Mueller's visit is part of an ongoing program at APA—through its political action committee, APA*PAC*—in which APA members educate federal and state legislators and policymakers about mental health issues.

clinical & research news

Pregnancy

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that any medication is safe during pregnancy and lactation," Stotland said, there is a growing body of literature on the impact of SSRIs on the fetus and nursing baby, research she called "quite reassuring."

Marcus said the more well-established risks associated with not treating depression in expectant mothers include premature delivery, low birth weight, and preeclampsia in the mother.

The article "Depressive Symptoms Among Pregnant Women Screened in Obstetrics Settings" is posted on the Web at <www.liebertpub.com/jwh/default1.asp>. ■

ASTRA ZENECA SEROQUEL (EPS)

P4C

GID Diagnosis

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not as a disorder.

Wilson believes that to reduce stigma, what's now labeled GID should be replaced with a diagnosis "unambiguously defined by distress" rather than by "gender nonconformity." She took issue with the notion inherent in a psychiatric diagnosis of GID that cross-gender identity itself is not a legitimate mental and behavioral framework for some individuals, but rather a "perversion or defective development."

Wilson said that *DSM* fails to acknowledge that "many healthy, well-adjusted transsexual people exist" or to distinguish between such individuals and those who would benefit from a medical treatment.

She would like to see GID replaced with a term such as gender dysphoria, which would describe someone who is persistently distressed with his or her physical sex characteristics or with the limiting gender-based roles that society often imposes on men and women.

The current diagnosis, Wilson said, "poorly serves transgender and especially transitioning individuals," because it "contradicts the treatment goals for transsexuals who require sex-reassignment procedures."

A diagnosis based on dysphoria rather than evidence of "strong and persistent cross-gender identification" would be an important element in the long process leading up to sex-reassignment surgery, she added. It should also "exclude consequences of societal prejudice or intolerance" that are labeled as "symptomatic of mental illness," Wilson stated.

Psychiatrists and other physicians should assume that most transsexuals are "sane and responsible," Wilson stressed.

"Just as *DSM* reform reduced stigma surrounding same-sex orientation 30 years ago, reform of the gender identity disorder diagnosis holds similar promise today," she said.

Psychiatrists Take Issue

The two prominent psychiatrists who served as the symposium's discussants had serious disagreements with Hill's and Wilson's positions on the inclusion of GID in *DSM*.

Robert Spitzer, M.D., who chaired the work group that developed *DSM-III* (the volume that first included GID) and its revision, *DSM-III-R*, said that a key question regarding GID "is not where we place the boundary, but are there any cases of kids or adults for whom the diagnosis is appropriate?"

Spitzer maintained that certain behaviors "are part of being human—part of normal development." In all cultures, adults expect certain "essential" things to happen as children mature, and these always include fulfilling gender-based roles and engaging in gender-congruent behaviors. It is thus legitimate for psychiatrists to identify a disorder in which persons of one gender reject these roles and behaviors and assume those of the opposite sex. He rejected the view he ascribed to Hill that "everything is socially determined" and that straying far from those expectations is an acceptable variance of human behavior.

He also rejected Hill's contention that "gender is not dichotomous," with everyone somewhere between the two poles. All humans are "biologically one or the other" sex, Spitzer stated, and cultures view gender as a "dichotomy."

The failure to identify with the gender with which one was born "is a dysfunction," he said.

Former APA president Paul J. Fink, M.D., also a symposium discussant, has worked with 40 transsexuals in the process of surgically changing their gender. His extensive experience with these individuals has demonstrated, he said, that transsexualism is, in fact, a valid psychiatric diagnosis.

Transsexualism "is not a normal sexual variant," said Fink, a professor of psychiatry at Temple University. He agreed that there is a dearth of research on GID, but warned against correcting that situation by "legitimizing behaviors that are actually disadvantageous" to the person. Psychiatrists "know there are times when we have to intervene," he emphasized.

Having GID as a diagnostic option, Fink said, helps him work with and help a patient, even if the work is helping the person prepare to have a sex-change operation. ■

DSM-IV-TR Diagnostic Criteria For Gender Identity Disorder

A. A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex). In children, the disturbance is manifested by four (or more) of the following:
   1. repeatedly stated desire to be, or insistence that he or she is, the other sex
   2. in boys, preference for cross-dressing or simulating female attire; in girls, insistence on wearing only stereotypical masculine clothing
   3. strong and persistent preferences for cross-sex roles in make-believe play or persistent fantasies of being the other sex
   4. intense desire to participate in the stereotypical games and pastimes of the other sex
   5. strong preference for playmates of the other sex

B. Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex.

