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PSYCHIATRIC NEWS

Antipsychotics Bring Little Long-Term Benefit in Alzheimer's

When an Alzheimer's patient becomes suspicious of family and hostile or violent, medication may be indicated. Despite their side effects in this population, antipsychotics are the primary tools available for these symptoms.

Clinical & Research News

BY MARK MORAN

Second-generation antipsychotic medications appear to improve some specific clinical symptoms in patients with Alzheimer's disease but do not improve cognition, functioning, or quality of life.

Compared with placebo, patients treated with olanzapine or risperidone showed improvement on total scores on the Neuropsychiatric Inventory and on the hostile suspiciousness factor of the Brief Psychiatric Rating Scale (BPRS), according to an analysis of data from the Clinical Antipsychotic Trials of Intervention Effectiveness–Alzheimer's Disease (CATIE-AD).

In addition to those benefits, patients taking risperidone also showed improvement on the Clinical Global Impression of Change (CGIC) and on the BPRS psychosis factor. The CGIC is a global assessment of clinical change over time, based on the clinician's overall impression of change in cognitive, behavioral, and functional symptoms. Change over time is rated on a seven-point scale from "very much improved" to "very much worse." The BPRS psychosis factor measures unusual thought content and hallucinations.

The report was posted online June 2 in *AJP Advance*. It will appear in print in the July *American Journal of Psychiatry*.

Patients in the trial were assigned randomly to flexible-dose treatment with olanzapine, quetiapine, risperidone, or placebo for up to 36 weeks and could be randomly reassigned to a different medication at the clinician's discretion. The time of reassignment was defined as the end of phase 1 and the point at which change in symptoms was measured.

At week 12, investigators found no significant differences between patients treated with an antipsychotic medication and those treated with placebo in scores on measures of cognition, function, and quality of life.

The study underscores the less-than-desirable state of treatment for Alzheimer's patients who are agitated, hostile, and aggressive Among psychotropic medication classes, the evidence for efficacy has been strongest for atypical antipsychotics, and they can be beneficial in an acute situation for patients who are dangerous to self or others. Their effects, however, are limited to discrete symptoms and have little or no impact on long-term functioning and quality of life, according to CATIE-AD.

"The results from this study support modest symptomatic benefit on some rating scales," said David Sultzer, M.D., lead

please see ***Alzheimer's*** *on page 12*

Professional News

Conflict-of-Interest Policies Earn Many Med Schools an 'F'

Most medical schools are still struggling with conflict-of-interest policies as pressure mounts on them to either restrict or ban accepting gifts from drug companies.

BY JUN YAN

In the midst of increasing calls to ban pharmaceutical companies' gifts to physicians and medical students, a recent report from the American Medical Student Association (AMSA) says that most U.S. medical schools do not have adequate policies to address conflicts of interest involving industry marketing.

In a survey of 150 medical and osteopathic schools, 21 (14 percent) received grades of A or B for their conflict-of-interest policies, while 60 schools (40 percent) received a failing grade, according to a June 3 AMSA announcement. The survey, known as the AMSA PharmFree Scorecard, was conducted by the organization in collaboration with the Prescription Project, an industry watchdog group created by the Pew Charitable Trusts.

The scores were derived from assessments of each school's conflict-of-interest policies regarding acceptance of gifts and meals from industry, interaction with sales representatives, consulting and speaking relationships, disclosure of financial con-

please see ***Conflict of Interest*** *on page 25*

Association News

Who Should Lead APA Next?

Individual members play a key role in the nomination process for national offices in APA. The Nominating Committee, chaired by Carolyn B. Robinowitz, M.D., is inviting suggestions for candidates for the 2009 election for the offices of president-elect, vice president, and early career trustee-at-large. Please help by submitting your suggestions online by clicking on "Submit Your Nominations for the 2009 Election" on APA's homepage at <www.psych.org>; you may also submit suggestions by fax to (703) 907-7852 or by e-mail to cbrooks@psych.org. Suggestions should be received at APA no later than July 28.

Few States Act on Parity Improvements This Year

State action on mental health bills is unlikely for the rest of the year as most states have ended their legislative sessions, although New Jersey is still considering a parity law change.

Government News

BY RICH DALY

Few states have taken action to upgrade their health insurance parity laws this year as many wait for movement on a federal measure stalled in a congressional conference committee.

Among the few states to act on their parity laws, the most significant change was Illinois' addition of two eating disorders to the mental illnesses that health insurers are required to cover.

"It's very hard to get these mandates passed in Illinois, so we felt very good about the whole thing," said Meryl Camin Sosa, executive director of the Illinois Psychiatric Society (IPS).

The measure (HB 1432) amended the state's parity requirement to include anorexia nervosa and bulimia nervosa as "serious mental illness[es]" that insurers are required to cover at parity with other medical benefits.

The push to enact the legislation was led by the IPS, which had tried to have eating disorders included when the state enacted its initial health insurance parity law in 2002. The eating-disorders bill became the focus of the IPS's biennial advocacy day at the state capitol, and several of the legislators that Illinois psychiatrists lobbied eventually became cosponsors.

The measure had stalled in the Illinois General Assembly until the IPS and the coalition it led sought the support of Blue Cross and Blue Shield. The insurer, a powerful force in the Illinois legislature, agreed to support the bill if a provision requiring coverage of "eating disorders not otherwise specified," such as binge eating, was dropped. The IPS and its allies agreed, and the measure passed both chambers of the state legislature by wide margins in May.

In Illinois and other states, opponents of the addition of eating disorders in state parity laws have criticized it over cost concerns and the belief that the illnesses are not as serious as other mental health conditions.

Proponents counter that the disorders severely affect the health of those who suffer from them. The mortality rate of anorexia nervosa, for example, is nearly 12 times greater than the rate due to all causes of death among females aged 15 to 24, according to Sheldon Miller, M.D., IPS president.

"Typical coverage for eating disorders by insurance companies fails to provide adequate reimbursement for even the most basic evidence-based treatment, as recommended by the American Psychiatric Association," said Miller in testimony before a committee of the Illinois House in May. "Routine denial by third-party payers for a full course of treatment for eating disorders is unfortunately common and has been shown to actually increase costs in the long term."

The legislation was sponsored by Rep. Fred Crespo (D), a first-term representative and former high school girls' track-and-field coach. After learning the extent to which eating disorders were having a negative impact on the lives of the girls he coached, he vowed to make expanded access to treatment his first priority as an elected official, according to Sosa.

"We did everything we knew how to do," Sosa said.

The only other state to pass a change to its parity law this year was Vermont, which made technical changes to what advocates consider one of the strongest parity measures in the nation. The Vermont legislation (S 114), signed into law in May, mandated that the state insurance commissioner step up enforcement of the existing parity law, among other provisions.

Among the few state legislatures that have not yet concluded their work for the year, only New Jersey appears to be considering further parity changes. A bill (A 2077) that passed an Assembly committee in March would add mandatory insurance coverage of alcohol and drug addiction treatment to the state's parity law.

Specifically, policies would have to cover detoxification and other treatments, screening and assessment, case management, medication management, psychiatric consultations, and individual, group, and family counseling.

New Jersey Republicans praised the intent of the bill but criticized its timing for adding an unknown additional financial burden on the state—which would have to add the benefit for its employees as well—during a time of tight budgets.

The national economic downturn and resulting lean state budgets were one likely factor in the low number of insurance parity expansions state legislatures considered this year, according to Paula Johnson, deputy director for state affairs in APA's Department of Government Relations. Another factor in the lack of

please see ***Parity*** *on page 25*

The More Things Change … or Do They?

BY NADA STOTLAND, M.D., M.P.H.


Credit: David Hathcox

I am 64 years old. I didn't have to walk a mile to school in the snow, study by the light of the fireplace, or milk the cows at 4 a.m., but some things were different in "my day." When I was in medical school, internship, and residency, family responsibilities were supposed to be delayed until after training was completed, and then seen to by the nonmedical spouse (in other words, wife). Medicine was meant to be not just a job, not even just a profession, but a life. Women who applied to medical school were warned that we would get married and waste our medical training. If admitted to medical school (there were four women in my class), we often had to prove we deserved to be there. Women physicians who had children were accused of neglecting them, and women physicians who didn't were assumed to have unconscious resistance to femininity. Fathers bragged that they had never changed a diaper.

My husband and I got married shortly before I started medical school. We agreed to share household chores. Our first daughter's birth was carefully timed for my "off" quarter in medical school; over the next nine years, we had three more daughters. With parenthood came years of joy, guilt, conflict, and negotiation. As our children were born and grew up, I spent time as a medical student, intern, resident, stay-at-home mom, part-time worker, and full-time worker.

One of our daughters is a physician. No one told her that women shouldn't go to medical school. She had reasonable maternity leave from her university medical center, but there is no provision for part-time work. Child care is harder to find and more expensive than when she was a little girl. The nanny does not do laundry or clean the house or cook meals. There is no school bus for her 5-year-old. As in many families, her husband is much more comfortable with diapers, babies in front carriers, and laundry than the men of my generation, but she still carries most of the responsibility for the house and children. In many ways, her life is harder than mine was. Here are some of the suggestions I have given her:

• Recognize that medicine and caring for dependent loved ones are each 24/7 and demanding roles. Something is always going to have to give—within each role and between roles. That's life.

• Feeling guilty does not help anybody; in fact, it is harmful. When you have a conflict (important meeting versus your child's championship game), do your best to choose one or the other. If you regret your choice afterward, do it differently the next time.

• If you have a partner, negotiate. Examine every assumption about who should do what. Each person should do what he or she is best at, and the remaining undesirable tasks should be divided or rotated. Don't apologize to your children; they can and should help.

• Get paid help. What do you really need to do, and what can you pay someone to do? Is it really quality time with your family when you drive the carpool? Making some time to work uninterrupted or relax is an investment in yourself and your family. That is particularly difficult for those of you who graduate from medical school with heavy debt loads. That's unacceptable, and we're working on it.

• Have realistic standards. Perfectionism is your enemy. Organization is your friend. So what if your house is messy or you don't read every word of every professional journal? What really matters? Fast food doesn't have to be bad food. An exhausted parent poses more risk to a child than the occasional pizza. Even McDonald's has low-fat milk, fruit, and salads. Kids actually prefer cupcakes from the store to the ones you make at midnight.

• Invest in your career even if you are working part time. Maintain your memberships in professional associations, attend meetings, develop networks. You may not make major financial contributions to the family for a while, but you will be prepared when it's time to send your children to college.

• Don't accept arbitrary limitations. Do what you love, whether it's having children or doing research and working your way up the academic ladder.

• Somebody will find fault with whatever choices you make. That's fine; it proves there is no one "right" choice.

• In airplanes they tell us "put on your oxygen mask first." You can't help anybody else if you don't take care of yourself. ■

APA Dues Policy Payment Change

Effective with the 2008 dues year, annual membership dues must be paid by October 31 or membership in APA will lapse. If you have not already done so, please pay your dues immediately or enroll in the Scheduled Payment Plan to have your current APA and district branch dues automatically charged to your credit card in monthly installments. Act now to ensure that your membership benefits do not lapse. For more information, contact membership@psych.org or call (888) 357-7924.

Telepsychiatry Offers Option for Private Practices

Psychiatrists in Missouri and Kentucky can see patients in Arizona and Texas without leaving their chairs—or their houses.

BY AARON LEVIN

Psychiatrist Dehra Glueck, M.D., lives in Ballwin, Mo., just outside St. Louis, but all her patients are in Arizona.

No, Glueck doesn't jet down to the desert Southwest each day. She just walks into a room in her house and switches on the Internet-based telepsychiatry system that is the core of her practice.

Until recently, telepsychiatry has been the realm of large medical centers and universities, but that is changing.

Small private group practices like Glueck's Adapt Psychiatric Services are jumping into the pool, drawn by a combination of lower technology costs, payment arrangements that cover time and capital costs, good patient outcomes and acceptance, and perceived lifestyle advantages for psychiatrists.

"Kids take to the two-way video system right away," said Glueck, the CEO of Adapt, who is triple-boarded in pediatrics, adult psychiatry, and child psychiatry, in an interview. With a new patient, she zooms out the camera lens to show her home office, then describes to the child what he or she is wearing and doing. "They think that's so cool."

Long-distance telepsychiatry also provides a level of privacy for both patients and psychiatrists, avoiding the awkward encounters on the street that bedevil practicing psychiatry in small towns or rural areas.

"They're not going to see me in Wal-Mart, so you can talk about anything," she said.

Psychiatrists are licensed in the state where they live and in the states where they practice or would like to practice. Glueck said that she and her colleagues have a malpractice insurance provider who is comfortable with telemedicine and provides coverage regardless of state of residence or practice.

Three paths came together to form the road for Glueck's practice, now a single-member, professional limited liability corporation. For a start, she and LaDonya Cassidy, M.D., who now works for Glueck, gained experience with telepsychiatry during their residencies at the University of Kentucky. Glueck also wanted a working life that allowed her more time with her husband and two young children.

Finally, she learned of a behavioral health service with a contract for care in rural areas that wanted to start clinics in small towns but couldn't find doctors to relocate there. She and Cassidy agreed to provide care remotely and installed T1 telephone lines in their homes. A T1 line is a fiber-optic cable that carries about 60 times the data of an ordinary phone line. T1 lines are especially useful for streaming heavy data loads such as live video links.

Credit: Adapt Psychiatric Services

Dehra Glueck, M.D. (left), and LaDonya Cassidy, M.D., started Adapt Psychiatric Services, a private practice specializing in telepsychiatry, out of a desire to balance work and home life.

"A private practice of telepsychiatry is still somewhat unusual, but this is the wave of the future," Kathleen Myers, M.D., M.P.H., an associate professor of psychiatry at the University of Washington in Seattle, told *Psychiatric News*. Myers has published several studies on the use of telepsychiatry and is familiar with Adapt and similar practices around the United States.

"These people are very entrepreneurial," she said. "Equivalency trials with adult patients have shown no difference in outcomes, although there are no studies comparing telepsychiatric care in remote communities with whatever patients would get from their primary care providers."

Adapt contracts with clinics, and physicians work on a salaried basis. Besides Cas-

please see ***Telepsychiatry*** *on page 10*

Diverging Trends Characterize Age-Related Illicit Drug Use

While substance use is showing signs of decline among youth, it appears to be rising in some segments of the population. Meanwhile, the amphetamine epidemic is abating in Western states.

BY JUN YAN

There appears to be a decline in the use of some illicit substances in certain populations but an increase of such use among people in their early 50s, according to national survey data presented at APA's annual meeting in May.

By collecting data from various sources, public health officials can monitor substance use trends, predict use patterns in the near future, and take steps to stem rising tides of risky behavior.

According to the most recent National Survey on Drug Use and Health (NSDUH), presented by Moira O'Brien, M.Phil., health scientist administrator at the Division of Epidemiology Services and Prevention Research at the National Institute on Drug Abuse (NIDA), an estimated 20.4 million people aged 12 and older were projected to be using illicit drugs nationwide in 2006, not including tobacco and alcohol.

Credit: David Hathcox

Moira O'Brien, M.Phil., tells annual meeting attendees that the overall trend of illicit substance use among youth is improving as attitudes change toward substances commonly abused. However, substance abuse is increasing among older Americans.

The NSDUH, an annual survey sponsored by the Substance Abuse and Mental Health Services Administration, also found that the substances most frequently used by people aged 12 and over were marijuana (14.8 million people) and psychotherapeutics for nonmedical reasons (7 million), with cocaine (2.4 million) a distant third. Psychotherapeutics refer to painkillers, tranquilizers, stimulants, and sedatives.

Substance use by teenagers has been in slow decline for the past several years, as shown by data from the NIDA-sponsored Monitoring the Future survey, an annual school-based survey of substance use patterns in youth.

"The overall trend in recent years is good news," said O'Brien. "The overall rate of illicit drug use in students in the eighth, 10th, and 12th grades has declined significantly, by 24 percent from 2001 to 2007."

"Attitude is a good predictor of future use trends," she noted. For example, while the growing rate of disapproval of marijuana among eighth to 12th graders is a good sign that use of this substance may lessen, youth—especially eighth graders—now perceive ecstasy use as less risky than their older counterparts do. Thus, ecstasy use is expected to increase, and more public health education and interventions may be needed with regard to this drug, she said.

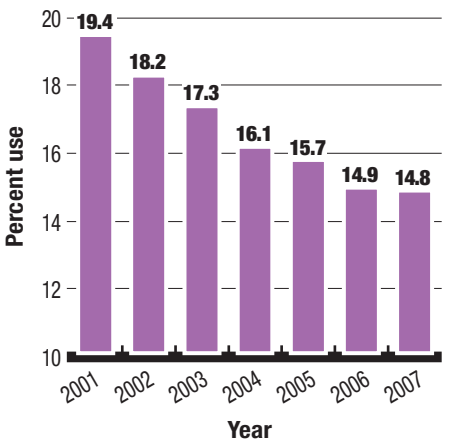
Although substance use trends among youth have captured much public attention, a notable problem revealed by the NSDUH data is "a significant increase of illicit drug use for those aged 50 to 54 from 2002 to 2006," O'Brien pointed out. "These are people who grew up in 1960s, when drug use became common." She advised clinicians to be aware of substance use problems in this often-overlooked population. In contrast, the rates in the 55 to 59 age group showed no significant difference between 2002 and 2006.

"The baby-boom generation had an exposure to growing substance use in [the] '60s and '70s," Timothy Condon, Ph.D., deputy director of NIDA, explained. A large proportion of them have less aversion to drug use than their parents, he said. Adding to the change of attitude toward sub-

please see ***Drug Use*** *on page 24*

Illicit Drug Use Drops Among Youth

Current use of any illicit drug (that is, within the past month) reported by students in the 8th, 10th, and 12th grades has declined by 24 percent from 2001 to 2007.