C. The disturbance is not concurrent with a physical intersex condition.

D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Awards

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atry and neurology at Case Western Reserve University, and a clinical professor of psychiatry at Wayne State University.

APA Award for Research in Psychiatry Lecture: *Ming T. Tsuang, M.D, Ph.D., D. Sc.*, Stanley Cobb professor of psychiatry and psychobiology at Harvard University and director of the Harvard Institute of Psychiatric Epidemiology and Genetics.

APIRE/AstraZeneca Young Minds in Psychiatry Awards: *Paolo Brambilla, M.D.*, a senior postdoctoral clinical research fellow at the University of Pavia in Italy; *Kiki D. Chang, M.D.*, an assistant professor of psychiatry and behavioral sciences in the division of child and adolescent psychiatry at Stanford University School of Medicine and director of the Pediatric Mood Disorders Clinic; *Dost Ongur, M.D., Ph.D.*, a PGY-3 resident in adult psychiatry in the MGH/McLean residency training program; *Hao-Yang Tan, M.D.*, a junior faculty member and psychiatrist with the department of psychological medicine at the National University of Singapore.

APIRE/GlaxoSmithKline Faculty Fellowship for Research Development in Biological Psychiatry: *C. Daniel Salzman, M.D., Ph.D.*, an assistant professor of neuroscience in psychiatry at Columbia University College of Physicians and Surgeons and Columbia's Center for Neurobiology and Behavior.

APIRE/GlaxoSmithKline Severe Mental Illness Research Fellowship: *Raymond J. Kotwicki, M.D.*, a graduate of the Emory University department of psychiatry and behavioral sciences research training program and a fellow in community psychiatry and public health; *Katalin Szanto, M.D.*, assistant professor of psychiatry at the Western Psychiatric Institute and Clinic of the University of Pittsburgh Medical Center.

APIRE/Lilly Psychiatric Research Fellowship: *K. Luan Phan, M.D.*, a graduate of the five-year research track of the University of Michigan psychiatry residency program.

APIRE/Wyeth M.D./Ph.D. Psychiatric Research Fellowship: *E. David Leonardo, M.D., Ph.D.*, chief resident in psychiatry at the New York State Psychiatric Institute at Columbia University; *Gabriel Vargas, M.D., Ph.D.*, a clinical fellow at the University of California, San Francisco.

Simon Bolivar Award Lecture: *Juan J. Lopez-Ibor, M.D., Ph.D.*, a professor of psychiatry and head of the psychiatric unit of the San Carlos Hospital of the Complutense University in Madrid, coordinator for mental health for Madrid Area 7, and director of the World Health Organization Research and Training Center for Spain.

Solomon Carter Fuller Award Lecture: *James H. Carter, M.D., M.Div.*, a professor in the department of psychiatry and behavioral sciences at Duke University School of Medicine, senior consulting psychiatrist and co-founder of the social work-mental health unit at Lincoln Community Health Center in Durham, and medical director of the South Light program in Raleigh.

Alexander Gralnick, M.D., Award for Research in Schizophrenia: *Marvin I. Herz, M.D.*, emeritus professor of psychiatry at the University of Rochester.

Manfred S. Guttmacher Award Lecture: *Diane H. Schetky, M.D.*, a clinical associate professor of psychiatry at the University of Vermont College of Medicine at Maine Medical Center in Portland; *Elissa P. Benedek, M.D.*, a clinical professor of psychiatry at the University of Michigan, Michigan State University, and Wayne State University, and consultant for the forensic psychiatry residency program at the Center for Forensic Psychiatry.

Health Services Research Early Career Award: *Sheryl Kataoka, M.D.*, M.S.H.S., an assistant professor in the division of child and adolescent psychiatry at the University of California-Los Angeles.

Health Services Research Senior Scholar Award: *Stephen J. Bartels, M.D., M.S.*, an associate professor of psychiatry at Dartmouth Medical School, director of aging services research at the New Hampshire-Dartmouth Psychiatric Research Center, co-director of the Behavioral Health Policy Institute, and medical director for the Division of Behavioral Health, state of New Hampshire.