Source: Monitoring the Future Study, University of Michigan, 2007

Therapy Is Sometimes a Laughing Matter

Psychiatrists at a psychiatry-humor workshop at APA's annual meeting got not only some chuckles out of it, but also tips on how to brighten their practices and therapeutically engage some of their patients.

BY JOAN AREHART-TREICHEL

It was one of the last sessions of APA's 2008 annual meeting, yet there was a remarkably good turnout. The psychiatrists in attendance had obviously come to get if not the best laugh at the meeting, then certainly the last one.

It was a workshop on humor and psychiatry. "I've been waiting for a session like this for some time," one of them exclaimed.

The session was conducted by Waguih IsHak, M.D., a psychiatrist affiliated with Cedars-Sinai Medical Center in Los Angeles; Anna Bokarius, B.A., a psychiatric researcher at Cedars-Sinai Medical Center; and Ed Dunkelblau, Ph.D., a Northbrook, Ill., psychologist and past president of the Association for Applied and Therapeutic Humor, whose Web site can be accessed at <www.aath.org>.

Dunkelblau told the audience a little joke, and the audience chuckled. Dunkelblau also asked the audience of about 100 psychiatrists how many were good at telling jokes. Only two raised their hands. "No problem," he said. "Humor is a lot more than just telling jokes; it's also about laughter and play."

This laughter and play, he said, then generate "mirth or internal good feelings," which in turn have been found to provide (anecdotally or in psychological studies) a plethora of mental and physical benefits: a reduction in stress, anxiety, and depression; an increase in pain tolerance; heightened self-esteem; enhanced creativity and problem solving; improved interpersonal interactions and relationships; a building of group identity; and even an enhancement of memory. "Madison Avenue knows the latter and capitalizes on it," he noted.

Humor, Dunkelblau added, can also "give us ballast and balance during difficult times." And sometimes people use humor to equalize things when they feel threatened by a person in power, he noted. A psychoanalyst in the audience provided an anecdote from his clinical experience that illustrated this point: A well-dressed lawyer arrived for his first session with the analyst. The lawyer saw a nickel on the analyst's couch. The lawyer said to the analyst, "Say, someone left you a tip."

Psychiatrist Gets Crowned

A psychiatrist in the audience who had been conducting group therapy also provided an anecdote that illustrated the same point: Usually the patients in group therapy sat in a circle. But one day, they changed the configuration of the chairs from a circle to two rows, ran a red carpet between the two rows, and placed a chair at the head of the carpet. When the psychiatrist came in to lead the group therapy, they indicated that he should walk up the red carpet and sit in the chair. Which he did. They then whipped out a crown and placed it on his head.

Yet even with all the apparent psychological benefits that people appear to derive from humor, virtually no scientific studies have explored humor's potential value as a psychiatric therapeutic tool, Bokarius reported. So she and her colleagues decided to undertake a study in this domain. They assessed 200 depressed subjects to determine the extent of their depression. Subjects also were evaluated to determine whether they liked humor.

The researchers then looked to see whether there was any significant correlation between the level of depression that subjects were experiencing and their tendency to like or dislike humor. There was not, suggesting that depression does not seem to dampen people's ability to appreciate humor. Moreover, subjects indicated that they would not mind humor being incorporated into their therapy. So humor might not only be an acceptable therapeutic tool for depressed patients, it might even help them, Bokarius and her colleagues believe.

But how might humor be deployed as a psychiatric therapeutic tool? It might be most valuable in improving patients' quality of life, IsHak suggested, as opposed to reducing symptoms or in restoring function, which is where medications and psychotherapy excel.

In fact, a quandary reported by a psychiatrist in the audience suggested one possible application of humor in the quality-of-life domain. The psychiatrist had a patient who was convinced that she would never find a husband. Could humor perhaps be deployed to alter this negative conviction? the psychiatrist asked. Dunkelblau replied that he thought that it might. "Surveys have found that 40 percent of men looking for a spouse want one with a sense of humor," he said. "You might want to tell your patient that and to encourage her to develop her sense of humor."

Of course, psychiatrists might decide to use humor themselves during therapeutic sessions, Dunkelblau indicated. But if they do, he advised, they should avoid sarcasm, sardonic humor, or humor directed at their patients and instead use humor directed at themselves. Also, they should be careful about when they use humor, he cautioned, since ill-timed humor could make patients feel that their psychiatrist is not taking them seriously.

Using Humor With the Right Patients

Aside from using the right kind of humor at the right time, it is also crucial for psychiatrists to use it only with certain patients, Dunkelblau continued. For example, humor is often a good way to

please see ***Laughing*** *on page 24*

Insel: 'Different Kind of Science' Poised to Transform Psychiatry

Understanding genomic variation and how it affects normal or abnormal development of brain circuits in different ways at different points in time will help push psychiatric diagnosis and treatment into the 21st century.

BY MARK MORAN

Psychiatry is still awaiting the "disruptive innovations" in scientific research that have helped to reconceptualize disease in other areas of medicine, said Thomas Insel, M.D., director of the National Institute of Mental Health (NIMH), at APA's 2008 annual meeting in Washington, D.C., in May.

The study of genomic variation and its role in leading to changes in complex brain circuitry, recognition of the longitudinal and developmental nature of disorders, and the discovery of biomarkers linked to a more precise understanding of the pathophysiology of disease are the tools of a 21st-century science promising to transform the treatment of mental illness.

Insel said those same tools have been applied in other areas of medicine to reconceptualize the nature of disease and to reduce mortality dramatically for people with such disorders as cardiovascular disease and cancer.

In contrast, the diagnosis and treatment of mental illness, he said, have been stuck in a 20th-century model.

"By comparison, when one looks at mental illness, I think it's fair to say that unlike the rest of medicine we are locked into diagnosis by observation, we make our diagnoses late in the [trajectory of disease], and our ability to predict disease is not very good," Insel said. "We don't know much about the causes of the disorders we treat, and treatment is largely by trial and error."

Nonetheless, progress is being made. He outlined a number of areas in which psychiatric research is moving slowly in the direction of new strategies of scientific discovery—what Insel called "disruptive innovations"—that will provide a radically altered understanding of the nature of mental illness.

These include recent research showing that the conditions psychiatrists treat are disorders of complex brain circuitry; that they typically begin years before they come to the attention of a clinician; and that they are the result of multiple genetic variations, each of which may confer a degree of risk over time until the balance is tipped toward disease.

He cited, for instance, research from the intramural program at NIMH using structural imaging to compare brain changes in healthy children with those of children with a variety of neuropsychiatric illnesses. In one study, the brains of children between 7 and 12 years of age with and without ADHD were studied at two-year intervals over several years. The children with ADHD were found to have marked thinning of cortical areas.

The study, "Attention-Deficit/Hyperactivity Disorder Is Characterized By a Delay in Cortical Maturation," was published in the December 7, 2007, *Proceedings of the National Academy of Sciences*. An abstract of the article is posted at <www.pnas.org/cgi/content/short/104/49/19649>.

"It turns out that children with ADHD are about three years behind [their healthy counterparts] in cortical maturation," Insel said. "This tells us that this disorder that we have defined on the basis of cognitive and behavioral manifestations is a brain disease, a disease of cortical maturation.

"Looking at it in this way raises all sorts of new questions," he continued. "What causes the delay in maturation? Do medications that reduce the behavioral and cognitive aspects have any impact on this maturation? So now we have an opportunity to think about this disorder in a way that is very different from where we have been."

Credit: Mark Moran

NIMH Director Thomas Insel, M.D.: "Genes code for proteins that play out in particular brain areas at particular times to change the way brain circuitry develops. It's all about variation and how it plays out at each of these levels."

But Insel cautioned that to say that psychiatric illnesses are brain disorders is not to equate them with neurological disorders, which typically stem from lesions in a particular part of the brain. Rather, it appears that complex social behavior—including the abnormal behavior, feelings, and cognition that are typically called mental illness—is related to abnormal development of interrelated networks, or circuits, in the brain.

"Neurology deals primarily with focal lesions, places where you can find dead cells," he said. "Psychiatry is going to deal with circuit problems. You might use as an analogy the difference between studying myocardial infarction versus studying left bundle branch block. Both of them can kill you, but only one of them is going to give you gross pathology in the way that we think about when we think about neurological illness."

He highlighted work by Helen Mayberg, M.D., of Emory University, showing that the so-called Brodmann's area 25 of the brain, located under the corpus collosum, may be central in depression. Area 25 appears to be decreased in volume and increased in metabolic activity among people who are depressed; moreover, there appears to be a reduction in metabolic activity among people who receive antidepressant medication or cognitive-behavioral therapy (*Psychiatric News*, June 20).

But he stressed that decreased volume in area 25 should not be thought of as a focal lesion that is the cause of all depression; rather, it appears to be a conduit for serotonin and other neurochemicals known to be associated with depression and negative rumination.

"It would be a mistake to think of this as the 'home of depression,' " Insel said. "It is important to remember that this is a circuit, a gateway for many of the fibers [associated with depression]."

Moreover, many psychiatric disorders are developmental, beginning many years before they typically come to clinical attention, said Insel. "They start early in life, but we tend to make the diagnosis many years after the onset," Insel said. "It is almost a truism that psychiatric diagnosis is made so late that it is unlikely we will be able to get the full recovery that we would like."

Insel cited research showing that adolescents with the APOE4 gene for Alzheimer's have decreased volume in critical areas of the cortex and show subtle deficits in cognition, decades before they would ever show symptoms of Alzheimer's.

That kind of predictive capability is now being developed, slowly, for schizophrenia. "We still think of schizophrenia as psychosis," he said. "But that is the worst outcome of a very long developmental process that we are unable to detect until one of these very severe events, when it is most difficult to get the kind of full recovery and remission you want."

He said research on the schizophrenia prodrome—the preclinical period that precedes an acute psychotic break—has shown that adolescents with a family history of schizophrenia along with functional deficits and other anomalous symptoms can be predicted with 80 percent accuracy to convert to psychosis.

Finally, Insel said, the deepening understanding of genomic variation and how it affects normal or abnormal development of brain circuits in different ways at different periods over time will help push psychiatric diagnosis and treatment into 21st-century medicine.

"One thing we won't get is a code for diagnosis," Insel said. "These are variations that contribute small amounts of risk; each variation may contribute 2 or 3 percent risk."

At some point the balance of risk and protective factors tips toward disease. But he cautioned that it would be a mistake to think that research will identify specific genes that cause schizophrenia.

"Genes code for proteins that play out in particular brain areas at particular times to change the way brain circuitry develops. It's all about variation and how it plays out at each of these levels."

Ultimately, a 21st-century neuropsychiatry in which the true pathophysiology of mental illness is understood—from genes to neurons to brain circuits and systems to behavior—will yield a new individualized psychiatry.

"We need a different kind of science to tailor treatments and allow clinicians to choose from many different options . . . that are personalized and preemptive," Insel said. "That is where we are going to get the biggest impact." ■

APA Announcement on PRMS

APA Medical Director James H. Scully Jr., M.D., has announced that APA will continue its relationship with Professional Risk Management Services (PRMS) Inc. to offer APA members a comprehensive professional liability insurance program through The Psychiatrists' Program (The Program). Many thousands of psychiatrists have looked to The Program, which is managed by PRMS, for professional liability protection for over 20 years, said Scully.

The Program offers psychiatric-specific risk management, insurance, and litigation services. Program participants have access to numerous risk management services, including the toll-free Risk Management Consultation Service (RMCS) helpline, Online Education Center with multimedia tutorials, complimentary CME risk management seminars, a subscription to *Rx for Risk*, and more.

The policy includes coverage for forensic psychiatric services and administrative defense benefits. Discounts are available for part-time, child/adolescent, early career, and moonlighting members-in-training.

More information on this APA member benefit is available by phone at (800) 245-3333, ext. 389, online at <www.psychprogram.com>, or by e-mail at theprogram@prms.com.

States Show Varying Rates of Stress, Emotional Problems

The prevalence of "frequent mental distress" in the United States should be viewed as a serious public-health problem, says a CDC epidemiologist.

BY STEPHANIE WHYCHE

A scene from the 1991 film "Grand Canyon" finds two young working women commiserating over the stress and anxiety in their lives.

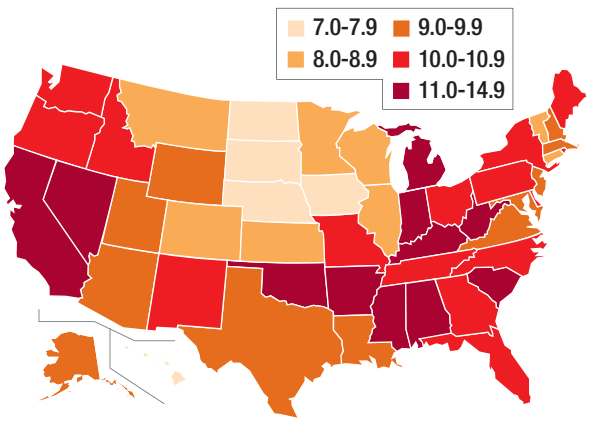
"Do you ever feel like you're just this far from being completely hysterical?" the first woman asks, holding her thumb and forefinger a hair's length apart.

The other woman replies, "Half the people I know feel that way. . . . They are the lucky ones. . . . The rest of the people *are* hysterical."

This fictional dialogue is, of course, hyperbole. But a studied look at the country's emotional health was on display at APA's 2008 annual meeting in May via a research poster shown by scientists from the Centers for Disease Control and Prevention (CDC).

Mental Distress Prevalence Varies by State

Researchers used a data smoothing technique, developed at the National Cancer Institute, to better detect and map regional patterns of frequent mental distress (FMD) in the United States. The data below came from the CDC's 2003-2006 Behavioral Risk Factor Surveillance System.



Source: CDC's Behavioral Risk Factor Surveillance System

Frequent mental distress (FMD)—as self-reported in the agency's survey of more than 2 million U.S. adults—has increased in over half the country since the early 1990s. FMD, the poster explained, is a nonspecific CDC construct that aims to capture at a specific moment in time how many of the previous 30 days the mental health of a noninstitutionalized adult aged 18 or older was not good. The term "mental distress" was defined as having "stress, depression, and problems with emotions."

According to the poster, when the researchers compared geographic patterns of FMD by state across two time periods (1993-2001 and 2003-2006), they found "areas of consistently high and low FMD, as well as changes in [some] states." More than 1.2 million adults were surveyed over each study period.

"The overall prevalence of FMD for the combined period was 9.4 percent," the researchers reported. During the 2003-2006 period, the prevalence of FMD rose by 1 or more percentage points in 27 states from the levels reported in the earlier study period, 1993-2001. The 2003-2006 FMD in 23 states and the District of Columbia remained within a percentage point of the 1993-2001 FMD prevalence. The 2003-2006 FMD increased by 3 percent or more in Oklahoma, Mississippi, and West Virginia from the 1993-2001 levels.

Over the two study periods, the states that showed the highest prevalence of FMD were Kentucky (14 percent), West Virginia (11.2 percent), Nevada (10.9 percent), Alabama (10.8 percent), and Mississippi (10.8 percent), while the states that showed the lowest prevalence were Hawaii (6.6 percent), South Dakota (6.7 percent), Washington, D.C. (7.4 percent), Kansas (7.5 percent), and Nebraska (7.5 percent). The average spread between the five highest-prevalence states and five lowest-prevalence states grew from 4 percent to 5.9 percent.

The researchers found that in general the prevalence of FMD was higher in California and Nevada and the Appalachian and Mississippi Valley regions of the country, and lower (or diminishing) in the upper Midwest.

"Just as we are seeing obesity and other physical health problems as rising public health concerns, we should also see the rising prevalence of frequent mental distress as a public health concern," Daniel Chapman, Ph.D., a psychiatric epidemiologist and one of the four authors of the CDC poster, told *Psychiatric News*.

The data studied by Chapman and his colleagues, led by David Moriarty, B.S., came from the CDC's Behavioral Risk Factor Surveillance System. It is the largest continuing, state-by-state telephone survey, typically reaching more than a million U.S. adults aged 18 and older in a given study period. Interviews are conducted 12 months a year—every year—by state health departments in all 50 states, the District of Columbia, and three U.S. territories (Puerto Rico, the U.S. Virgin Islands, and Guam). CDC analyzes the collected data annually (on a calendar-year basis).

Since early 1984, the survey has tracked the health of the population based on answers given by participants about their disease status, their disease-prevention and safety-oriented behaviors, and their high-

please see ***States*** *on page 26*

Alarm Sounded About Failure to Address Elderly Suicides

To make a big impact, huge funds are not needed for programs to educate the public and primary care physicians about suicide risk among older Americans.

BY RICH DALY

A failure to recognize and address the large number of suicides among elderly Americans has allowed thousands of Americans to die every year. To curb rates of suicide among older people—older white men in particular have the highest suicide rate among major U.S. demographic groups—advocates have launched an effort to force the issue onto the federal legislative agenda.

During a June briefing before congressional staff, mental health advocates, led by the Suicide Prevention Action Network (SPAN USA), discussed the scope of the problem and urged support for legislation that would bolster senior suicide-prevention efforts.

The legislation that could help reduce these suicides include companion House and Senate bills (HR 4897 and S 1854, both known as the Stop Senior Suicide Act) that would coordinate the efforts of federal agencies on the issue. The bills also would lower Medicare's out-of-pocket coinsurance rate for outpatient mental health services from 50 percent to 20 percent, a change long advocated by APA. Some of these bills' provisions also have been included in must-pass Medicare overhaul legislation (S 1715).

The high rate of suicide among senior citizens "is an issue that frequently flies under the radar," said Yeats Conwell, M.D., a psychiatrist who has researched suicide among seniors.