Marmor Award Lecture: *Sir Michael Rutter, M.D.*, a professor of developmental psychopathology at the Kings College Institute of Psychiatry in London and director of the Neuroscience Research Division of the Wellstone Trust.

Frank J. Menolascino Award for Psychiatric Services for Persons With Mental Retardation/Developmental Disabilities: *Harvey Stabinsky, M.D., J.D.*, director of education and clinical director of the Mentally Ill/Mentally Retarded Dual Diagnosis Unit at St. Vincent's Hospital and an assistant professor of psychiatry at New York Medical College.

Adolf Meyer Award Lecture: *David Reiss, M.D.*, the Vivian Gill Distinguished Research Professor and director of the division of research and the Center for Family Research in the department of psychiatry and behavioral sciences at George Washington University School of Medicine and Health Sciences.

Patient Advocacy Award Lecture: *Robin J. Munro*, a member of the Centre of East Asian Law and the Law and Public Health in Developing Countries Research Group in the School of Oriental and African Studies at the University of London, founder of the Hong Kong office of Human Rights Watch, and the author of numerous Human Rights Watch publications.

Kun-Po Soo Award Lecture: *Masahisa Nishizono, M.D.*, a professor of psychiatry and former dean of the Fukuoka University School of Medicine in Fukuoka, Japan.

Jeanne Spurlock, M.D., Minority Fellowship Achievement Award: *Patricia I. Ordorica, M.D.*, an associate professor and director of the Addictive Disorders Section of the Department of Psychiatry and Behavioral Medicine at the University of South Florida College of Medicine and associate chief of staff of mental health and behavioral sciences at Tampa VA Medical Center.

Alexandra Symonds Award Lecture: *Donna E. Stewart, M.D.*, Lillian Love chair in women's health at the University Health Network and the University of Toronto and a professor in the faculty of medicine in the departments of psychiatry, obstetrics/gynecology, medicine, anesthesia, family and community medicine, and surgery at the University of Toronto.

George Tarjan Award Lecture: *Prakash N. Desai, M.D.*, a professor of psychiatry and associate dean in the College of Medicine at the University of Illinois at Chicago and chief of staff at the Veterans Affairs Chicago Health Care System/West Side Division.

Arnold L. van Ameringen Award in Psychiatric Rehabilitation: *Rose Hill Center*, a residential rehabilitation facility for patients with severe psychiatric disorders in Holly, Mich.

APA/NIMH Vestermark Psychiatry Educator Award Lecture: *Frederick S. Sierles, M.D.*, chair of psychiatry at Chicago Medical School. ■

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Web Site

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the latest news quickly and decide what interests them most. For those trying to access APA resources or support, the icons for these functions will jump out. Most of the complaints I have heard about the old site—some of them my own—centered on how cumbersome it was to find what you needed."

APA Medical Director James H. Scully Jr., M.D., commented, "Our commitment here at APA is to continue to improve our service to our members every day. This new Web site is an important step along the way."

"APA's Web site is the front door of our Association," said Laurie Oseran, director of APA's Division of Communications and Marketing.

One of the goals of the redesign was to make the content more timely by including breaking news on research and clinical developments, as well as on developments that impact on the practice of psychiatry and its patients.

"The site will be continually updated," said Vergare. "In fact, I expect it to serve as a news resource that can get information out immediately."

Under "Advocacy," members will find up-to-the-minute information on legislation, "Action Alerts" that let members know when their efforts are needed to contact legislators about a particular bill or issue, and information on government regulations that affect the practice of psychiatry, such as the HIPAA privacy rule.

To help users move quickly from one part of the Web site to another is a "navigation box" on the left side of each Web page. The box lists the Web site's major sections, many of which are new, including "District Branches and State Societies," which will link members to the Web sites of their home societies; "Career Corner," which will provide news and information to help psychiatrists advance in their careers, and "Calendar," which lists the dates of APA meetings, along with the meetings of other major psychiatric organizations.

The new site will include more features and information accessible to members only. A recently updated APA membership directory will help members locate one another and make referrals. There are also improved links to other professional and subspecialty organizations of interest to psychiatrists, said Vergare.

Another improvement to the Web site is a new search engine that is vastly superior to the current one. As content is added to the Web site, it is assigned keywords that categorize the information. When the search engine performs a search, it uses these keywords along with its own independent analysis to provide more accurate search results.

To ensure that information is posted and removed in a timely manner, the content "will be put back in the hands of the APA staff and members who develop it," said Oseran. Thus, staff will have the capability to add, delete, or update content. Moreover, the Division of Communications and Marketing has developed a style manual to ensure that all content is edited following the same rules and that the look of each document is consistent with the rest of the site.

APA's Web site was first launched in 1996. Over the course of about a year, APA staff compiled and arranged the site's content. While the site was innovative at the time and made many of APA's informational resources and publications accessible to APA members, the site has not undergone a major overhaul until now.

In addition to Vergare, the members of the Council on Membership and District Branch Relations are Nioaka Campbell, M.D., John Gaston, M.D., Ellen Haller, M.D., Mary Marrocco, M.D., William Matuzas, M.D., Rekha Ranade-Kapur, M.D., Sarah Spratt, M.D., Margo Adams, M.D., Robin Huffman, M.D., Helen Montague Foster, M.D., and Priscilla Ray, M.D.

APA's revamped Web site at <www.psych.org> goes live this fall. More information will be published closer to the launch date. ■

association news

Art Exhibit

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M.D. **Second:** "Two Windows," Sonia Pawluczyk, M.D. **Third:** "Quartet–4," Stephen S. Dashef, M.D.

Poetry
First: "Gem," William A. Alvarez, M.D. **Second:** "Vermont Drive Home," Gail M. Barton, M.D. **Third:** "Love/Amor," William A. Alvarez, M.D.

Sculpture
First: "Pampero IV," Astrid Rusquellas, M.D. **Second:** "Memorial Day," Robert S. Lampke, M.D. **Third:** "Snake," Robert S. Lampke, M.D.

Other
First: "Heritage Days in Windsor: A Celebration of the Founding of the Republic of Vermont in 1777" (an anthology of photos), Gail M. Barton, M.D.

The APA Art Association encourages APA members and spouses to join the association, not only as exhibiting artists, but also as patrons of the arts. The annual membership fee is $30. Included in the fee is the opportunity to exhibit two items at the annual meeting. (The fee to exhibit additional items is $5 each, up to a maximum of six items.) Also included in the membership fee is a newsletter with information about member artists, the proceedings of the APA Art Association, and exhibits.

The categories for the 2004 art exhibit are ceramics; computer art; crafts; glass; graphics; jewelry; painting: mixed media, oil, water based, and acrylic; black-and-white photography; color photography; poetry; sculpture; textiles; and "other."

Participants in the annual exhibit of the APA Art Association find that it is a stimulating and convivial event and a haven of calm amid the frenzy of the meeting—and it's just plain old fun.

Those interested in joining are asked to contact the APA Art Association's president, Gail M. Barton, M.D., M.P.H., by mail at 56½ Merchant's Row, Rutland, Vt. 05701; by phone at (802) 773-8929; by fax at (802) 773-9026; or by e-mail at gbarton@vermontel.com. ■

AMA

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ability to do advocacy work on behalf of APA and the rest of organized medicine. "In turn, I bring experience about managed care, ethics, parity, and scope of practice to the AMA," he added.

Last January Lazarus was a featured speaker at a roundtable discussion on scope-of-practice legislative initiatives at the AMA State Legislative Conference in Tucson, Ariz.

Members of APA's delegation and other psychiatrists also gained new influence and visibility. APA Trustee-at-Large Patrice Harris, M.D., recently was appointed to the Council on Legislation and elected co-chair of the AMA's Women's Caucus. Emmanuel Cassimatis, M.D., was re-elected to the Council on Medical Education. Dudley Stewart, M.D., was appointed to the Council on Ethical and Judicial Affairs (CEJA).

In another upset, John C. Nelson, M.D., a Salt Lake City obstetrician-gynecologist, became the new president-elect of the AMA's Board of Trustees. He defeated John Knote, M.D., speaker of the HOD.

Psychiatry Scores in HOD

APA and the American Academy of Child and Adolescent Psychiatry (AACAP) emerged almost totally victorious from the debate and subsequent actions on their proposed resolutions in reference committees and the HOD.

Specialty and state societies submit draft resolutions and testify on their behalf in front of one of eight reference committees. Those committees then recommend action to the HOD. The recommendations are subject to debate on the floor of the HOD. Final disposition of the resolution depends on a vote of the HOD.

A particularly significant victory was passage of a resolution directing the AMA to circulate a letter for state medical societies to sign urging the Senate and House of Representatives to bring parity legislation to a vote during the 108th session of Congress.