Its low profile masks the extent of the problem. There were 6,860 suicides by people older than 60 in 2004—the highest rate of suicide for any age group—according to a 2007 report by the Centers for Disease Control and Prevention. People over age 60 make up 12 percent of the U.S. population, but they complete 16 percent of suicides.

The high rate of suicide among seniors, said Jerry Reed, executive director of SPAN USA, is driven by the high rate of untreated mental illness in that population. As many as 90 percent of suicides by seniors, he and other advocates noted, are likely related to untreated mental illness. "It's a very real problem," he said.

The most recent effort to get Congress to take steps that could reduce suicide by the elderly was led, in part, by Senate Majority Leader Harry Reid (D-Nev.), who lost his father to suicide years ago.

"Clinical depression and suicidal feelings are not a normal part of aging, yet these treatable conditions are often misdiagnosed, untreated, or ignored in far too many seniors," said Reid in a Senate floor speech when he introduced S 1854 in July 2007. "Out-of-pocket expenses under Medicare, the health insurance program for 37 million Americans aged 65 years and older, is a key reason."

Reid and mental health advocates said the copayment difference discourages Medicare beneficiaries, especially low-income and fixed-income individuals, from seeking mental health treatment. This financial disincentive exacerbates the stigma that also keeps many seniors from seeking needed mental health care. The Medicare copay policy dates back to the inception of the program in 1965.

The Reid bill and its House version also would establish the Federal Interagency Geriatric Mental Health Planning Council. This council would coordinate suicide-prevention efforts by federal agencies that interact with older Americans.

Local Approaches Encouraged

In addition, the legislation would provide small grants to state and local governments to develop suicide-prevention strategies aimed at seniors.

Mel Kohn, M.D., Oregon's state epidemiologist, helped coordinate that state's first-in-the-nation senior suicide-prevention initiative.

"We had a youth suicide-prevention program for years in Oregon, but the data showed that we were really missing the boat on where the problems lay," said Kohn, about the high rates of senior suicide.

The Oregon plan funded a data collection effort to understand the scope of the problem and research to find the most effective prevention approaches. As others have done, the Oregon planners found that one of the biggest missed opportunities to address suicide by seniors involved primary care physicians. Seniors have the highest rate of primary care contact of any age group, with 58 percent of seniors who commit suicide having visited their doctor within a month of their death, according to SPAN USA. Part of the effort to reduce suicide among seniors has to include education for general practitioners about the high rates of untreated mental illness among seniors and the increased risk of suicide when this population remains untreated, according to the advocates.

Prime Opportunity Awaits

Outreach and treatment especially are needed for the 1.4 million seniors who have attempted suicide and who are likely to try again, Reed said.

One-on-one intervention efforts between physicians and their patients can be supplemented by state and local governments' use of education and risk reduction plans, according to advocates. Suicide-prevention strategies among older people in other countries that have shown some promise, Conwell said, include making senior-focused telephone assistance available and reducing the availability of the most common means of suicide. For example, the most common means of suicide in Great Britain was carbon monoxide poisoning through residential gas appliances before the government mandated that domestic gas suppliers cut the carbon monoxide content in gas for household use.

Supporters said they are confident that state and local prevention strategies can be inexpensive but effective at reducing suicide rates among the older population, although research on the effectiveness of risk reduction and education plans for seniors has not yet been conducted.

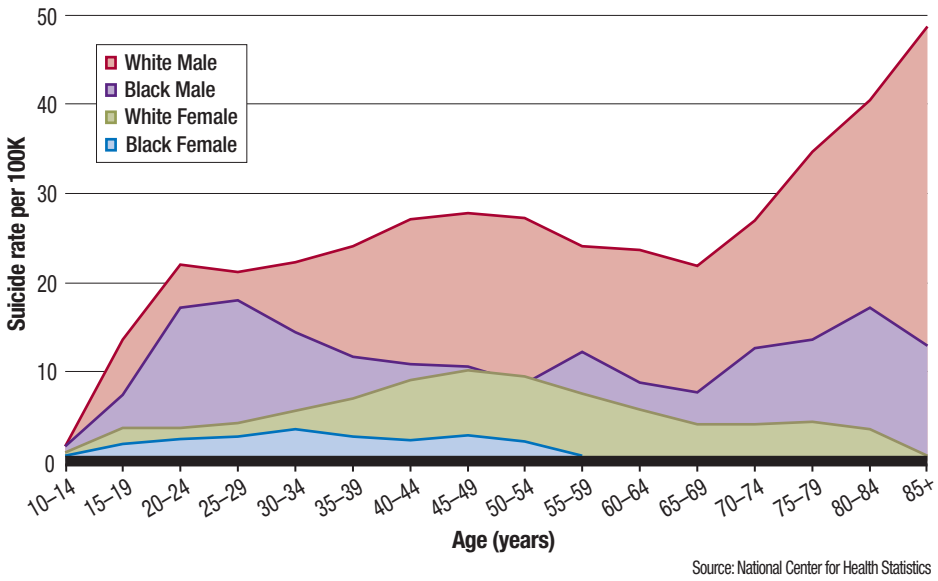
The legislative outlook for the senior suicide-prevention bills is poor during the current Congress, according to congressional staff. However, some of the bills' provisions may pass as part of a Medicare overhaul, which has stalled over Republican opposition to spending increases for domestic programs.

The need for federal action on the issue will grow in the coming years, mental health advocates said, as the number of seniors is expected to grow from about 35 million now to 70 million by 2030. They plan to continue pushing Congress to act until the problem of suicide by seniors receives the federal attention it deserves.

The senior suicide prevention and Medicare overhaul bills can be accessed at <http://thomas.loc.gov> by searching on the bill numbers, S 1854, HR 4897, and S 1715. ■

Suicide Rates Highest Among Those Over 60

A growing body of research indicates that suicide is a serious health problem among older Americans—especially white males—that calls for a national response, according to suicide-prevention advocates. The graph uses data from 2004, the most recent year for which there are data.



Source: National Center for Health Statistics

As Adoption Lags, Govt. Steps Up Electronic Medical Records Push

The government issues a strategic plan to have a national electronic information network in place by 2014. Since President Bush announced this goal in 2004, adoption of electronic medical records has been slow.

BY MARK MORAN

The federal government has issued a strategic plan for the next four years designed to speed the adoption of health information technology to meet President Bush's goal of widespread national adoption by 2014.

The Office of the National Coordinator for Health Information Technology's report, titled "ONC-Coordinated Federal Health Information Strategic Plan, 2008-2012," describes broad goals, objectives, and specific strategies and timelines for implementing those strategies.

The plan is a sweeping blueprint for coordinating government agencies to help promote adoption of health information technology. It comes four years after Bush established a 10-year goal of achieving a national health information network. Since that time, however, physicians have been slow to adopt electronic medical records, and some leaders in the field have urged that the government take a more active role in promoting the effort (*Psychiatric News*, April 18).

The plan outlines two broad goals: patient-focused health care and population health.

Patient-focused health care is described as "the transformation to higher quality, more cost-efficient, patient-focused health care through electronic health information access and use by care providers and by patients and their designees." Population health is described as "the appropriate, authorized, and timely access and use of electronic health information to benefit public health, biomedical research, quality improvement, and emergency preparedness."

Each goal has objectives, and for each objective specific strategies are given, as well as timelines for implementation.

In a letter accompanying the strategic plan, psychiatrist Robert Kolodner, M.D., who is the national coordinator, described the vision of a national health informa-

please see ***Medical Records*** *on facing page*

Mass. Makes Huge Dent in Uninsured Population

Critics' fears that low-income Massachusetts residents would choose taxpayer-subsidized care over employer insurance have not been realized.

BY RICH DALY

Massachusetts cut its rate of uninsured adult residents nearly in half during the first year of its near-universal health insurance program, according to a recent survey.

In the first 12 months of the landmark insurance program, which began in fall 2006, the rate of uninsurance among adults in the state dropped by almost half, from 13 percent to 7.1 percent, according to an Urban Institute survey released in June. As of April, more than 355,000 state residents had obtained coverage as a result of the reforms.

The survey found that access to care for low-income adults in particular increased, and the portion of adults with high out-of-pocket health care costs and problems paying medical bills dropped in the first year.

The survey found no evidence that the program has "crowded out" residents, that is, caused low-income earners in employer-sponsored coverage to drop it in favor of a lower-cost and more generous taxpayer-supported alternative. And while many feared that employers would begin dropping health coverage as the new law took effect, that hasn't happened.

The survey found that the share of working adults who were offered employer-sponsored health coverage remained stable between fall 2006 and fall 2007, even though the subset of this group eligible for subsidized coverage could have opted out of employer coverage in favor of a government-subsidized plan.

The survey was based on two rounds of telephone interviews with nearly 3,000 randomly selected Massachusetts adults, one in fall 2006 and the other in fall 2007.

Massachusetts' insurance initiative included an expansion of the state Medicaid program, MassHealth; the creation of income-related state subsidies for the purchase of health insurance, a program known as Commonwealth Care; and establishment of an online insurance-purchasing tool listing insurance policies that provide the minimal standards the state has set for private health insurance, called Commonwealth Choice.

The program also includes a controversial "individual mandate" that requires state residents to purchase health insurance if they can afford coverage. If they fail to do so, they face escalating fines.

Five percent of taxpayers failed to obtain health coverage last year, and more than half of those—about 97,000—were forced to forfeit their $219 personal tax exemption after it was determined they could have afforded health care.

The biggest drop in the number of uninsured residents came from adults with incomes below 100 percent of the federal poverty level who were eligible for fully subsidized coverage under Commonwealth Care, according to the Urban Institute survey. The uninsurance rate among these residents dropped by nearly two-thirds, down to 10 percent by fall 2007.

Advocates of the Massachusetts program praised the finding that 83 percent of low-income adults said they now had a regular source of medical care, up from 80 percent before the program went into effect. This was described by survey author Sharon Long, an economist at the Urban Institute, as an important factor in establishing care coordination and continuity.

"As a result of reform, low-income adults in Massachusetts were more likely to have a place that they usually go to when they are sick or need advice about their health—an important indicator for continuity of care," she noted.

Among the major challenges the survey identified was the program's rising costs, which are increasing faster than expected, in part because planners underestimated the number of uninsured adults. The legislature estimated when the reforms began that they would cost about $725 million in the fiscal year starting this July, but in recent months the governor said the cost likely will top $869 million.

Another problem is that more state residents are reporting problems finding a health care provider for needed treatment—6.9 percent in fall 2007, up from 4.1 percent a year earlier. This problem points to the likelihood that there is a shortage of health care workers in the state or in some areas of the state.

State officials also have yet to solve the problems caused by the rapidly rising cost of premiums for private insurance plans. For 2008, the cost rose between 8 percent and 12 percent, which undermines affordability, expands the number of people who are exempt from the individual mandate, and threatens the affordability of the entire system.

The survey is posted at <http://content.healthaffairs.org/cgi/content/abstract/hlthaff.27.4.w 270>. ■

Medical Records

continued from facing page

tion system and the urgency required to make it happen.

"Clinicians will have at their fingertips all of the information needed to provide the best care; individuals will have access to this and other information that can help them engage and insert their values in the decision-making process about their health and care; and secure and authorized access to health data will provide new ways that biomedical research and public health can improve individual health and the health of communities and the nation," Kolodner wrote. "…In order to reach the goal of most Americans having access to [electronic health records] by 2014, adoption of interoperable health [information technology] systems needs to remain at the forefront of national priorities."

"ONC-Coordinated Federal Health Information Strategic Plan, 2008-2012" is posted at <www.hhs.gov/healthit/resources/HITStrategicPlan.pdf>. ■

Medicare Adverse-Event Data Now Available to Public

Federal officials plan to expand the adverse-event detection program to include data from many public and private insurance programs.

BY RICH DALY

A long-discussed initiative to make Medicare data related to adverse medication reactions and malfunctioning devices publicly available went into effect in June.

Under the so-called Sentinel Initiative, the Department of Health and Human Services (HHS) began to release information on medications prescribed and medical devices reimbursed through Medicare—stripped of any personally identifiable information—to federal agencies, such as the National Institutes of Health and the Food and Drug Administration (FDA), as well as state agencies and any interested academic researchers. The goal is to provide data to ensure that medication and medical devices continue to be safe for consumers after they enter the market.

The new program aims to improve the safety of medications and medical devices because adverse reactions to these products account for as many as 100,000 deaths every year, according Rep. Jan Schakowsky (D-Ill.), who has urged stronger postmarketing surveillance.

Originally proposed in 2005 by HHS Secretary Mike Leavitt, the program was finally enacted under legislation (HR 3580, PL 110-85) passed by Congress in May 2007.

Sentinel will start with a database of more than 25 million people enrolled in Medicare's Part D prescription drug program, but HHS officials also are in discussions with private insurers to add their plans' drug and device data.

The system aims to go beyond the FDA's current approach, which calls for physicians, other health care providers, and patients voluntarily to report adverse reactions. Federal officials rethought that approach because they believed that it results in reporting of fewer than 10 percent of medication- and device-related problems.

Even when patients and health care providers do report such problems, "it often takes many cases before someone detects a pattern worth reporting," said Leavitt at a May press conference. "So getting enough reports to raise a red flag can take time."

The new approach should reduce that reaction time, saving lives and money, its backers believe. The program could help reduce the nearly $900 million spent to treat preventable adverse drug reactions annually, according to Kerry Weems, acting administrator of the Centers for Medicare and Medicaid Services. The FDA also plans to use the data collected to study the cost and effectiveness of treatments.

Data on adverse drug reactions will be disseminated to physicians through the MedWatch Partners Program, in which APA and other physician organizations participate. The program educates physicians and other health care providers about the need to report serious adverse events and how to make those reports.

All drug and device data collected will exclude the personal information of Medicare beneficiaries, according to HHS officials. The program is designed so that the personal data stay with insurers, within medical practices, or within Medicare.

Potential problems with the Sentinel Initiative raised during congressional consideration of the program included whether Medicare data, which are collected only when a doctor, hospital, or other medical provider seeks payment, are as accurate as patient health records. Another potential problem with identifying adverse reactions is that they may occur because patients are sick, not because of the medication.

Additionally, because Medicare beneficiaries receive an average of 28 prescriptions annually, including refills, compared with a U.S. average for all age groups of 13, it could be difficult to determine which treatment caused a complication. Federal officials said the increased medication use among the elderly, in addition to their "multiple health problems," makes the study of related Medicare statistics that much more critical to ensure the safety of those beneficiaries.

The pharmaceutical industry is generally supportive of the program, although it has cautioned that false concerns could be raised by data analyses that are less rigorous than those used in clinical trials.

Additional information on the Sentinel Initiative is posted at <www.fda.gov/oc/initiatives/advance/reports/report0508.html>. ■

European Systems Could Be Models for U.S. Health Care Reform

European approaches to health care financing may not have a chance to be tried in the United States because of the country's resistance to government mandates and the power of the insurance industry.

BY RICH DALY

In the midst of a presidential election in which competing health care reform plans have brought widespread attention to disparities in health care access in the United States, health care policy experts discussed two European systems that could serve as models for reform in this country.

The national approaches of the Netherlands and Germany to health care financing have many differences from and some similarities to the more fragmented U.S. approach. Among the chief differences—and possible lynchpins for a future U.S. system—is the requirement in both European countries for mandatory individual health insurance through affordable and widely available plans.

"I think there are some really important lessons to be learned from these countries in terms of the individual mandates in making payments affordable to individuals by, if not having contributions proportional to income, then at least having bigger subsidies for lower-income people," said Patricia Danzon, chair of the Health Care Systems Department at the Wharton School of the University of Pennsylvania.

Her comments and those of other U.S. and European health care experts came during an April roundtable discussion before congressional staffers on possible European models for a U.S. health care financing overhaul. The discussion came not only in the context of competing presidential candidates' health care plans but also amid an increasing amount of research data showing that the U.S. system spends much more money for lesser amounts of overall care than do those of other industrialized nations.

Recent research has found that U.S. health care spending—about 16 percent of gross domestic product, and growing—is significantly higher than that of every major European nation. However, the U.S. ranks lowest on a variety of health-outcome categories, including deaths that could be avoided through available interventions, according to the 2006 Commonwealth Fund National Scorecard on U.S. Health System Performance.

As a key feature that the European systems share, mandated health insurance remains a controversial proposal for many Americans. Additionally, it is very hard to implement on a state basis because the use of state tax exemptions and fines to enforce it—as Massachusetts uses to enforce its individual mandate—are seen as relatively weak compared with enforcement under the federal tax code.

The Dutch system provides legal sanctions to force enrollment and then deducts the cost of the premiums from government payments scofflaws would have received. The German approach also is technically an individual mandate, but because employers pay the premium, all sanctions for lack of payment are aimed at them.

Federal Approach Advocated

The barriers to state-level enforcement of individual insurance mandates argue for a federal health care approach in the United States, Danzon said. Such a national system could use the Internal Revenue Service to enforce it.

National mandatory individual insurance "would be easier to do, and having an individual mandate immediately solves some of the problems of insurance markets, because once everybody has to buy insurance, the risks of adverse selection that individual insurers face are somewhat reduced," she said. "It is not just the sick people who are out looking for coverage."

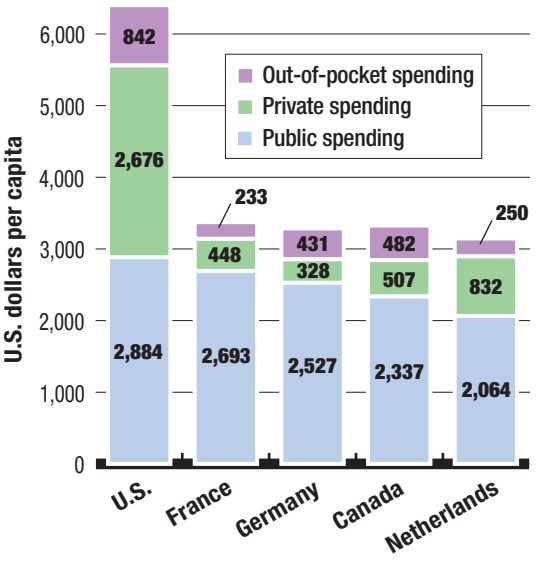
The possibility of an individual insurance mandate drew criticism, however, from Stewart Butler, vice president of domestic and economic policy studies at the Heritage Foundation, a conservative think tank. He noted that Americans are much more resistant to mandated insurance than are Europeans. In Switzerland, for example, there is near-universal adherence to the auto insurance requirement, while fewer then 80 percent of American drivers have it. Americans also have much higher demands for privacy from the government and from each other than do their European counterparts.

"The idea that people can find out what insurance you have and share it with the government and then come and knock on your door if you haven't signed up is something that all Americans" would be concerned about, Butler stated.

Another obstacle to a mandatory insurance system, Butler maintained, is that a national approach would eliminate a potential advantage of the U.S. federal system, which can allow for states to experiment with various funding approaches to find the best ones, he said.

Is European Health Care More Cost-Effective?

Research consistently indicates lower overall spending on health care by European nations compared with combined U.S. public and private health care expenditures.



Source: Organisation for Economic Cooperation and Development Health Data, 2007

Industry Opposition Key Factor

Likely to be less controversial with most Americans, said Butler, are the Europeans' use of a variety of mechanisms to mandate that insurers provide affordable insurance plans to all citizens, regardless of preexisting conditions. However, those provisions draw fire from U.S. insurers, who maintain that this strategy would undermine the entire insurance market.

A possible way to address insurers' concerns are found in the Dutch system, which pays insurers for accepting sicker patients while requiring that they pay the government for every healthy person they cover.

"It is not a free market," said Wynand van de Ven, a professor of health insurance at Erasmus University in Rotterdam, of the Dutch system. "The government manages the market to achieve socially desired outcomes, and this requires that many preconditions have to be fulfilled."

More information about health financing system comparisons is posted at <www.allhealth.org/briefing_detail.asp?bi=126>. ■

Telepsychiatry

continued from page 4

sidy, two other psychiatrists are employed full-time by Glueck's practice and three others are subcontractors. They have a patient base of about 1,300 patients. Most of their work involves direct patient care, including evaluation and follow-up. Other similar practices also use their telepsychiatry systems to train primary care and other providers.

"We use a shared-risk model where the clinics bill for our services," said Glueck.

"Telepsychiatry is probably more expensive than face-to-face clinical encounters because technological costs go beyond what can be recouped by reimbursement," said Myers. "Some mental health centers may have to do fundraisers to afford the technology, and others are willing to take the loss as a way to build referral networks."

Glueck said that Adapt's contracts are structured to cover technology costs.

"Many insurance companies pay for the services, and some of the ones that don't can be contested if the patient is in a rural area without many mental health resources," said Myers.

Other psychiatrists who want to use telepsychiatry may not be as fortunate as those at Adapt. Some studies show that inadequate reimbursement has slowed the spread of telepsychiatry even after grant-funded trials have shown its ability to improve patient outcomes and increase access.

By now, Adapt has enough experience to guide a clinic that contracts for its services. Adapt provides telemedicine-specific consent forms and electronic health records. It handles the credentialing process for the clinic. It uses a different prescription pad for each clinic, and when a faxed prescription won't do, as in the case of scheduled drugs, it routinely sends an original to the clinic by overnight delivery services.

Adapt outsources the majority of its support services, including information technology, payroll, a 401(k) plan, and employees' health insurance.

The clinical encounter at the remote location is managed by a "physician extender," usually a nurse or a behavioral health technician who remains in the room with the patient. "You don't need someone with a lot of heavy professional credentials—just someone with great people skills and organizational skills," said Glueck.

Each psychiatrist also visits the clinics he or she serves once or twice a year to see the staff and patients, if the latter so desire. Glueck originally thought that face-to-face contacts would be needed more frequently, but it's a measure of the acceptance of telepsychiatry that these visits seem more important to the doctor than the patient, she said.

"Patient-satisfaction studies indicate that patients like telepsychiatry, but psychiatrists seem reluctant to try it," said Myers. That may be because they're not trained in using it or because it goes against longstanding traditions in the profession.

"If patients come back, I guess they're OK with it," said Myers. "It does make you think about the nature of the therapeutic relationship though."

Once psychiatrists become as comfortable with telepsychiatry as patients, however, their choices of where and how to live and practice expand. The seven psychiatrists who comprise Adapt live in Missouri, Kentucky, Texas, and Pennsylvania. They serve patients in Yuma and Casa Grande, Ariz., and in Dallas, Corsicana, Wilmer, and Waxahatchie, Texas.

She and the other psychiatrists break down some of the isolation of private practice by maintaining a "virtual water cooler" where they can use video, e-mail, and instant messaging to catch up with each other, trade information, and consult on questions about patients. Instant messaging permits real-time consults with another doctor in the practice.

There's lifestyle flexibility. One partner lives on a boat and docks it each morning before going to the office. If one of Glueck's patients is a no-show, she can spend a bonus half hour with her 4-year-old and 2-year-old children, who are otherwise looked after by a nanny during the workday.

"People can integrate telemedicine into what they already do and enjoy that flexibility while seeing patients who would otherwise be unable to see a psychiatrist," she said. "You end up with happy doctors with rewarding practices and happy patients."

More information on Adapt Psychiatric Services is posted at <http://adaptpsych.us/>. ■

JANSSEN PHARMACEUTICA

P4C

Antipsychotics Linked to Serious Adverse Events in Some Elderly

Researchers say the findings may be only the tip of an iceberg, since the follow-up was only 30 days and included only adverse events serious enough to warrant acute hospitalization.

BY MARK MORAN

Acute hospitalization and death appear to occur frequently among older adults with dementia who have been prescribed antipsychotic medication within the previous 30 days.

That was the finding of a retrospective cohort study of community-dwelling elderly and nursing-home residents with dementia who were prescribed antipsychotic medication. The study appeared in the May 26 *Archives of Internal Medicine*.

Older adults in the community with dementia who received atypical antipsychotic medications were 3.2 times more likely to experience a serious adverse event within 30 days of starting therapy than were similar older adults who did not receive such therapy; those receiving a conventional antipsychotic were almost 3.8 times as likely.

The pattern was similar, though less pronounced, among nursing-home residents who were and were not prescribed antipsychotics: those receiving atypical antipsychotics were 1.9 times more likely to experience an adverse event within 30 days than those who did not, and those who received conventional antipsychotic therapy were 2.4 times more likely.

The study authors stated that the findings may represent only the tip of an iceberg because the study focused only on events serious enough to result in hospital admission, and because the 30-day follow-up cannot account for adverse events such as tardive dyskinesia that take longer to develop or to be recognized by the physician.

But soon after the Archives of Internal Medicine report appeared, a follow-up analysis of the Clinical Antipsychotic Trials of Intervention Effectiveness–Alzheimer's Disease (CATIE-AD) was published, showing that psychiatric and behavioral symptoms associated with Alzheimer's disease, such as agitation, aggression, and paranoid thoughts and ideas, may improve with the use of second-generation antipsychotics. That report is posted on AJP in Advance at <http://ajp.psychiatryonline.org/pap.dtl> and will appear in print in the July American Journal of Psychiatry (see Antipsychotics Bring Little Long-Term Benefit in Alzheimer's).

In an interview with *Psychiatric News*, lead author of the *Archives of Internal Medicine* report Paula Rochon, M.D., said her study was looking only at adverse events and not at efficacy, and said she believes the two studies do not contradict each other.

"I think our message is not necessarily that these drugs should never be used," she said. "Clearly, there is a role for them in people who have dangerous behaviors. But there are also side effects. If these medications are going to be used, clinicians need to balance the risks and the benefits.

"One of the things we are concerned about is that these are fairly commonly used and perhaps well beyond their indications," Rochon told *Psychiatric News*.

In the report, she and colleagues noted that a 2004 study in the *Journal of the American Geriatrics Society* found that 17 percent of nursing-home residents were prescribed an antipsychotic within 100 days of their being admitted.

Rochon said that for patients with dementia whose behavior poses a danger to themselves or others, antipsychotics are likely to be useful. But for patients with mild agitation that is not dangerous, clinicians should consider nonpharmacological approaches to managing the agitation.

She is a geriatrician and scientist at the Institute for Clinical Evaluative Studies and a professor of medicine at the University of Toronto.

Rochon and colleagues conducted a population-based, retrospective, cohort study using Ontario, Canada, administrative health care data between April 1, 1997, and March 31, 2004. They looked at two cohorts: community-dwelling elderly and nursing-home residents with a diagnosis of dementia based on *ICD-9* criteria. Individuals were

please see ***Antipsychotics*** *on page 16*

Alzheimer's

continued from page 1

author of the report. "The CATIE-AD study does not show any impact on quality of life."

Moreover, there are adverse effects associated with their use. A report in the Archives of Internal Medicine last month found that hospitalization and even death associated with use of antipsychotics in elderly patients with dementia were not uncommon (see Antipsychotics Linked to Serious Adverse Events in Some Elderly).

Only a minority (19 percent) of the 421 enrolled patients in the CATIE-AD study continued on their initial randomized treatment beyond 12 weeks, with some patients being switched to another medication as early as at two weeks.

An earlier analysis of CATIE-AD, whose primary endpoint was time to discontinuation, found no differences in time to discontinuation due to any cause between any of the treatment groups. A somewhat longer time to discontinuation due to lack of efficacy was seen for olanzapine and risperidone over quetiapine, but that was offset by more frequent discontinuation due to intolerability.

That report was published in the October 12, 2006, *New England Journal of Medicine* (*Psychiatric News*, November 3, 2006).

David Sultzer, M.D.: "We know these medications have adverse effects, but in an individual patient we are weighing those risks against potential benefits. What CATIE-AD does is help us understand what the upside may be."

Study Demonstrates Upside of Treatment

Still, the new analysis focusing on clinical symptoms shows that antipsychotic medications do improve specific, discrete symptoms, especially symptoms—such as hostile suspiciousness—that can be most distressing to caregivers and family members.

"We know these medications have adverse effects, but in an individual patient we are weighing those risks against potential benefits," Sultzer told *Psychiatric News*. "What CATIE-AD does is help us understand what the upside may be."

And that upside can be most desirable when a patient has become suspicious of family members and caregivers and hostile or violent, he said. Nonpharmacologic behavioral measures for reducing agitation are important and should be considered as a first line of recourse. They can be difficult to implement, however, and when a patient has become dangerous to self or others, medication may be of value, Sultzer said.

He is a professor of psychiatry and biobehavioral sciences at UCLA and director of the Gero/Neuropsychiatry Division at the VA Greater Los Angeles Healthcare System.

Robert Roca, M.D., chair of APA's Council on Aging, said the appropriate use of antipsychotics in people with Alzheimer's will be a topic at the council's meeting during APA's fall component meetings.

In an interview with *Psychiatric News*, he expressed the dilemma of clinicians who have only imperfect tools for treating patients with Alzheimer's when they are dangerous to self or others. "The drugs seem to be helpful in those situations, but clinicians who use them have never been entirely satisfied that they are sufficiently effective and safe to make them comfortable with their use," he said.

Paul Newhouse, M.D., chair of the Research Committee of the American Association of Geriatric Psychiatry, echoed that ambivalence. "They may not be very good tools, but they are the only ones we have for psychosis," he told *Psychiatric News*.

Clinicians Switch Despite Improvement

The study involved 42 clinical sites and enrolled 421 patients, who were randomly assigned initially to masked treatment with olanzapine, quetiapine, risperidone, or placebo. At any time after the first two weeks of treatment, the clinician could discontinue the initially assigned medication for insufficient efficacy, adverse effects, or other reason.

At that point of discontinuation, phase 1 ended, and the patient could enter phase 2 and be assigned randomly to masked treatment with a second-generation antipsychotic that had not been assigned in phase 1 or with citalopram. Patients could also go directly to an open-choice treatment.

The following instruments were administered at study baseline and after two weeks, four weeks, eight weeks, 12 weeks, 24 weeks, and 36 weeks of treatment: Neuropsychiatric Inventory, BPRS, Cornell Scale for Depression in Dementia, and Alzheimer's Disease Cooperative Study–Clinical Global Impression of Change Scale.

The benefits seen with olanzapine and risperidone on specific measures were not seen for quetiapine. Sultzer said he believes that may reflect the low dose that was used, although some side effects were seen; at the time of the study, the optimal dose of quetiapine was uncertain, and study authors were cautious about dosing.

Sultzer noted that since clinical symptoms were being measured at the last observation of the patient when he or she was still on the initial treatment, it represents a snapshot of the clinical picture at the time that clinicians had, for whatever reason, determined that a change in medication was indicated.

"The last observation was by definition when clinicians were ending phase 1, though the data show patients were actually getting better," Sultzer said. "Our understanding of this is that clinicians were seeking more improvement than what was recorded on our rating scales or in some cases were concerned about side effects. It reflects an interesting treatment issue—the belief of what constitutes efficacy varies across caregivers, and clinicians probably felt the amount of benefit our scales show wasn't sufficient."

The following instruments were administered at baseline and after 12 weeks, 24 weeks, and 36 weeks of treatment: Alzheimer's Disease Assessment Scale, Alzheimer's Disease Cooperative Study–Activities of Daily Living Scale, Dependence Scale, Caregiver Activity Survey, and Alzheimer's Disease Related Quality of Life.

Improved clinical symptoms with antipsychotic treatment did not translate into functional benefits or improved quality of life on these measures, according to ratings at 12 weeks in those taking their originally assigned treatment.

"This may be due to additional factors that contribute to functional disability and poor life quality, such as progression of dementia, caregiver interactions, environmental factors, and perhaps adverse effects of the drugs," the authors wrote.

"Clinical Symptom Responses to Atypical Antipsychotic Medications in Alzheimer's Disease: Phase 1 Outcomes From the CATIE-AD Effectiveness Trial" is posted at <http://ajp.psychiatryonline.org/cgi/reprint/appi.ajp.2008.07111779v1>. ■

Worsening of Symptoms Prevented by Early Detection

Negative symptoms such as cognitive deficits and lack of affect and volition have long been considered unmodifiable and appear to represent core neurobiological deficits of schizophrenia.

BY MARK MORAN

Reducing the duration of untreated acute psychosis in first-episode patients appears to prevent the worsening of negative symptoms—such as cognitive deficits and lack of volition, among others—at two-year follow-up.

That finding, from analysis of a public health intervention in Norway, suggests that early identification and treatment of acute psychotic symptoms may affect the core neurobiological deficit process of schizophrenia, and through this alter the course and prognosis for the better.

The study, which appeared in the June *Archives of General Psychiatry*, compared two distinct geographical areas of Norway. In one of those areas researchers implemented a comprehensive early detection (ED) system based on public-information campaigns and training of teams in the community to detect low-threshold psychosis.

The other geographical location received no such intervention. However, treatment protocols for people who were identified were identical in each location.

Earlier analysis had already determined that patients in the area who received the ED intervention entered treatment with less severe clinical symptoms, less serious suicidality, and shorter total duration of their first episode. That analysis appeared in the May 2006 *American Journal of Psychiatry*.

Thomas McGlashan, M.D., senior author of the current study, explained that the follow-up study shows that the differences seen at baseline between patients in the two geographical areas continued two years later.

"The intervention is not treating the negative symptoms, but preventing them from getting worse," he told *Psychiatric News*. "The ED group was younger, so clearly we got them into treatment when their negative symptoms weren't as well developed. Now, it looks like getting them into treatment prevents those symptoms from getting worse."

The study was carried out between January 1, 1997, and December 31, 2001, in four Scandinavian health care sectors. The ED area consisted of the North Rogaland and South Rogaland health care sectors in Rogaland County, Norway, with a combined total population of 370,000. The no-ED area consisted of the Ullevaal health care sector of Oslo County, Norway, and Roskilde County, Denmark, with a combined total population of 295,000.

There were no differences in age and sex distribution between the two areas, and no differences in mean income levels and unemployment rates.

Because of Norway's national health insurance system, all sectors were publicly funded, with no differences in utilization of inpatient psychiatric services. All first-episode patients in all sectors of both areas were assessed by trained personnel at first contact and assigned to the first-episode treatment programs without delay. The programs adopted a standard treatment algorithm for antipsychotic medication, individual psychosocial treatment, and psychoeducational multifamily groups.

The ED program consisted of educational campaigns about psychotic symptoms and their treatment directed at the general population through newspaper advertisements and information campaigns directed at schools and general practitioners. Specialized low-threshold early detection teams were established that could be reached by a phone call from potential patients, families, or friends from their social networks.

A total of 281 patients with a *DSM-IV* diagnosis of nonorganic, nonaffective psychosis coming to their first treatment during the four consecutive years were recruited, of whom 231 participated in the two-year follow-up.

Results from the follow-up showed a statistically significant improvement in the Positive and Negative Syndrome Scale negative component, cognitive component, and depressive component in favor of the ED group. Statistical analysis gave no indication that these differences were due to confounders.

McGlashan said that preventing negative symptoms from getting worse is important because it is those symptoms that appear to reflect the core neurobiological deficits resulting from acute psychosis and that affect long-term outcome, functioning, and quality of life.

"The negative symptoms have clearly come to be seen as where the disability resides," he said. "One hundred years ago, schizophrenia was regarded as a deteriorating illness. Now, that deterioration is better described in terms of negative symptoms."

Moreover, he said, effective treatment of the symptoms has been elusive. Some drug company trials of antipsychotic medications have claimed to treat social isolation, for instance, by diminishing paranoia associated with psychosis, but it is the lack of affect and volition—the "loss of the joie de vivre" as McGlashan put it—that is characteristic of the socially withdrawn patient with schizophrenia and more representative of the core neuobiological deficits.