McIntyre said, "Support has been growing for issues related to our patients during the decade I've been coming to AMA meetings. Now, our colleagues in other specialties speak almost as frequently about the importance of parity as we do."

A resolution sponsored by AACAP and APA generated a rare burst of applause from delegates and an editorial in the *Chicago Tribune* titled "Three's a Crowd in Exam Room."

AACAP delegate and APA trustee David Fassler, M.D., who introduced the resolution, said that it called into question the practice by pharmaceutical companies of having sales representatives sit in on patient visits with physicians.

The practice, called "shadowing," is often a required part of the sales job. Former sales representatives confirmed that there was no oath or directive protecting any patient confidences, according to Fassler.

He testified to the committee, "As child and adolescent psychiatrists, we were also particularly concerned when we learned that this kind of shadowing was occurring in situations involving young children since issues of informed consent are even more complex with younger patients."

Fassler introduced Barbara Felt-Miller, a former drug company salesperson who had been required to engage in shadowing.

"I was never trained to view a human body like a physician does," she said. "I personally found sitting in on an exam embarrassing."

Delegates applauded her comments and ultimately passed a resolution saying that the practice of shadowing should be prohibited and that the AMA should cooperate with industry representatives in promulgating guidelines to that effect.

AACAP, with the support of APA, won passage for another resolution related to the pharmaceutical industry.

The resolution called for the AMA's CSA "to study the impact of funding sources on the outcome, validity, and reliability of pharmaceutical research and to develop guidelines to assist physician researchers in evaluating and preserving the scientific integrity, validity, and reliability of pharmaceutical research, regardless of funding source."

Fassler testified that recent reports in the *Journal of the American Medical Association* (January 22) and *New England Journal of Medicine* (May 18, 2000) raised issues about "subtle bias" in study design and subject selection and about selective reporting and publication of results.

As passed by the HOD, the amended resolution calls for the study to be conducted jointly by the CSA and the CEJA, because the issues have ethical as well as scientific dimensions.

The American Academy of Pediatrics joined APA and AACAP in sponsoring a resolution calling for the CSA to study the reported increase in the incidence of serious neurodevelopmental disorders, including autism, Asperger's, and other developmental disorders.

Alternate AACAP delegate Louis Kraus, M.D., testified that an increasing number of children have been diagnosed with autism during the past decade. Theories about the increase include improved recognition, changing diagnostic criteria, and possible environmental etiology. The result is confusion among members of the general public.

Pediatrician Eugenia Marcus, M.D., said, "[Parents] are grasping at straws because they don't know what to believe. They are spending millions of dollars on alternative treatments that are not supported by science."

Kraus also argued successfully in favor of an amendment to a resolution asking the AMA to evaluate gender-specific rehabilitation programs, mental health services, and educational services in juvenile detention centers.

Kraus's amendment added community-based programs for delinquent girls to the list of items to be evaluated.

He also offered a second amendment that was adopted asking that the AMA support comprehensive health education for female delinquents, including information on responsible sexual behavior and the prevention of sexually transmitted diseases and HIV/AIDS.

APA and AACAP requested that the AMA state that the Medicaid funding crisis "is a matter of deepest concern to the membership" and that the AMA urge Congress to appropriate "significant increases in federal assistance."

Kraus also testified that Medicaid reaches 44 million Americans, more than Medicare or any other form of health insurance, and covers Americans who are "among the poorest and most disadvantaged populations" in the country.

Delegates passed a resolution in lieu of the APA-AACAP resolution that supports recommendations of a report calling for federally funded, refundable, and advanceable individual tax credits that would replace Medicaid for those patients in the medical care portion of the Medicaid population. The report is part of an ongoing effort by the AMA's Council on Medical Services to develop models for financing care for people with low incomes.

The number of delegates for each specialty society in the HOD is determined by the number of AMA members who indicate they want to be represented by that society.

McIntyre urges APA members who are also AMA members to watch their mail and e-mail for instructions on how to designate psychiatry as their specialty.

AMA Considers Reorganization—Again

Delegates put a temporary halt to efforts to restructure the AMA and address issues related to the increasing importance of specialty medical associations and declining membership in the AMA.

The Committee on Organization of Organizations (COO), which represented 137 of the 171 societies in the HOD, completed a yearlong review of AMA products, services, membership models, funding, and governance and reported their findings to the HOD.

APA was represented by McIntyre, Scully, APA President Marcia Goin, M.D., and Saul Levin, M.D., during the two COO meetings.

The critical challenge for the COO at the beginning of the most recent series of meetings was to find ways of compensating for a loss of $50 million in individual membership dues if that form of revenue were eliminated.

During the discussion, tax and legal issues also surfaced. The AMA has a 501(c)(6) tax status, while many of the specialty societies have a 501(c)(3) status. If the AMA became an organization of organizations, the tax status of those societies could be threatened.

In addition, there was a danger that the societies' political action committees "would all be considered a single committee for purposes of contribution limits."

The HOD voted to retain the current governance and membership models. ■

Suicide Risk

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MHRA press release noted that in reviewing data that Paxil's maker, GlaxoSmithKline (GSK), had filed with the MHRA only a week before, the agency initially found that the trials failed to demonstrate efficacy of paroxetine (sold in the U.K. under the trade name Seroxat) in children and adolescents with major depression. Further analysis by the agency's Committee on Safety of Medicines revealed that children in the trials randomly assigned to receive paroxetine were 1.5 to 3.2 times more likely to exhibit "harmful outcomes, including episodes of self-harm and potentially suicidal behavior," compared with children randomly assigned to receive placebo.

The British warning concluded that "it has become clear that the benefits of Seroxat in children for the treatment of depressive illness do not outweigh these risks."

The MHRA also ordered labeling changes for Seroxat to include the warning.

Clinical Trials Uncover Problem

The data submitted to the U.K. agency the last week in May included a series of nine clinical trials involving paroxetine and were reported by the agency to be part of an ongoing application by GSK seeking approval of Paxil for pediatric indications. An MHRA spokesperson could not confirm the particular indication sought in the U.K.; however, GSK submitted the same data to the FDA at about the same time in support of U.S. supplemental new drug applications for the treatment of depression, obsessive-compulsive disorder, and social anxiety disorder in pediatric populations.

GSK officials did not respond to multiple requests by *Psychiatric News* for interviews; however, Alan Metz, M.D., vice president for clinical development at GSK, told the *Washington Post* that of the 1,200 patients represented in the nine clinical trials, 33 had shown "signs of mood swings that included suicidal thinking and suicide attempts. In that number, the rate was about 1 percent to 2 percent in the group taking placebos, and about 2 percent to 3.5 percent in the group taking the medicine."

The company issued a written statement in which David Wheadon, M.D., GSK's vice president for regulatory affairs, was quoted as saying, "The FDA is communicating with patients and physicians while [it continues] to review the data on Paxil in children and adolescents. We have been working with the FDA as [it reviews] the data in what is an important and difficult-to-treat population."

The GSK statement went on to clarify that "in the company's pediatric trials, which included more than 1,000 patients treated with Paxil, not a single person committed suicide."

In a previous written statement regarding the British warning, Alastair Benbow, M.D., GSK's head of European psychiatry, noted, "While we believe that [the warning] will inevitably limit the choices available to doctors treating children and teenagers under 18 years with major depressive disorder, and the conclusions we draw from the data differ, we recognize the MHRA's decision for U.K. pediatric patients, and we will work with [the MHRA] to implement changes [in product labeling] as soon as possible."

Mounting Pressure

Regulators in the U.K. and the U.S., as well as in other countries, were closely reviewing data on SSRI medications and possible associations with aggressive, self-harming, and suicidal behaviors for several years and until now had not found compelling evidence to issue any previous warnings. Regulators in several countries—including the U.S.—had required changes in advertising and labeling to remove references to Paxil not being addictive.

In the week between the U.K. and U.S. warnings, political pressure appeared to mount on the U.S. agency. Immediately after the U.K. warning was issued, Canada and France announced similar warnings, based mostly on the information shared from the U.K. In addition, members of the U.S. Congress, led by Sen. Charles Schumer (D-N.Y.), requested in a June 13 letter to FDA Commissioner Mark McClellan, M.D., Ph.D., that the FDA "expedite its own study [of Paxil in children]—a necessary step to banning the drug's use for kids in the United States."

In 2002 American physicians wrote 30.4 million prescriptions for Paxil and Paxil CR, making it the leading antidepressant in the U.S. market, according to NDCHealth, an independent Atlanta firm that tracks the pharmaceutical market. Total sales topped $2.5 billion, representing approximately 13.5 percent of total U.S. sales for GSK. Worldwide sales for 2002 were estimated at $4.93 billion.