Traditionally those symptoms have been regarded as unmodifiable, with an inevitably deteriorating course. In the Norwegian study, he said, "We haven't treated them, but we have modified them."

He emphasized that clinicians who are seeing someone that they suspect may be psychotic should try to get them evaluated and into treatment as soon as possible.

"Delaying an evaluation and treatment can have serious consequences," he said. "Earlier detection really makes a difference."

An abstract of "Prevention of Negative Symptom Psychopathologies in First-Episode Schizophrenia: Two-Year Effects of Reducing the Duration of Untreated Psychosis" is posted at <http://archpsyc.ama-assn.org/cgi/content/abstract/65/6/634>. ■

Prolonged Exposure Therapy Helps Ward off PTSD

A controlled confrontation with reminders of one's trauma seems to facilitate recovery from acute stress disorder and avoid PTSD.

BY AARON LEVIN

Patients with acute stress disorder had fewer posttraumatic stress disorder (PTSD) symptoms at follow-up after a clinical trial of exposure-based therapy than did patients getting cognitive restructuring therapy or placed on a treatment waiting list, according to Australian psychologist Richard Bryant, Ph.D.

More attention in recent years to early intervention following traumatic events has increased interest in what the primary therapeutic approach should be, wrote Bryant and colleagues in the June *Archives of General Psychiatry*.

The researchers studied 90 patients who had experienced nonsexual assault or a motor vehicle crash and were diagnosed with acute stress disorder (ASD) from 2002 to 2006. They were randomized to receive five 90-minute sessions of either prolonged exposure therapy or cognitive restructuring therapy. A third group was placed on a wait list and told they would be reassessed after six weeks and then offered active treatment.

Prolonged exposure patients were told to "verbalize reliving the trauma experience in a vivid manner that involved all perceptual and emotional details." They were given homework exercises. Later sessions and homework included visualizing images of trauma exposure and real-life exposure to associations with their trauma. The last session included relapse-prevention strategies to help patients damp down PTSD symptoms if they recurred.

Cognitive restructuring (CR) treatment involved identifying and monitoring maladaptive thoughts by "Socratic questioning, probabilistic reasoning, and evidence-based thinking." Some homework and relapse prevention were included in this treatment too.

Prolonged exposure showed large effect sizes, and cognitive restructuring showed moderate effect sizes, compared with the wait-list group. After six weeks, 33 percent of the exposure group met PTSD criteria compared with 63 percent of the cognitive restructuring patients, and 77 percent of those on the wait list.

At the six-month follow-up, 37 percent of the exposure group met PTSD criteria while 63 percent of the cognitive restructuring group did. The researchers did not compare a combination of the two therapies with the single treatments.

The effect was seen early in the course of exposure treatment, even as cognitive restructuring patients continued experiencing distress.

Many therapists hesitate to use exposure therapy because it can cause distress and possibly drive patients away from therapy, according to the researchers. However, only five subjects reported adverse effects, all due to high distress, and dropped out of the study. Two subjects were in the exposure arm, and two were in the CR arm. Overall, patients getting exposure therapy reported less distress at the end of the last three sessions than did patients getting CR therapy.

"Dropout rates in the present study were comparable to dropout rates across chronic PTSD studies," wrote Bryant and colleagues.

In a rigorous review of treatments for PTSD, the U.S. Institute of Medicine last fall said that the only treatment for PTSD supported by a strong evidence base was exposure therapy.

"The current findings suggest that direct activation of trauma memories is particularly useful for prevention of PTSD symptoms in patients with ASD," they wrote. "[A]daptation occurs when the individual repeatedly engages with trauma reminders and learns that there is no aversive outcome."

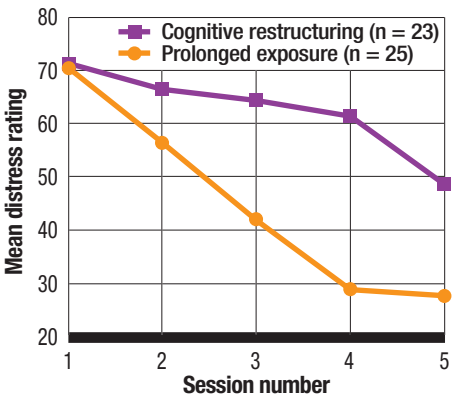
The study showed that not only was using prolonged exposure treatment beneficial, but also it did not result in more therapy dropouts or aversive responses than other approaches.

For Bryant and colleagues, the conclusions are clear. "[T]here is a need to better educate mental health care providers about the use of [prolonged exposure] as a frontline intervention for ASD," they said.

"Treatment of Acute Stress Disorder: A Randomized Controlled Trial" is posted at <http://archpsyc.ama-assn.org/cgi/content/short/65/6/659>. ■

Prolonged Exposure Treatment Effective

Prolonged exposure therapy for acute stress disorder reduces PTSD symptom severity, as expressed in scores on the Clinician-Administered Posttraumatic Stress Disorder Scale 2 (CAPS-2).



Source: Richard Bryant, Ph.D., et al., *Archives of General Psychiatry*, June 2008

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Successful BPD Therapies Focus on Clinician-Patient Relationship

Clinicians treating patients with borderline personality disorder need to fit each patient to a specific psychotherapy that meets the patient's unique challenges.

BY MARK MORAN

An expanding body of evidence indicates that a variety of psychotherapies for patients with borderline personality disorder (BPD) are effective. But convincing insurance companies and other payers of the effectiveness of psychotherapy is challenging because all of the psychotherapies are lengthy, said John Oldham, M.D.

He served as discussant at the symposium "Comparison of Three Therapies for BPD" at APA's 2008 annual meeting in May in Washington, D.C.

Moreover, since BPD represents a constellation of symptoms, with individual patients meeting different criteria for the disorder, the challenge for clinicians is to fit the individual patient to a specific psychotherapy that meets his or her unique challenges.

Oldham made his comments following presentations on mentalization-based therapy (MBT), dynamic deconstructive psychotherapy (DDP), and transference-focused therapy (TFP). He is senior vice president and chief of staff at the Menninger Clinic and professor and executive vice chair of the Menninger Department of Psychiatry and Behavioral Sciences at Baylor College of Medicine.

The three therapies focus on the relationship between the therapist and patient and on sustaining that alliance over a period of time in the face of the problems that BPD patients typically have with interpersonal relationships.

"One of the most important things that needs to happen [in therapy] regardless of the nature of the treatment is to pay attention to the treatment alliance and to sustain that alliance," Oldham said. "That can be hard to do in part because frequently [health care payers] disallow treatment plans that support that kind of need. So the more evidence we have, the better.

"I think our biggest challenge is to figure out how to get that word out there to the people who pay for treatment so that they understand that it is cost-effective in the end to pay for treatment that lasts long enough for therapy [to work], because we know that it does."

Oldham cited one insurance company in his region that indicated it was willing to pay for six weeks of inpatient therapy for a patient with BPD. The company "called and said, 'We have figured out we are breaking the bank on this patient, paying over and over again for all the things that aren't working.'

"That was an enlightened insurance company," Oldham said. "There aren't many of them."

Credit: David Hathcox

John Oldham, M.D., says that when treating patients with borderline personality disorder, therapists need to pay attention to the treatment alliance and sustain that alliance.

Therapies Focus on Treatment Alliance

At the symposium, Anthony Bateman, M.A., presented information about the use of MBT. It is a manualized psychotherapy based on attachment theory and on observations that BPD patients have a failure of "mentalization"—the ability to observe their own emotions and those of other people and to appreciate how their behavior may affect others.

A report appearing in the May *American Journal of Psychiatry* showed that eight years after the beginning of treatment and five years after discharge, patients with BPD treated with mentalization-based therapy during partial hospitalization followed by maintenance mentalizing group therapy showed clinical and statistical improvement on a range of measures compared with patients receiving treatment as usual (*Psychiatric News*, April 18).

Robert Gregory, M.D., an associate professor of psychiatry and behavioral sciences at the State University of New York Upstate Medical University, described DDP. It is based on the hypothesis that borderline pathology and related behaviors reflect impairment in specific neurocognitive functions that form the basis for a coherent sense of self.

Gregory said that because of these neurocognitive deficits, BPD patients typically reduce interpersonal relationships to polarizing binary states such as helpless victim versus guilty perpetrator or angry victim versus demigod perpetrator. The therapy seeks strategies to "deconstruct" each state and facilitate the development of new ways to think about relationships.

The therapy is described in "A Manual-Based Psychodynamic Therapy for Treatment-Resistant Borderline Personality Disorder" in the March 1 *Psychotherapy: Theory, Research, Practice, Training.*

John Clarkin, Ph.D., discussed TFP. He is codirector of the Personality Disorder Institute at New York Presbyterian Hospital and a clinical professor of psychology in psychiatry at Weill Medical College and Graduate School of Medical Sciences of Cornell University.

Clarkin said that the therapy focuses on the current behavior and experience of the patient both during and outside of therapy, interpreted in the context of the patient's transferential relationship with the therapist.

A report in the June 2007 *American Journal of Psychiatry* found that patients receiving TFP, dialectical-based therapy, and supportive therapy all showed significant positive change in depression, anxiety, global functioning, and social adjustment across one year of treatment, but that only TFP was effective in resolving specific symptoms (*Psychiatric News*, June 1, 2007).

No Such Thing as the 'Answer' to BPD

In discussing the three approaches, Oldham noted that despite differences in nuance, all three therapies share common elements—especially a focus on the present and on current challenges and experience, as opposed to exploring past and childhood origins of problems. And all of them emphasize the maintenance of an alliance between patient and therapist and the exploration and resolution of problems in that relationship.

He cautioned against crowning any one therapeutic approach as the "answer" to managing BPD.

"Sometimes inadvertently there develops a cult or religious flavor" around a particular favored therapy, he said. "We get bands of followers, and that translates into a belief that the treatment is the one therapy for BPD. And that is never going to be the case."

He noted that the *DSM* criteria for BPD describe patients who meet five of nine possible criteria, in any combination. "If you do the math, that means there are 256 different types of BPD," he said. "Often we talk about BPD as if it is one thing, and it just isn't. It's a family or a constellation of disorders.

"So we really have a range of types of patients," Oldham said. "We have a need for many different types of approaches."

"Eight-Year Follow-Up of Patients Treated for Borderline Personality Disorder: Mentalization-Based Treatment Versus Treatment as Usual" is posted at <http://ajp.psychiatryonline.org/cgi/content/165/5/631>. "A Manual-Based Psychodynamic Therapy for Treatment-Resistant Borderline Personality Disorder" is posted at <http://psycnet.apa.org/index.cfm?fa=search.displayRecord&uid=2008-02963-002>. "Evaluating Three Treatments for Borderline Personality Disorder: A Multiwave Study" is posted at <http://ajp.psychiatryonline.org/cgi/content/full/164/6/922>. ■

Antipsychotics

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included in the nursing-home cohort if their index drug claim was submitted by a long-term-care facility. Otherwise, they were assumed to be community dwellers.

For each cohort, they identified three groups of equal size based on antipsychotic drug exposure: none, atypical, or conventional. The most frequently prescribed atypicals were risperidone, olanzapine, and quetiapine. The most frequently prescribed conventional antipsychotic drugs were haloperidol, loxapine, and thioridazine.

The "none" group was a control group that included older adults with dementia who had not been given prescriptions for antipsychotic drugs but had been given at least one other medication. Acute-care hospital admissions were divided into two categories: known serious events including extrapyramidal symptoms (EPS), falls or hip fractures, and cerebrovascular events; or other events.

There were several groups of patients who were excluded: those with a history of schizophrenia, tics, Huntington's disease, and dialysis during the previous five years; those with a history of parkinsonism or other EPS during the previous five years; and individuals with a history of brain tumor. Similarly, the researchers also excluded individuals with a diagnosis of epilepsy or trauma or a history of pathological fractures or hip fractures.

To ensure that death was likely related to antipsychotic therapy, they excluded deaths among individuals receiving palliative care because, although antipsychotic drugs may be used in this setting, death is an expected outcome.

Among 6,894 community-dwelling subjects who received an atypical antipsychotic, 13.9 percent experienced a serious event, and 2.7 percent of the subjects died. The percentages for community-dwelling subjects who received a conventional antipsychotic were higher: 16 percent and 4.6 percent for serious events and deaths, respectively.

Among 6,853 nursing-home subjects who received a prescription for an atypical antipsychotic, 9.4 percent experienced a serious event, and 5.2 percent died within 30 days of receiving a prescription for an atypical antipsychotic drug. Among the same number receiving a conventional antipsychotic, the figures were again higher: 11.6 percent for serious events and 6.5 percent for deaths.

By comparison, 4.4 percent of the 6,894 community subjects who did not receive an antipsychotic experienced a serious event, and 1.2 percent died. And for the 6,853 nursing home subjects who did not receive an antipsychotic, 5.6 percent experienced a serious event, and 3.3 percent died.

An abstract of "Antipsychotic Therapy and Short-Term Serious Events in Older Adults With Dementia" is posted at <http://archinte.ama-assn.org/cgi/content/abstract/168/10/1090>. "Neuroleptic Drug Therapy in Older Adults Newly Admitted to Nursing Homes: Incidence, Dose, and Specialist Contact" can be accessed at <www.blackwell-synergy.com/toc/jgs/52/5>. ■

Pediatric Depression, Anxiety Symptoms Often Overlooked

Depression and anxiety in children and teens frequently present with a different appearance than that of the adult conditions.

BY RICH DALY

Two common psychiatric disorders are frequently overlooked in children and adolescents by psychiatrists and mental health professionals who may be focused on higher-profile conditions, according to child psychiatrists.

Depressive symptoms, in particular, are common in pediatric practices, said Jefferson Prince, M.D., director of child psychiatry at North Shore Medical Center in Massachusetts and an instructor in psychiatry at Harvard Medical School. Some research has found that up to 10 percent of patients seen on routine follow-up by pediatricians displayed symptoms of depression. He made his comments at a session on pediatric psychopharmacology, which was part of a Presidential Institute organized by APA and the American Academy of Child and Adolescent Psychiatry at APA's 2008 annual meeting in Washington, D.C., in May.

Despite the prevalence of pediatric depression, however, it frequently goes undiagnosed because psychiatrists and other physicians are not looking for the right symptoms. Prince said physicians as well as mental health professionals need to look for dysphoria and irritability, instead of the sadness seen in adult depression patients.

"There may be sadness that comes with it, but primarily we see irritability," he pointed out.

These young patients, who often can't see the problem as stemming from themselves, are sensitive to rejection and can't sustain happiness. The condition also is marked by abnormal sleep patterns, changes in appetite, and suicidal ideation.

A genetic predisposition to depression may be brought out by stressful situations, from which healthy children could recover by themselves. But in these children, stress often leads to depression.

In pediatric depression patients, the depression is a chronic condition that parents often initially attempt to address themselves. Patients brought to him for treatment, Prince said, are usually well into their second or even later depressive episode.

Comorbidity a Challenge

He noted that pediatric depression is a highly comorbid condition, which may make it harder to recognize because it is obscured by conditions that are sometimes easier to detect, such as anxiety. A further diagnostic complication is that about half of younger pediatric depression patients thought to have unipolar depression are later diagnosed as having bipolar depression.

Despite the challenges, treatment for pediatric depression is critical because of the demonstrated toxic effects of depression on the brain.

One of the leading challenges to medical treatment for pediatric depression is the Food and Drug Administration's label warnings about the risk of suicide in individuals younger than 25 who take antidepressant medications.

While Prince challenged the accuracy of the studies on which those warnings are based, the one positive aspect of the warnings is that they spur conversations about a sensitive topic that is difficult for psychiatrists to discuss with parents and youth, he said.

Because the time of highest suicide risk once medication is begun is during the first nine days, Prince urged psychiatrists to follow their pediatric patients closely during this time. "So during this time we want to make sure that people are aware that we are changing things in them and that if it goes in the wrong direction, we need to know that," Prince said.

One way to address the suicide risk directly is to ask parents if they have a gun in the home, and if they are gun owners, educate them about the risks when someone in the home has depression. Psychiatrists also should rehearse a "safety plan" with young patients that reviews dangers in their lifestyle and whether they have a proper diet and sufficient sleep.

"I tell them 'no marijuana,' " he said. "That is an extraordinarily important intervention."

Anxiety Often Overlooked

Psychiatrists also frequently miss pediatric anxiety disorder, the symptoms of which are among the easiest to detect, said John Walkup, M.D., deputy director of the Division of Child and Adolescent Psychiatry at Johns Hopkins Medical Institutions.

He noted that anxieties are highly comorbid and overlap heavily. Research indicates that 70 percent of patients with a phobia have another anxiety disorder.

Anxiety disorders have a range of symptoms but some of the most common are chest pains, an urge to urinate before stressful events, a constant lump in the throat, difficulty swallowing foods, dizziness, and exhaustion.

"So if you have kids who are consistently irritable and exhausted when they get home from school, these are children who [may be] tired from managing their anxiety all day," Walkup said.

Although anxiety disorders are often underdiagnosed and discounted as "not meaningful," he said, they are "quite impairing" and should not be minimized. And the burden to urge treatment for these conditions frequently falls on psychiatrists and other clinicians because educators and school counselors are so used to seeing symptoms of anxiety that they often don't see the need to push parents to get their child treated.

To treat children with anxiety disorders, he uses SSRIs first because they are easier to use than other medication options, and kids respond to "more reasonable doses." Many children with anxiety are treated with benzodiazepines, but, he warned, long-term efficacy data in this population are lacking for those drugs.

The length of treatment is based on patients achieving a lasting "recalibration of how they think of themselves." Then, he suggested, pick a time of year when a relapse would have the least impact on the child and slowly taper off the medication. He urged clinicians to watch patients closely for complications or relapses for at least a year after they stop taking medication. ■

Credit: David Hathcox

John Walkup, M.D., says that if children are consistently irritable and exhausted when they get home from school, it may be because they are expending great effort to manage their anxiety.

Parenting, Development Problems Predict Mental Illness in Infants

Certain factors in the first year of life can predict poor mental health in the second year—another knowledge advance in the burgeoning field of infant psychiatry.

BY JOAN AREHART-TREICHEL

If a child is a terrible sleeper or eater during the first months of life it does not mean that he or she is going to experience poor mental health during the second year.

But if the child's relationship with its parents during the first few months is disturbed, mental health problems in the second year might be the outcome.

These are some of the implications to emerge from a study headed by Anne Mette Skovgaard, M.D., an associate professor of health sciences at Denmark's University of Copenhagen. Results appeared in the May *Journal of Child Psychology and Psychiatry*.

In 2000 Skovgaard and her colleagues launched a longitudinal study called the Copenhagen Child Cohort (CCC 2000) to investigate developmental psychopathology prospectively from birth in a general population. The study included 6,090 children, or 9 percent of children born in Denmark that year. The researchers then randomly selected 306 children from the cohort for this leg of the study. Out of the 306, 210 participated.

Various instruments were used to evaluate the 210 children's development during the first 10 months of life as well as the quality of parenting they experienced during this time. And once the children reached 1.5 years of age, clinical observations and videotape recordings were used in combination with standardized measures to diagnose mental health disturbances according to the *ICD* and Diagnostic Classification Zero to Three. Out of the 210 subjects, 73 were found to have an eating disorder, a sleeping disorder, or other disorder.

Finally, Skovgaard and her colleagues found that there were links between a child's development and parenting experiences during the first 10 months of life and its mental health at 1.5 years of age.

Delays in cognitive functioning, poor language development, and aberrations in social communication during the first 10 months of life significantly predicted any psychiatric disorder and especially a neurodevelopmental one at 1.5 years of age. Moreover, being an unwanted child or being abused by a parent significantly predicted a relationship disturbance at 1.5 years of age. And eating problems that started after age 6 months significantly predicted an eating disorder at 1.5 years of age.

However, eating problems that started before 6 months of age did not significantly predict a psychiatric disorder at 1.5 years of age; nor did sleeping problems from birth to 10 months.

please see ***Parenting*** *on page 26*

Buyouts, Layoffs Can Be Toxic to Mental Health

Voluntary buyouts offered to American workers at every level of the job ladder may be just as disturbing to health—mental or physical—as getting fired.

BY AARON LEVIN

Taking a buyout from an employer may be just as damaging to a worker's mental health as getting fired, said *New York Times* economics writer Louis Uchitelle at APA's 2008 annual meeting in Washington, D.C., in May.

Layoffs were traditionally considered part of life for blue-collar Americans and hence not so important to the middle and upper classes, said Uchitelle. "But once it got to white-collar workers, it suddenly seemed important," he said.

Job loss acts as a social stressor that may diminish self-worth and lead to syndromes such as depression or anxiety. One recently published study found, for example, that the number of men presented by police for involuntary psychiatric admissions increased during a downturn in the labor market in Florida between 1999 and 2003.

Other studies, conducted by William Gallo, Ph.D., and colleagues at the Yale School of Public Health and based on the federal Health and Retirement Survey, have concluded that involuntary job loss is correlated with increased physical and mental health problems among workers over age 50.

The differences between layoffs and buyouts are only superficial, said Uchitelle. Buyouts may appear voluntary, but there is often an implicit or explicit threat to let go employees who don't take a buyout offer.

In researching a book on the subject (*The Disposable American*, Knopf, 2006), Uchitelle found that people who took buyouts were hurt far more profoundly than they would admit at first during his interviews with them. No matter what the circumstances, being asked to leave a job left them—and their former coworkers—with a sense that they were not worthy of continued employment.

People who are laid off or take buyouts often blame themselves for their situation. When Uchitelle told the people he interviewed for his book that they were facing a societal problem and that others were going through the same experience, they would agree but then quickly go on again about their own perceived failings.

"People who professed not to be damaged were damaged," said Uchitelle. "There's always some sense of diminishment."

Uchitelle has seen the effects firsthand at the *Times*, where many of his fellow employees have taken buyouts, as have colleagues at many U.S. newspapers. He hopes he'll never have to do the same.

When he was hired by the *Times* in 1980, his editor told him he would spend the rest of his career there. He felt he was part of a communal organization whose combined expertise made the paper possible. That sense has been fractured by the buyouts in recent years, he said.

He cited other examples from his book research, like the airline mechanic who had earned an engineering degree by going to school at night. When the company outsourced its respected maintenance program, the man was not offered a job in the engineering department and took the offered buyout. But somehow, the plans he made for his new life, like rehabbing and selling houses, never seemed to work out. He took a job as a school janitor at two-thirds his previous salary. Six months later, his wife called Uchitelle to ask for help in getting her husband into therapy.

He also noted the case of a woman who took a buyout from a large bank in New York, yet held on to the fantasy that bank officials would soon call and invite her back to work. When they failed to call after the September 11 attacks, she was first crushed by the feeling of being unwanted, but eventually managed to face up to the reality of her situation and move on, he said.

The problem is wider than just those who take the buyouts, are the victims of downsizing, or just laid off, said Uchitelle. There is widespread underemployment throughout the American economy.

"We've set up a system across our society of defense mechanisms against acknowledgement of the problem," he said. "Both Democrats and Republicans have the same response. They blame the victim and assume the job is obsolete. If a person gets further training and education and doesn't get a job—well, then everyone still assumes it's the worker's fault."

In the past businesses had at least some sense of social obligation, he noted. During downturns or recessions, workers might be furloughed (a term rarely heard these days, he added) but they would be hired back once the economy picked up steam again. Today workers are on their own, and their bosses may be no better off.

"People really want to look the other way," said Duane Hagen, M.D., who introduced Uchitelle at the session. "This should be a major public health issue but it's not."

Hagen, a psychiatrist at St. John's Mercy Medical Center of St. Louis, collaborated with Barrie Greiff, M.D., and Nick Kates, M.B.B.S., on a book titled *The Psychosocial Impact of Job Loss* (APPI, 1990).

"Not much has changed in 20 years," he told *Psychiatric News*.

When Uchitelle spoke to students in Dartmouth's M.B.A. program, he suggested that perhaps executives might take a cut in pay rather than letting workers go permanently. The idea was met with dead silence. These future captains of industry, it turned out, appeared to have as bleak a view of the future as any assembly-line worker. One told him that the only way to survive was to earn as much money as possible before they, too, were asked or told to leave.

"Our only solution is to push back as a society against layoffs," he said. ■

Large Studies Provide Clues to Alzheimer's Risk, Prevention

It looks as though depression is a risk factor for Alzheimer's disease. There is also reason to believe that the nonsteroidal anti-inflammatory drug ibuprofen might protect against Alzheimer's.

BY JOAN AREHART-TREICHEL

In 1994 some 1,000 older Catholic priests, nuns, and brothers signed up for a mission that had nothing to do with saving souls but plenty to do with saving minds.

The mission, headed by David Bennett, M.D., director of the Rush University Alzheimer's Disease Center, was called the Rush Religious Orders Study. Subjects were evaluated medically, neurologically, cognitively, and psychologically, both at the start of the study and annually thereafter. Differences between those who develop Alzheimer's and those who do not are being analyzed to identify factors that might predict subsequent susceptibility to Alzheimer's.

During the past few years, the study has identified several putative Alzheimer's risk factors. One is rapidly progressing Parkinson's disease (*Psychiatric News*, June 20, 2003). Another is an enduring tendency to experience negative emotions (*Psychiatric News*, July 20, 2007). Yet a third is depression.

And now still more results from the study, published in the April *Archives of General Psychiatry*, go a step further by suggesting that depression is truly a risk factor for Alzheimer's and not the result of the disease itself.

In this phase of the study, 917 subjects without Alzheimer's were evaluated annually for 13 years to determine both whether they were depressed and whether they might be developing Alzheimer's. Of the 917 subjects, 190 developed the illness during this time span. Consistent with earlier findings in this cohort, having more depressive symptoms at the start of the study was linked with an increased risk of developing Alzheimer's. However, Bennett and his coworkers did not find that the subjects who developed Alzheimer's experienced an increase in depressive symptoms during the four years or so leading up to the onset of their Alzheimer's. So depressive symptoms indeed seem to be a risk factor for Alzheimer's rather than an early sign of its pathological process, Bennett and his colleagues concluded.

Yet if, as these data imply, depressive symptoms are a risk factor for Alzheimer's, how might they be contributing to the risk? Since major depression has been linked with brain atrophy, such atrophy in turn might make the brain more susceptible to Alzheimer's, Bennett and his team speculated. Understanding the means by which depression preps the brain for Alzheimer's might lead to some way of preventing Alzheimer's, they suggested.

Meanwhile, two other groups of scientists have been looking into whether nonsteroidal anti-inflammatory drugs (NSAIDs) might do so.

In the first study, Steven Vlad, M.D., of Boston University and coworkers evaluated prescription NSAID use by some 49,000 veterans who had developed Alzheimer's and by some 197,000 veterans who had not. The NSAID classes assessed included arylpropionic acids such as ibuprofen or naproxen, enolic acids such as piroxicam, COX-2 inhibitors such as celecoxib, nonacetylated salicylates such as salsalate, and high-dose aspirin.

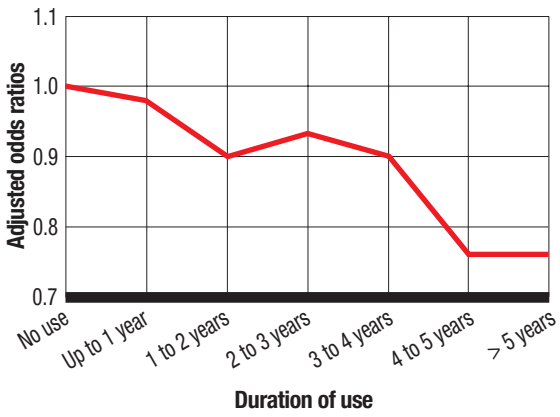
The researchers found that the odds of developing Alzheimer's decreased with longer NSAID use. Compared with persons not using NSAIDs, the odds of getting Alzheimer's decreased from 0.98 among those with use for one year or less to 0.76 for those using NSAIDs for more than five years. However, the researchers found that the protective effect did not seem to be identical for each NSAID. Some, such as ibuprofen, showed clear protective effects; others, such as the COX-2 inhibitors, did not, and in yet others the effect on Alzheimer's risk was unclear. The results appeared in the May 6 *Neurology*.

In the second study, Barbara Martin, Ph.D., of Johns Hopkins University and her colleagues allocated some 2,100 sub-

please see ***Prevention*** *on page 26*

Can NSAIDs Protect Against Alzheimer's?

Researchers found that the longer subjects took NSAIDs, especially ibuprofen, the better protected they were against Alzheimer's.



Source: Steven Vlad, M.D., et al., *Neurology*, May 6, 2008

Antidepressant Use Linked to Small Uptick in Accidents

Antidepressants have been linked to a slightly increased risk of having a traffic accident. The risk, however, is much lower than for drugs such as benzodiazepines and opioids.

BY JOAN AREHART-TREICHEL

There is a slightly increased risk of being involved in a traffic accident after having been dispensed an antidepressant. This is the case whether the antidepressant is one of the older sedating types or one of the newer nonsedating ones.

However, whether the increased risk is actually due to antidepressant use, to being depressed, or to some other factor is unknown.

These findings emerged from a large population study conducted in Norway. The lead investigator was Jorgen Bramness, M.D., Ph.D., a psychiatrist and senior researcher at the Norwegian Institute of Public Health in Oslo. Results were published in the June 3 online edition of the *Journal of Clinical Psychiatry*.

Bramness and colleagues used three population-based registries in Norway to obtain data for their study—the Central Population Registry, the Prescription Database, and the Road Accident Registry.

Using the Central Population Registry, the investigators focused on some 3 million Norwegians aged 18 to 69 who had been included in the registry from 2004 to 2006.

Using the Prescription Database, Bramness and his colleagues determined which of the 3 million Norwegians had filled prescriptions for antidepressants, on what date, for which kind of antidepressant, and for how many days of use, during the 2004 to 2006 period. (The database did not provide information on actual antidepressant use, but the researchers assumed that individuals who filled antidepressant prescriptions used them.)

And using the Road Accident Registry, Bramness and his group determined which of the 3 million had been involved, as motor-vehicle drivers, in traffic accidents causing personal injuries, and on what date, from 2004 to 2006. (The registry did not say who was responsible for these accidents.)

The researchers then tabulated the number of traffic accidents with personal injuries in which the 3 million Norwegians had been involved from 2004 to 2006, finding 20,494 such incidents. They then assessed how many of the drivers involved in those accidents had been dispensed older sedating antidepressants such as the tricyclics, newer nonsedating antidepressants such as the selective serotonin reuptake inhibitors, or no antidepressants. They found that 204 had been dispensed older sedating antidepressants before the accidents, 884 had been dispensed nonsedating ones, and the remaining 19,406 had not been dispensed any antidepressants prior to the accidents.

The researchers then assessed the risks for experiencing a traffic accident with personal injury in these three groups of drivers. There was a statistically significant, although modest, increased risk for the two groups that had been dispensed antidepressants. The standardized incidence ratios were 1.4 for those getting older sedating antidepressants and 1.6 for those getting newer nonsedating ones.

The risks were similar for both male and female drivers and did not change even when the coprescribing of benzodiazepines or opioids was taken into consideration.

Finally, they determined whether the traffic-accident risk for persons who had been dispensed an antidepressant for the first time (presumably new users) was the same as that for individuals who had previously been dispensed antidepressants. They found that new users of the newer antidepressants had a traffic-accident risk similar to that incurred by seasoned users of either the older or newer antidepressants. However, they also found that new users of the older antidepressants had no higher traffic-accident risk than nonantidepressant users did.

Several of these results surprised Bramness, he told *Psychiatric News*. First, he had expected that the older antidepressants would be linked with a higher traffic-accident risk than the newer ones because of their sedating qualities. They did not find this, however. Second, he had expected that new antidepressant users would be linked with a higher traffic-accident risk than experienced antidepressant users, because a person not used to taking a drug might be at higher

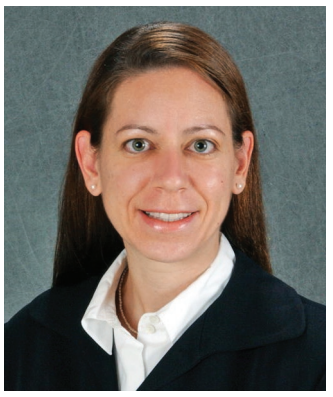
please see ***Accidents*** *on page 26*

ALL ADVERTISING

ALL ADVERTISING

Become Part of Something Bigger Than Yourself

BY LAUREN SITZER, M.D.



I recently came across my 1996 City Year yearbook. Glancing through the pages, I realized that while I did not remember everyone's name, I recognized all of my 300-plus former City Year colleagues. Together in our red uniform jackets, we had spent countless hours tutoring children, cleaning up parks, and preparing meals for sick people as part of this AmeriCorps program. The program was adept at bringing people together, helping us recognize the veracity in Rev. Martin Luther King Jr.'s saying, "Everyone can be great, because everyone can serve."

Looking back now, I understand that what City Year was able to accomplish through service was to allow people the opportunity to be part of something bigger than themselves. As a psychiatrist in training, I am again beginning to recognize that I am part of something much bigger than myself.

I first came to the Massachusetts Mental Health Center (MMHC) in 2004 as a fourth-year medical student for an elective in community psychiatry sponsored by Dr. Robert Goisman. It was during this rotation that I began to realize that the MMHC had history, lore, and pride unlike anything I had experienced elsewhere. It was the subtle reminders; a mention of "how things used to be done" or a glance at a commemorative plaque on a wall that reminded me that psychiatry is a field with a rich and deep history.

My attraction to that history was part of what led me to my current residency program. Over the course of my training at the Harvard Longwood residency program, I have spent a significant amount of time at the MMHC. Many of our supervisors are graduates of the program and still practice there. They speak fondly of their own supervisors and often teach us using the same words they heard from such greats as Dr. Elvin Semrad, who had eloquently stated that "the patient is the only textbook we require."

With their guidance, it has been easy to see that it is not enough just to appreciate the history of psychiatry. To truly be a part of this profession, I must also help to shape the future of psychiatry—a realization that led me to join and become involved in APA.

Originally conceptualized in 1844 by 13 superintendents drawn from the 24 existing mental hospitals and calling themselves the Association of Medical Superintendents of American Institutions for the Insane, APA today is 38,000 members strong and the preeminent organization representing psychiatrists. Now, as the incoming member-in-training trustee, I have the honor of representing fellow trainees to the APA Board of Trustees.

Sitting on stage as part of the official Opening Session at the 2008 annual meeting in Washington D.C., in May, I watched the inspiring procession of past APA presidents and incoming officers. These are psychiatrists who themselves carry much of the vibrant history of both APA and the field of psychiatry and who, through donating their time and effort, are shaping what psychiatry will look like for years to come. As a woman, it was inspiring to see Dr. Carol Nadelson, who in 1985 became the first woman president of APA, seated with the 2007-2008 APA Board of Trustees led by four accomplished women: President Carolyn Robinowitz, M.D., President-elect Nada Stotland, M.D., Vice-President Carol Bernstein, M.D., and Secretary-Treasurer Donna Norris, M.D. An enormous amount of growth and development in both the organization and the field was clearly evident on that stage.

By learning from the past and working to influence the future, I am beginning to play a part in something that is much bigger than myself. I still believe, as City Year taught me many years ago, that dedication to serve is what gives all of us the chance to be great. As we learn how to best serve our patients and their families, we must remember that we can be powerful in our service to the profession as a whole.