The FDA's Talk Paper on Paxil for Pediatric Populations is posted on the Web at <www.fda.gov/cder/drug/infopage/paxil/default.htm>. The U.K. warning is posted at <www.info.doh.gov.uk/doh/intpress.nsf/page/2003-0223?OpenDocument>. GSK's response is posted at <www.gsk.com/press_archive/press2003/press_06192003.htm>. ■

MH Bills

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Senate's version of the Child Mental Health Service Expansion Act (HR 5078), introduced in the House by Reps. Patrick Kennedy (D-R.I.) and Ileana Ros-Lehtinen (R-Fla.) last year to address the national shortage of child mental health specialists.

APA and AACAP support this legislation, which would provide educational incentives including scholarships and other training support to individuals entering the field of child mental health.

"This bill will remove one of the key barriers to treatment for children and adolescents with mental illnesses—the lack of available specialists trained in this field," said AACAP President Marilyn Benoit, M.D., in a press release. "Enactment of this legislation will allow child and adolescent psychiatrists to receive federal support to complete their training, which will remove a significant financial burden on the hospitals and medical schools operating these training programs. It will also improve recruitment into this shortage specialty."

Mentally Ill Offenders

Sen. Mike DeWine (R-Ohio) and Rep. Ted Strickland (D-Ohio) introduced the Mentally Ill Offender Treatment and Crime Reduction Act of 2003 (S 1123) last month.

When introducing the bill, DeWine said, "The bill provides a unique approach to treating mentally ill offenders while reducing crime. It would promote public safety by curbing the incidence of repeat offenders and public health by ensuring that individuals with a serious mental illness are treated as efficiently and effectively as possible to stop the revolving door of arrest, release, and re-arrest."

The bills would establish a five-year grant program at the U.S. Department of Justice that states and local communities could use to establish mental health courts, provide treatment and transitional services to inmates, and provide additional training for mental health personnel, police, judges, prosecutors, and corrections officers.

Stickland, who introduced a companion bill (HR 2387) in the House of Representatives, said, "This is phase two of an effort that started in the 106th Congress when Sen. DeWine and I successfully passed America's Law Enforcement and Mental Health Project [Public Law 106-515] in 2001. This bill created a Department of Justice grant program to assist state and local governments in establishing mental health courts."

The 2003 bill provides incentives for the criminal justice, juvenile justice, mental health, and substance abuse treatment systems "to work together at each level of government to establish a network of services for the offender with mental illness," according to the press release.

The bill specifically calls for the creation of an interagency task force at the federal level to include the attorney general; the secretaries of the departments of Health and Human Services, Housing and Urban Development, Labor, Education, and Veterans Affairs; and the commissioner of Social Security.

Assistance for Elderly

Reps. Patrick Kennedy and Steny Hoyer (D-Md.), the Democratic whip of the House of Representatives, introduced the Positive Aging Act in May. The bill is similar to the Advancement of Geriatric Education Act (S 1362) introduced in the Senate last year *(Psychiatric News*, April 5, 2002).

The bill's goal is to integrate mental health services into primary care settings and community-based mental health treatment programs for elderly individuals, according to a press release from both congressmen.

The legislation would do the following:

- Create a competitive grant program to reward projects that integrate mental health programs for geriatric patients into primary care settings.
- Create a competitive grant program to reward public or private, nonprofit, community-based programs that deliver geriatric mental health services where senior citizens reside, such as assisted-living communities and senior-citizen centers.
- Establish a deputy director for senior mental health services within the Center for Mental Health Services. That person would be responsible for the development and implementation of initiatives to address the mental health service needs of elderly people.

The text of the bills described in this article can be accessed on the Web at <http://thomas.loc.gov> by searching on the bill number. ■

professional news

Take to the Air

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ABC television stations. When the CBS station bought a local radio station, the manager asked Croft to do a call-in show. Croft said yes, and "Psych Talk" was born.

The NBC "Talk Net" producer saw Ruben on "Oprah" and invited him to host a weekend call-in show.

Austin became interested in hosting her own radio show after she was interviewed by a television station about her psychiatry department's response to Hurricane Hugo in South Carolina. She also was the psychiatric expert in a film on depression produced for television. Austin persuaded a local public radio station in South Carolina to give her an hour of radio time. There was a learning curve, she and other panelists discovered.

"Interviewing people as a psychiatrist is very different from interviewing people on radio. The pace is much faster, the content more superficial, and three seconds of silence can seem like an eternity."