Whether as medical students, residents, or fellows, we have much to contribute to the field of psychiatry and to APA. We cannot sit back and hope others do the hard work of advancing the field and our professional organization. It is crucial that we, as the future of psychiatry, stay aware of issues facing psychiatry today, such as the need for mental health parity, nonphysicians who want to practice medicine, and new developments in health-information technology.

We must advocate in our training programs, our district branches, and on Capitol Hill. APA encourages us to be active and listens to what we have to say. There are many opportunities to get involved. Dr. Benjamin Rush, the "father of American psychiatry," whose face is on APA's seal, is a reminder that we are part of an organization with a longstanding commitment to a vision of a society in which people can receive quality psychiatric diagnosis and treatment. As we stand on the shoulders of our forebears and sculpt the future of our profession, we must remember that we are part of something bigger than ourselves. ■

Lauren Sitzer, M.D., is the member-in-training trustee on the APA Board of Trustees and a PGY-3 resident at Harvard Longwood Psychiatry Residency Training Program.

COMPILED BY JUN YAN

This is Part 2 of a special edition of Med Check featuring summaries of new research posters presented in May at APA's 2008 annual meeting in Washington, D.C.

These presentations are usually preliminary in nature and often involve results that have not been peer reviewed for publication. In addition, the reports, which may involve the use of medications for indications that the FDA has not approved, are largely funded by product manufacturers.

• A ***frontal-quantitative electroencephalogram*** (fqEEG) index may prove a useful early predictor for an individual patient's response to antidepressant treatment and his or her remission, according to interim results from the multicenter Biomarkers for Rapid Identification of Treatment Effectiveness in Major Depression (BRITE-MD) trial.

This poster was presented by Andrew Leuchter, M.D., from Semel Institute at UCLA, and colleagues. They used a composite EEG index known as ATR (Antidepressant Treatment Response) to try to predict whether patients would respond to antidepressant treatment. Adults with major depressive disorder were started on escitalopram 10 mg/day for one week, assessed with fqEEG, and then randomized to continue on escitalopram (n=73), switch to bupropion extended-release 300 mg/day (n=73), or take both medications (n=74) for seven weeks. All patients were regularly evaluated with fqEEG and the Hamilton Rating Scale for Depression (HAM-D).

Sixty-eight percent of patients who were predicted by the ATR index to be responders at week 1 and remained on esciptalopram alone achieved response at week 7, compared with 28 percent of those who were predicted as nonresponders (p=0.001).

Statistical analyses revealed that after one week of escitalopram treatment, the ATR index findings significantly predicted patient response and remission rates at week 7. ATR index correlated with clinical assessment measured by HAM-D at every visit.

Among patients predicted by ATR as nonresponders to escitalopram after one week of treatment on this medication, those who were randomized to switching to bupropion had a higher response rate at week 7 (53 percent) than those who were kept on further escitalopram treatment (28 percent).

The BRITE-MD trial is ongoing and funded by Aspect Medical Systems Inc., which owns the EEG-based ATR index for depression.

• Genetic variations may be associated with the increased rate of certain medication-related adverse events, according to analyses of DNA samples from 243 Caucasian participants in a randomized, double-blind, clinical trial of ***duloxetine*** for major depression. Researchers analyzed the incidence rates of the seven most commonly reported adverse events considered related to taking the drug and 145 single nucleotide polymorphisms (SNPs) in 14 genes potentially relevant to the antidepressant and side effects. Decreased appetite was statistically significantly associated with SNP rs5569 in the norepinephrine transporter gene NET1. Gastric discomfort was significantly associated with SNP rs8071667 in the serotonin transporter gene SLC6A4.

The researchers cautioned that the findings must be confirmed with further replication and placebo-controlled data. The study was funded by Eli Lilly and Co.

• Pooled data from five randomized, double-blind, placebo-controlled, eight-week clinical trials of ***desvenlafaxine*** in patients with major depressive disorder showed that the drug is associated with small but statistically significant increases in systolic and diastolic blood pressure, compared with placebo. The analyses included 1,365 adult patients who received at least one dose of desvenlafaxine at dosages ranging from 50 mg/day to 400 mg/day and 636 who received placebo. The mean change in supine systolic blood pressure from baseline to the final treatment was -1.4 for the placebo group and +1.2, +2.0, +2.5, and +2.1 mmHg for the desvenlafaxine 50 mg, 100 mg, 200 mg, and 400 mg groups, respectively. The mean change in supine diastolic blood pressure was -0.6 for the placebo group and +0.7, +0.8, +1.8, and +2.3 mmHg for the other groups, respectively.

The study was led by Michael Thase, M.D., of the University of Pennsylvania School of Medicine and funded by Wyeth Research Inc.

• ***Escitalopram*** has been shown to be more effective than placebo in improving depression symptoms in a randomized, placebo-controlled, double-blind clinical trial in adolescents. In this phase 3 clinical trial conducted by Forest Laboratories, 316 patients from ages 12 to 17 with major depressive disorder received either 10 mg to 20 mg escitalopram (n=155) or placebo (n=157) for eight weeks. At the end of the trial, patients' scores on the Children's Depression Rating Scale–Revised, decreased on average by 22.1 points in the escitalopram group and 18.8 points in the placebo group. The difference was statistically significant. Adverse events led to 2.6 percent of patients in the escitalopram group and 0.6 percent of patients in the placebo group discontinuing the trial.

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Special Tracks Invite You to Customize Your Meeting

Several special features will highlight this year's Institute on Psychiatric Services including "Practical Pearls," a full-day session on working with homeless mentally ill people.

BY JACQUELINE MAUS FELDMAN, M.D.

Go for the razzle dazzle. Go for the pizza. Go for the jazz poetry. But most of all, go for APA's Institute on Psychiatric Services, which is being held in—you guessed it—Chicago from October 2 to 5.

As chair of the institute's Scientific Program Committee, I want to extend an invitation for you to join us at APA's smaller, more intimate meeting. The beautiful (and newly renovated) Palmer House Hilton will serve as the backdrop for what is shaping up to be the best psychiatric meeting of the year, with CME credits and CEUs available for many disciplines (physicians, psychologists, nurses, social workers, and counselors).

Following our theme of "From Patient to Partner: Transforming Systems of Care," we have fashioned an incredible program. Just to give you a taste of the curriculum: a debate between proponents for single-payer medicine versus the AMA's point of view; lectures, workshops, and symposia covering a broad range of topics sure to answer your clinical questions; a Recovery Celebration to interface with consumers; an APA-community outreach to offer clinical updates by renowned scientific leaders; a new format called "Practical Pearls" with leading clinicians ready to discuss those things that throw us for a loop in our day-to-day practice—for example, how to publish a paper, how to prepare for court, what to do if the media call, how to teach public psychiatry, DBT and CBT with patients who are psychotic—and poster sessions that will knock your socks off! Child psychiatry? Got it covered (adolescents will be coming in to tell how they want to be treated). Advocacy? Come on down. Psychosocial rehabilitation and recovery models? They're here!

Tracks have been designed to meet the needs of members-in-training (starting with the Lilly Chief Residents Leadership Track, ending with presentations by APA/Bristol-Myers Squibb Fellows). On Saturday morning, October 4, the "Career Counseling and Career Development" forum will allow residents, early career psychiatrists, and anyone who's thinking about changing the course of their career to meet one on one with national experts in public psychiatry. The Health Services Research track is planned, APA's OMNA (Office of Minority and National Affairs) on Tour will offer an innovative curriculum and a community depression education event, and the Association of Gay and Lesbian Psychiatrists has designed a full-day track. On Saturday evening, there will be a "Conversations" event sponsored by the American Psychiatric Foundation.

On Sunday, October 5, there will be a full-day training session titled "Working With Homeless Mentally Ill Individuals."

Our local representatives assure us that Chicago is easy to get to and is breathtaking in the fall. The area around the meeting will be replete with music, concerts, sports, shopping, and museums, and upon arrival you will get a "Best of Chicago Synopsis (like pizza and jazz) to get you started. With all this, and more, how can you resist? Come on! Learn, network, play, and earn CME credits and CEUs. I'll see you there. ■

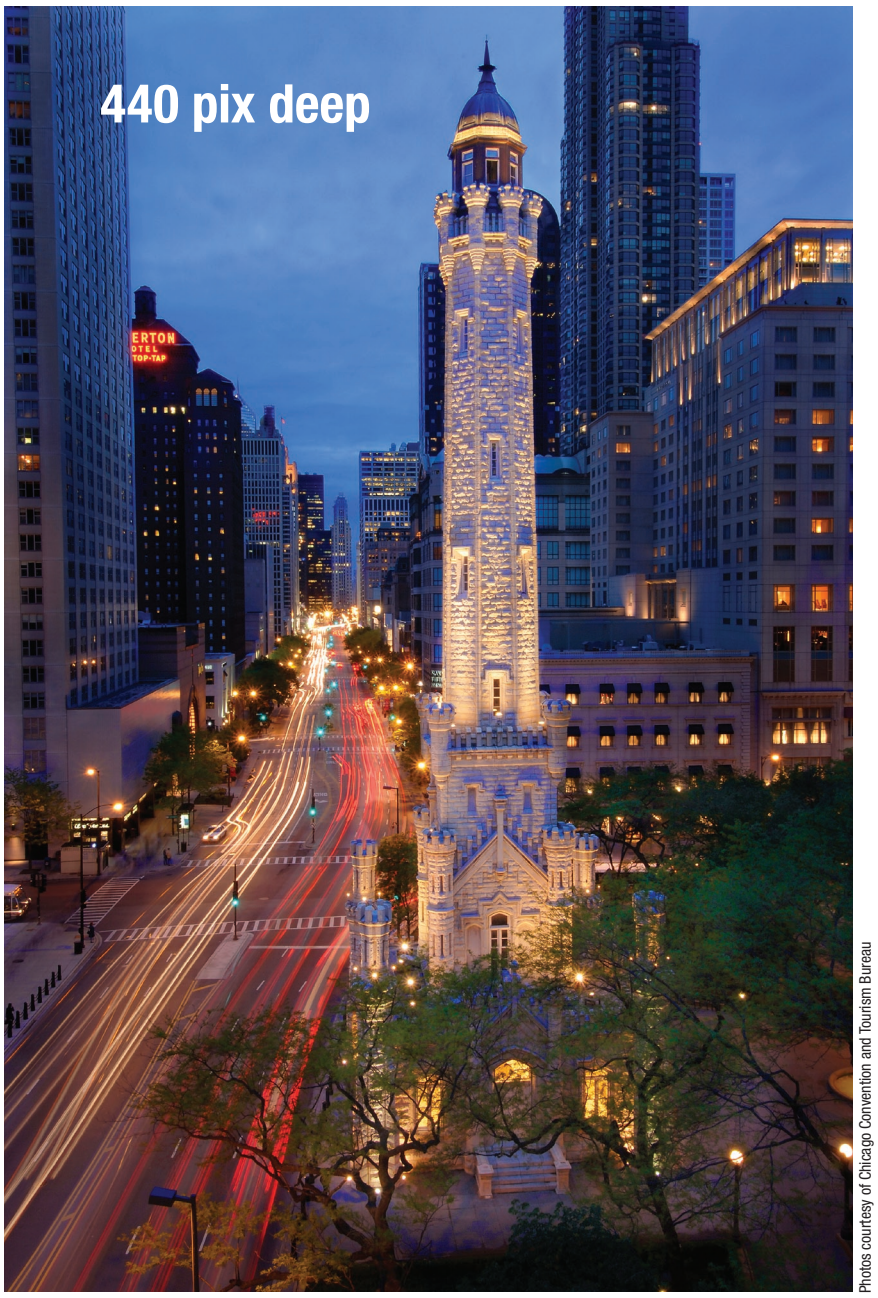
Jacqueline Maus Feldman, M.D., is chair of APA's Scientific Program Committee for the Institute on Psychiatric Services.

Photos courtesy of Chicago Convention and Tourism Bureau

Chicago skyline

Photos courtesy of Chicago Convention and Tourism Bureau

The Art Institute of Chicago



Photos courtesy of Chicago Convention and Tourism Bureau

The Water Tower, which looks like a miniature castle, is one of the few buildings to survive the famous 1871 fire.

Photos courtesy of Chicago Convention and Tourism Bureau

The Chicago Theatre is one of many theaters in a city that offers some of the best and most varied entertainment choices outside of New York.

How to Register

There are three easy ways to register for APA's 2008 Institute on Psychiatric Services, being held in Chicago from October 2 to 5:

- Register online at <www.xpressreg.net/register/iops108/regInfo.asp>.
- Use the registration form found in the preliminary program booklet and mail the completed form to APA. The booklet can be obtained by calling (888) 357-7924. Payment may be made by credit card or check payable to APA.
- Fax the completed form to (703) 907-1097. Payment must be made by credit card.

Register before September 12 and save on fees. A discounted fee is available for residents; medical students attend free.

Drug Use

continued from page 4

stance use is the increased availability and social acceptance of prescription drugs, including psychoactive medications, in the past several decades. "This is going to be a serious problem in the future when [they have] more leisure time," Condon said.

A number of other sources provide different perspectives on substance use in the general population that cannot be captured by large-scale surveys, such as new substances being abused or early signs of a local epidemic. "Electronic media are changing the dissemination of information about substance abuse," Edward Boyer, M.D., an assistant professor of emergency medicine at the University of Massachusetts Medical School, told the audience.

He pointed to two major Web sites as sources on which to monitor substance use trends: <www.erowid.org>, a massive online encyclopedia of legal and illegal substances; and <www.drugbuyers.com>, an aggregator of Internet pharmacy data popular among buyers of analgesics. The former site contains firsthand accounts of drug "trips" and pharmacological data on unusual substances. The latter site reflects market shifts (including the black market) in the availability and prices of opiates and psychotherapeutic agents.

NIDA also collects data from sources such as state and local public health departments, poison centers, drug abuse treatment centers, law enforcement and medical examiners' databases, and other surveillance efforts. The Community Epidemiology Work Group (CEWG), a network of public-health representatives from major metropolitan areas and some states across the country, has been meeting semiannually to exchange intelligence and monitor regional convergence and variations in drug abuse trends.

Findings reported at the January CEWG meeting, for example, indicated that the rise of methamphetamine use in Western regions in previous years may be leveling off or in decline, according to O'Brien. She also noted that in the past decade, data from Florida and the Detroit area showed decreasing numbers of heroin-related deaths and a parallel increase in prescription opiate-related deaths from methadone, hydrocodone, and oxycodone. ■

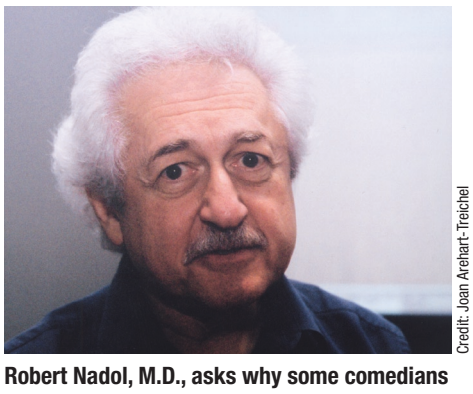
Laughing

continued from page 5

handle patients' delusions, but with paranoid patients, first "you put a couple of toes in and see how the patient responds."

On the whole, though, humor is an excellent tool to build a therapeutic relationship with patients, Dunkelblau pointed out. For example, psychiatrists should consider placing humor magazines in the waiting room or playful art on the waiting-room walls. One psychiatrist stationed little airplane-shaped fans around his office, which both amused and fascinated patients.

Meanwhile, many questions about humor's role in psychiatry beg to be answered. For example, does humor have any value in psychiatric diagnosis? One audience member—Robert Nadol, M.D., of Tucson, Ariz.—thinks that it does. If a patient demonstrates absolutely no sense of humor, he said, he worries that the patient might be depressed, psychotic, or even suicidal. And why are there so many comedians who experience depression when they are not making people laugh? Nadol asked at the workshop. To which Dunkelblau replied: "Some people who do comedy are seeking attention and love from others. It makes sense that they would be depressed when they don't get that attention and love." ■



Credit: Joan Arehart-Treichel

Robert Nadol, M.D., asks why some comedians experience depression when they are not making people laugh.

AMA, APA Conduct Physician Practice Information Survey

APA members who receive the survey are urged to complete and return it.

Watch your mail for the Physician Practice Information survey. APA, the AMA, and more than 70 other organizations are conducting a comprehensive multispecialty survey of America's physician practices. The results will be used to positively influence national decision makers to ensure accurate and fair representation for all physicians and patients, and to articulate the challenges of running a practice that provides expert patient care, while operating a business that is sustainable. Of particular importance is the section of the study pertaining to practice expenses and the amounts that are attributable to you. The Centers for Medicare and Medicaid Services has indicated it will use the results of this study to help determine physician payment.

The survey firm, Dmrkynetec, will contact randomly selected physicians and practice managers to collect responses. Please encourage your staff to make this information available, as the survey's success depends on accurate and complete data. All responses will remain confidential. ■

APA's 100% Club Picks Up Another Member Program

Seton Hall University's psychiatric residency Program, among the newest and smallest, is now a member of APA's 100% Club.

Seton Hall University's psychiatric residency program is among the newest—and smallest—around. The program, which opened its doors just a year ago this month, has a grand total of four residents.

But don't let size fool you. The new program embodies big ideas and strives for excellence in patient care and professional development. Toward that end, all four residents in the program are members of APA, which means the program is a member of APA's 100% Club.

"Our new psychiatry residency training program, sponsored by Seton Hall University, offers a unique blend of educational and practical experiences for the residents," said Purabi Bharatiya, M.D., the program's training director. "Based at Trinitas Hospital in Elizabeth, N.J., our faculty and residents are committed to training the next generation of psychiatrists."

A group photo of the members of the program will be turned into a poster and mailed to every medical school in the United States and Canada. It's a way to publicize the endeavor and encourage medical students and other residents to join APA. In addition, residency programs that are members of the 100% Club receive a major textbook from American Psychiatric Publishing Inc. and a free online subscription to *Focus: The Journal of Lifelong Learning* for each year that all of their residents are APA members.

From left: Michael Cunningham, M.D.; Anwar Ghali, M.D., chair; Purabi Bharatiya, M.D., program training director; Michael Zajfert, M.D.; Yahaira Espada, M.D.; Suma Srishaila, M.D.; and Eva Halkias, program director.

Information about Seton Hall University's psychiatry residency program is posted at <www.shu.edu/academics/gradmeded/psychiatry-residency/index.cfm>. More information about APA's 100% Club is available from Nancy Delanoche of APA's Division of Education at (703) 907-8635. Psychiatry residents and residency programs interested in signing up all their residents should also contact Delanoche. ■

letters to the editor

What's Old Is New Again

So working with farm animals can be beneficial to patients, as stated in the May 16 issue? What a revolutionary "discovery."

For many years in this country, and as late as the 1960s, mental hospitals in Wisconsin and many other states had farm operations, as well as gardens and orchards, as part of their operations. Here in Wisconsin, long-term patients who loved farming helped tend the herds and worked in the creamery. Women chatted, voluntarily and cheerfully, in the paring room and bakery. These were vocations—farming and homemaking—from which many patients came and of which they were very proud. These duties gave them a purpose, some productivity, and pride.

Along came the age of deinstitutional enlightenment. The civil liberties people cried "exploitation." The barns were dismantled, the gardens plowed under, and the orchards cut down. "Industrial therapy" didn't include these mundane duties. The patients were sent "home" to often nonexistent community programs. Now many patients get their heat from a steam grate and sleep under a bridge. Prisons have become the nation's largest repository of mentally ill individuals. Random violence and panhandling on the street give psychosis, once again, a bad name.

Just as we have now "discovered" that tending animals can be therapeutic for some patients, someone will "discover" that mental hospitals, for some long-term patients, are necessary and the best option. And that they might even suggest, as was the case in earlier times, that those hospitals should be rural and remote, away from the hustle and bustle and commotion, near blooming and growing things, a place to restore the spirit of people broken on the wheels of living. And then we will, once again, as in earlier times, decide that jails and prisons, and alleys and bridges, are not the best places for sick individuals who really deserve a hospital rather than a cell.

Who knows? Maybe the hospital will even have a farm, animals, gardens, and orchards because someone, in 2008, has discovered they can be helpful.

DAROLD A. TREFFERT, M.D.
Fond du Lac, Wis.

Readers are invited to submit letters not more than 500 words long for possible publication. *Psychiatric News* reserves the right to edit letters and to publish them in all editions, print, electronic, or other media. Receipt of letters is not acknowledged. Letters should be sent by mail to *Psychiatric News*, APA, Suite 1825, 1000 Wilson Boulevard, Arlington, Va. 22209 or by e-mail to pnews@psych.org. Clinical opinions are not peer reviewed and thus should be independently verified.

Conflict of Interest

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flicts, financial support for educational events, and other issues.

Seventy percent of the schools contacted responded to the survey. The 16 schools that declined to submit their policies and 29 that did not respond to multiple requests were graded F. Another 28 schools (19 percent) told the surveyors that they were currently revising existing policies or creating new ones; these schools were given a grade of "incomplete."

The AMSA scorecard echoes a study published in *JAMA* last year that found extensive relationships between the industry and medical schools and teaching hospitals. The *JAMA* study also found that conflict-of-interest policies vary widely on permissible relationships between faculty and industry, and many policies were under revision (*Psychiatric News*, April 18).

The financial relationships between industry and medicine are under increasing scrutiny, with demands from within and outside of the profession to increase and tighten regulations. The Association of American Medical Colleges' task force on industry funding of medical education released a report in April that urged medical schools to "prohibit the acceptance of any gifts from industry by physicians and other faculty, staff, students, and trainees of academic medical centers, whether on site or off site."

The task force report also recommended that schools restrict access by pharmaceutical representatives to students and trainees and prohibit industry-funded travel, food, and meals (except food provided in connection with continuing medical education programs accredited by the Accreditation Council for Continuing Medical Education). When medical schools across the country will adopt these guidelines remains uncertain in light of the AMSA Scorecard findings.

"It is time to extricate marketing practices from medical education," Brian Hurley, president of AMSA, said in a press release. In 2002 AMSA began its PharmFree campaign, "a national movement to limit the access and influence of pharmaceutical companies at medical schools and academic medical centers," according to the organization's Web site.

If the medical profession, medical educational system, and industry do not police themselves, lawmakers may step in and do it for them. In April, the Massachusetts state Senate passed a bill to prohibit all gifts of any value to health care providers from pharmaceutical and medical device companies. The bill is waiting for approval by the state House of Representatives and the governor. A month later, New York Gov. David Patterson (D) proposed legislation to ban gifts and payments from drug companies to physicians and other prescribers with values exceeding $50 a year. Minnesota's legislature has already enacted a similar ban.

The AMSA assessment of conflict-of-interest policies is posted at <www.amsacorecard.org>. "Report of the AAMC Task Force on Industry Funding of Medical Education to the AAMC Executive Council" is posted at <www.aamc.org/research/coi/industryfunding.pdf>. ■

Association News

APA Invites Nominations for Member-in-Training Position

The APA Nominating Committee is accepting recommendations for candidates for the member-in-training trustee-elect (MITTE) position for APA's 2009 election.

Each year an MITTE is elected by APA members-in-training and serves on the Board for one year without a vote. At the end of that year, the MITTE advances to member-in-training trustee (MITT) and serves on the Board for one year with a vote.

The resident elected in the 2009 election will serve as MITTE from May 2009 to May 2010, and as MITT from May 2010 to May 2011.

Residents must be APA members-in-training when recommended for the position; that is, they must have been accepted as APA members in both APA and their district branch. They must be in their PGY-2 or PGY-3 year in the summer of 2008.

Moreover, nominees must have written permission from their training directors to fulfill the two-year commitment as MITTE and MITT as a part of their training.

The Nominating Committee may consider the following in its deliberations: APA/DB activities; activity/work in psychiatry/medicine; previous organizational experience (need not be medically or psychiatrically oriented); grassroots community experience, medical and nonmedical training; research and publications; prior "life experience," such as training or a job in another field; previous career; unusual background; and leadership roles that show vision and creativity.

Information about the MITTE/MITT positions, eligibility criteria, and a submission form are posted on APA's Web site at <http://new.psych.org/Resources/Governance/MITTEForm.aspx>. The form to be signed by the resident's training director can be downloaded from <www.psych.org/Resources/Governance/2009DirectororChairForm.aspx>.

Nomination materials must be received by August 8. Items should be sent to Carolyn B. Robinowitz, M.D., Chair, APA Nominating Committee, APA, 1000 Wilson Boulevard, Suite 1825, Arlington, Va. 22209; Attn: Chanda Brooks. They can also be faxed to (703) 907-7852 or e-mailed to cbrooks@psych.org.

More information on the MITTE nominating process is available by contacting Brooks at the above e-mail address or by phone at (703) 907-8527. ■

Parity

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state action on parity, she said, was that many states were awaiting the outcome of ongoing congressional negotiations over competing federal parity bills (HR 1424, S 558).

Senate and House Democratic leaders have both made resolving differences in the two bills this summer a priority. In June the ranking Republican on the Senate Special Committee on Aging, Sen. Gordon Smith (R-Ore.), pushed to add the Senate parity language to a bill to provide updates for Medicare. However, the likelihood that any parity measure will pass this year remains unclear.

Information on the Illinois measure is posted at <www.ilga.gov/legislation/BillStatus.asp?DocNum=1432&GAID=9&DocTypeID=HB&LegId=30223&SessionID=51&GA=95>. The Vermont measure is posted at <www.leg.state.vt.us/docs/legdoc.cfm?URL=/docs/2008/acts/ACT142.HTM>. The New Jersey bill is posted at <www.njleg.state.nj.us/2008/Bills/A2500/2077_I1.PDF>. The text of the federal parity bills can be accessed at <http://thomas.loc.gov> by searching on the bill numbers, HR 1424 and S 558. ■

Association News

Nominations Invited for Human Rights Award

APA members are asked to submit nominations for APA's 2009 Human Rights Award. The award is conferred yearly on an individual and an organization whose efforts exemplify the capacity of human beings to act courageously and effectively to prevent human rights violations, to protect others from human rights violations and their psychiatric consequences, and to help victims recover from human rights abuses.

Nomination letters should succinctly describe the contributions that are the basis for the nomination and be accompanied by the individual's curriculum vitae or the organization's mission statement.

The recipients will receive a plaque at the Convocation of Fellows at APA's 2009 annual meeting. APA's Council on Global Psychiatry will determine the recipients of the award.

The deadline for nominations is August 15. Nomination materials should be sent by mail to the Office of International Activities, APA, 1000 Wilson Boulevard, Suite 1825, Arlington, Va. 22209; by fax to (703) 907-1087; or by e-mail to internationaloffice@psych.org. ■

Prevention

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jects aged 70 years or older and with a family history of Alzheimer's to one of three treatment arms—200 mg of celecoxib twice daily, 220 mg of naproxen twice daily, or a placebo. The researchers followed the subjects for three years to see whether those getting either celecoxib or naproxen were better protected against Alzheimer's than those getting a placebo.

The answer was no, the researchers found. In fact, there was weak evidence that the cognitive function of the naproxen group was inferior to that of the placebo group. Thus, neither celecoxib nor naproxen appears to shield people against Alzheimer's, Martin and her group concluded in their study report, which was posted May 12 on the *Archives of Neurology* Web site.

All three studies were financed by the National Institutes of Health.

An abstract of "Change in Depressive Symptoms During the Prodromal Phase of Alzheimer Disease" is posted at <http://archpsyc.ama-assn.org/cgi/content/abstract/65/4/439>. An abstract of "Protective Effects of NSAIDs on the Development of Alzheimer Disease" is posted at <www.neurology.org/cgi/content/abstract/70/19/1672>. An abstract of "Cognitive Function Over Time in the Alzheimer's Disease Anti-Inflammatory Prevention Trial (ADAPT)" is posted at <http://archneur.ama-assn.org/cgi/content/abstract/2008.65.7.nct70006v1>. ■

Accidents

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risk due to side effects. But they found this to be true only for the newer antidepressants.

So, what to make of these results? "First of all, we found only a slight increase in traffic-accident risk for patients on antidepressants," Bramness said. "The risk was much lower than for drugs like benzodiazepines, opioid analgesics, or carisoprodol (Soma). Still, physicians should be aware that patients on antidepressants may be at a higher risk of being involved in traffic accidents. This is not a reason for not giving antidepressants, and we cannot say on the basis of this research if one drug is better than the other. It may be wise to discuss driving with your patients. If they are still depressed or feel incapacitated by the medication, they should have someone drive them."

There was no outside funding for the study.

An abstract of "Minor Increase in Risk of Road Traffic Accidents After Prescriptions of Antidepressants: A Study of Population Registry Data in Norway" is posted at <www.psychiatrist.com/abstracts/abstracts.asp?abstract=oap/ej07m03661.htm>. ■

Parenting

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Thus, it looks as if certain factors that a child experiences during his or her first year of life can impact mental health during the second year of life, Skovgaard and her team concluded. Further research in this growing field of infant and toddler psychiatry will lead to innovative ways to treat and prevent mental illness in the very young, the researchers said.

An abstract of "Predictors (0-10 Months) of Psychopathology at Age One-and-a-Half Years—A General Population Study in the Copenhagen Child Cohort CCC 2000" is posted at <www.blackwell-synergy.com/loi/jcpp>. ■

States

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risk, unhealthy behaviors and activities.

The number of individuals completing the surveys in the two study periods ranged from a low of 98,619 in 1993 to a high of 334,606 in 2006. Those surveyed in both study periods (totaling 2.5 million individuals) were asked a series of validated, health-related, quality-of-life questions. As one example related to mental health, one of the questions asked each respondent to estimate if "for 14 or more days out of the previous 30 days you felt your mental health—including stress, depression, and problems with emotions—was not good."

The results of this question were analyzed and mapped by state to track the self-perceived FMD across the country (see accompanying map).

Chapman said that the finding most striking to him and his colleagues wasn't the expected though slight rise in FMD in New York and the Washington, D.C., metropolitan area following September 11, 2001. Rather, "There appears to be some patterns of relatedness between FMD and the 'stroke belt,' " said Chapman. "That's a geographical area in the U.S. that roughly follows the Mississippi Valley and Appalachian mountain range. That's because there appears to be a higher prevalence of stroke in those regions," he said, drawing on federal reports and academic studies. "However," Chapman noted, "the etiologic parallels of FMD and the stroke belt are strictly speculative at this point."

According to the literature, one of the most difficult health statistics to nail down is the prevalence of "mental disorders," given the breadth and complexity and sheer number of disorders inherent in that single term. Thus, most rates are typically estimates, and they can vary widely.

Chapman acknowledged this and said the weakness of the study is the construct of FMD, which they used to define the prevalence. FMD, he said, is a nonspecific measure that is self-reported; thus it relies on the subjective perceptions of the survey respondents without benefit of independent validation via medical and psychiatric assessments.

Even so, Chapman noted that "surveillance of FMD can be useful in identifying [geographical] regions characterized by unmet needs and disparities, targeting interventions, and evaluating programmatic interventions over time."

Data from the CDC's 1993-2006 Behavioral Risk Factor Surveillance System can be accessed by clicking on topic choice at <http://apps.nccd.cdc.gov/HRQOl/index.asp>. ■

Association News

Nominations Invited for Weinberg Award

The APA Council on Aging invites nominations for the 2009 Jack Weinberg Memorial Award for excellence in the field of geriatric psychiatry.

Established in 1983 in memory of Jack Weinberg, M.D., this award honors a psychiatrist who has demonstrated special leadership or who has done outstanding work in clinical practice, training, or research in geriatric psychiatry.

Candidates for the Weinberg Award must be psychiatrists who are nominated by an APA member. Nominations must consist of nomination letter summarizing the accomplishments of the nominee, two additional letters of endorsement by APA members, and a current curriculum vitae including bibliography.

The selected individual will receive a plaque at the APA Convocation and a $500 honorarium. Current members of the Council on Aging and its components are not eligible.

Nomination materials should be mailed to APA, Department of Government Relations, Attn: Clare Koller, 1000 Wilson Boulevard, Suite 1825, Arlington, Va. 22209.

The deadline for submissions is July 31. More information is available by contacting Koller by phone at (703) 907-8643 or by e-mail at ckoller@psych.org. ■

Erratum

The person in the top photo on page 17 of the June 6 issue was misidentified. He is Jon Davine, M.D., not Harvey Fernbach, M.D. *Psychiatric News* apologizes to both psychiatrists. ■

med check

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This poster was presented by Graham Emslie, M.D., from the University of Texas Southwestern Medical Center, and colleagues. Forest Laboratories plans to file an application with the Food and Drug Administration (FDA) to seek approval for escitalopram as a treatment for adolescent depression, according to the online newsletter FDANews.com in May. Fluoxetine is the only antidepressant approved by the FDA to treat depression in children and adolescents.

• The first randomized, controlled, single-blind study of implanting a ***cortical stimulation device*** in the left dorsal, lateral prefrontal cortex (DLPFC) in 12 patients with refractory depression suggests that cortical stimulation may be a treatment option that deserves further research. Robert Howland, M.D., at the University of Pittsburgh Medical Center, and colleagues from other institutions performed a feasibility study in 12 patients with severe, treatment-resistant depression who had been ill for 11 to 42 years and had failed seven to 13 courses of treatments, including 10 patients who had failed electroconvulsive therapy. An epidural electrode was implanted in the left DLPFC in each patient. The patients were randomly assigned to single-blind active or sham stimulation for eight weeks; after that all received active stimulation.

At the end of eight weeks, patients who received active stimulation (n=6) had a mean decrease of 22 percent in the HAM-D score, compared with an 8 percent decrease in HAM-D score in the sham group (n=5). "Preliminary results indicate that . . . cortical stimulation may have a treatment effect that . . . increases over time" beyond eight weeks, when all patients received active stimulation, the researchers noted. No serious adverse event related to the device was reported. The study was funded by Northstar Neuroscience, which developed the stimulation device.

• An open-label clinical trial of ***deep brain stimulation*** (DBS) conducted at three sites in Canada provides further support for the efficacy of DBS against treatment-resistant, severe depression. The results of this trial in 20 patients duplicate the findings from a previous pilot study by Helen Mayberg, M.D., and colleagues (*Psychiatric News*, June 23) that used the same method. Electrodes were surgically implanted in the subgenual cingulated cortex Brodmann area 25 (Scg25) on both sides of the brain, so that the white matter in this region received constant electrical currents. Study participants had all failed at least four treatments including cognitive-behavioral therapy and had a mean baseline HAM-D score of 28.

Sixteen patients had completed six months of continuous DBS at the time results were reported. Nine (56 percent) of the 16 patients achieved response, defined as a 40 percent reduction in HAM-D score. Three patients had so far achieved remission, defined as a HAM-D score of 7 or less. Two serious adverse events due to broken wires (which connect the stimulator in the brain and the battery in the chest) were reported. One completed suicide and one suicide attempt were judged by the clinicians as not related to the device. The majority of reported adverse events were mild; headache was the most common. The researchers, led by Sidney Kennedy, M.D., at the University Health Network (affiliated with the University of Toronto) and Mayberg, concluded that there were "no unexpected device-related adverse events" and "no acute stimulation-related adverse events."

The trial was supported by the St. Jude Medical ANS Division. ■