While Blumenfield served on the JCPA, he approached managers at local radio stations to suggest they take live reports from the APA annual meeting in New Orleans in 2001. A manager at a station in New Rochelle, N.Y., said he was looking for someone like Blumenfield to host a weekly radio show.

"I took the job and broadcasted live reports from the APA annual meeting on my show. I branched out into doing live phone interviews with experts at disasters, including ground zero after September 11," said Blumenfield.

When he sent his television-producer son a tape of his show, the response was, "'Dad, this is boring. You have a bunch of psychiatrists talking to each other,'" said Blumenfield. "That was my cue to pursue broadcast training."

Blumenfield, Ruben, and Croft attended the annual AMA Medical Communications and Health Reporting Conference. Blumenfield said he learned new techniques to hold listeners' attention from a peer critique at the conference.

Croft said he also picked up some presentation tips from media sessions at APA's annual meetings.

Since 1991, when Austin began hosting her show, she has hired three or four consultants to help her, including a voice coach.

He negotiated a contract with NBC that did not require him to do commercials while he was the host of Talk Net. "I thought of my time as a public service," Ruben said. Ruben's unwillingness to do commercials as a host caught up with him. "When another company acquired 'Talk Net,' it had only one slot. I couldn't compete with the host who had commercial sponsors," said Ruben.

He said the competition for airtime on commercial stations has increased dramatically since he started in radio in 1982.

Format and Resources

The formats the panelists used on their shows ranged from entirely call in to entirely guest interviews or a combination of the two.

Panelists referred listeners seeking psychiatric evaluations to colleagues, their family physicians or therapists, or the local mental health association.

Blumenfield and Ruben mailed callers educational pamphlets produced by APA and other national psychiatric organizations.

The panelists said they frequently reminded listeners that the show provided general psychiatric information rather than individual clinical evaluations, diagnoses, or treatment.

Ruben advised radio psychiatrists not to stray into politics or other areas beyond their expertise. A psychiatrist in the workshop audience noted he lost his television show after he repeatedly expressed his political opinions on the air.

Information about NAMC and the AMA spring medical reporting conference is posted on the Web at <www.ibiblio.org/namc/>. ■

Must Talk Money

Croft convinced a San Antonio psychiatric hospital, where he directed community education, to fund the production costs of his medical minute on local television stations. The CBS radio station sold commercials to pay for the production costs of "Psych Talk."

A pharmaceutical educational grant to the local mental health association paid for its executive director's time as the radio show's producer and call screener. Croft received a small stipend.

Austin uses an educational grant to pay for a full-time producer who screens callers, invites guests, and manages the show's Web site.

"Funding is my biggest challenge, especially with the downturn in the economy," said Austin.

Ruben received a "living wage" from NBC for his "Talk Net" call-in show that was broadcast live on Saturday and Sunday nights. NBC provided switchboard operators who worked 14 phone lines and answered about 100 calls an hour. The show's producers screened the calls, and Ruben talked to between eight and 10 callers per hour.

from the president

continued from page 3

A patient's willingness (or reluctance) to enter into a verbal or written suicide-prevention contract should not be viewed as an absolute indicator of suitability for discharge. In addition, such contracts are not recommended for use with patients who are agitated, psychotic, impulsive, or under the influence of an intoxicating substance. Furthermore, since suicide-prevention contracts are dependent upon an established physician-patient relationship, they are not recommended for use in emergency settings or with newly admitted or unknown inpatients."

Indeed, we have a good deal of knowledge about the risk factors for suicide. Suicidal ideation is a risk factor, and a previous attempted suicide is a risk factor. The danger of self-destruction is much higher for those who are younger as well as those who are older. The presence of a psychiatric disorder, with the exception of mental retardation, has been shown to increase suicide risk as measured by standardized mortality ratios. But, we still "cannot predict when or if a specific patient will die by suicide."

Would that a "contract" could reassure us in the face of such harsh news. The uncertainty that surrounds patients' suicidal ideation, acute and/or chronic, is one of the most emotionally troubling aspects of our professional lives. Anxiety surrounds the possibility, and should a patient suicide, it is a heart-rending experience.

We can make contracts with builders, insurers, and car dealers, but not with patients. When entrepreneurs break a contract, the rupture stirs a multitude of negative feelings, and legal action may follow. But a broken "no-suicide" contract stirs tragic feelings for all involved. No amount of legal action can restore the patient's life. ■