



Psychiatric Research Report

DSM-V Prelude

HOME TIMELINE RESEARCH ACTIVITIES SUGGESTIONS REGISTER LOGIN

DSM-V Prelude Project: Research and Outreach

APA has launched a new Web site designed to keep mental health professionals and the public informed about research and other activities related to *DSM-V*, the next revision of the *Diagnostic and Statistical Manual of Mental Disorders*. The site and associated links can be accessed at www.dsm5.org [see inset].

QUICK LINKS

- [DSM-V Timeline](#)
- [DSM-V Research Planning Activities](#)
- [DSM-V Research Planning Activities](#)
- [Comments on DSM-IV/Suggestions for DSM-V](#)
- [Register for DSM-V Newsletter](#)
- [DSM-IV-TR Web Page](#)

“Future of Psychiatric Diagnosis: Refining the Research Agenda.” As described more fully in the Winter 2004 issue of the *Psychiatric Research Report* (available online), the conference series was designed to “address an array of nosological topics deemed either to be particularly problematic in the current classification or most likely to benefit from new and emerging research capabilities and methodologic techniques.”

The new site is called **“DSM-V Prelude Project: Research and Outreach.”** It was designed and continues to be directed by Michael B. First, M.D., associate professor of psychiatry at Columbia University, and a consultant to APA on *DSM* activities. The site was developed under the auspices of APA’s Division of Research, led by Darrel A. Regier, M.D., M.P.H.

The purpose of the Prelude Project is to provide an opportunity for all *DSM* users to participate in the earliest stages of the process to revise the current manual. The revision is slated to begin formally in 2007, and publication of the revised manual is projected for 2012.

According to Dr. First, “We intend the *DSM* Prelude Project site to promote and facilitate an ongoing dialogue between APA and *DSM* users.” Toward that end, the site offers an “Outreach” section and a “Research” section.

The Outreach section allows *DSM* users to be a part of the *DSM-V* development process by providing a mechanism to submit comments about problems with *DSM-IV-TR* and suggestions for *DSM-V*. All suggestions will be entered into the *DSM-V* Prelude data base for eventual referral to relevant *DSM-V* Work Groups.

The “Research” section provides a venue for continuous updates on APA’s research activities in relation to *DSM*. Foremost among these research activities is the series of eleven research planning conferences launched in 2004 under the collective rubric

The conference series is organized and administered by APA’s research arm, the American Psychiatric Institute for Research and Education (APIRE) under a five-year, \$1.1 million cooperative grant jointly funded by the NIMH, NIDA, and NIAAAA. The purpose of each conference, according to Darrel Regier, Executive Director of APIRE, is to “stimulate empirical research in advance of the formal revision, and develop alternative research criteria for investigations into the etiology and pathophysiology of disorders. Regier continued to clarify, “Whereas much prior nosologic research has concentrated on the reliability of diagnostic criteria, the next challenge will be to study the validity of disorders by linking them to pathophysiology.”

One of the primary reasons for establishing the Prelude Project Web site, explained the site’s director, Michael First, was to share with the field at large the proceedings for each of the ten diagnosis-related conferences. Plans call for a summary of each conference to be posted in the “Research” section of the Prelude Project Web site soon after the proceedings conclude.

Accompanying this introduction to the Prelude Project is a summary of the first substantive conference, that on Personality Disorders. The summary was prepared by Dr. First and approved by the *DSM-V* Steering Committee in late January. In accord with the goals of Prelude, the summary will also appear on the Web site. ■



Psychiatric Research Report

In This Issue

DSM-V Prelude Project:
Research and Outreach Page 1

Dimensional Models of Personality Disorder
Etiology, Pathology, Phenomenology and Treatment Page 3

DSM-V Timeline Page 5

From the Committee on Research Training
“Knowing is Not Enough” Page 6

Building Research Careers
The K Years – Don’t Miss Out on the Fun Page 8

Society of Biological Psychiatry Page 10

APA Practice Guideline – ASD and PTSD
Future Research Needs Page 12

News and Notes Page 17

APA Institute for Psychiatric Services Page 19

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Dimensional Models of Personality Disorder

Etiology, Pathology, Phenomenology, and Treatment

A Summary prepared by Michael B. First, M.D.

The first of ten diagnosis-related conferences in the research planning series "Future of Psychiatric Diagnosis: Refining the Research Agenda," was held December 1–3, 2004, at the American Psychiatric Association headquarters in Arlington, VA. This significant initial meeting focused on the diagnosis and classification of Personality Disorders in future diagnostic classifications (*DSM-V* and *ICD-11*), and was accordingly titled, "Dimensional Models of Personality Disorders: Etiology, Pathology, Phenomenology, and Treatment."

The conference was co-chaired by Thomas A. Widiger, Ph.D., from the University of Kentucky, in Lexington, Kentucky, and by Erik Simonsen, M.D., of the Institute of Personality Theory and Psychopathology, Psychiatric Hospital, Fjorden, Denmark. Twenty-three invited participants, U.S. as well as international, presented papers and/or served as discussants.

Background

Both the *DSM-IV* and the *ICD-10* use a categorical model for psychiatric diagnoses: a patient either has or does not have Schizophrenia, Bipolar Disorder, etc. Categorical models of classification are used not only in making diagnoses of mental disorders but also for diagnosing medical conditions (a patient either has or does not have pulmonary tuberculosis), for classifying living organisms into families, genera, and species, and for virtually any other activity that involves classifying objects or concepts into types.

Although categorical classifications work well in terms of modeling how clinicians think about disorders and diseases, they have many properties that deviate from the actual presentations of psychiatric symptoms. For example, categorical systems assume that clear boundaries delineate one condition from another and distinguish disorder from normality, as exemplified by the use of "symptom thresholds" to determine the presence or absence of disorder (5 or more symptoms out of a list

of 9 indicate the presence of a Major Depressive Episode whereas 4 or fewer indicate its absence). In fact, most psychiatric symptoms, like those characteristic of depression, occur on a continuum without any clear demarcations between disorder and normality. A classification that describes a disorder in terms of points on a diagnostic continuum is referred to as a "dimensional approach."

The issue of how best to model psychiatric disorders (categorical, dimensional, or some combination of the two) applies to all disorders in *DSM-IV* and *ICD-10*, but the problematic nature of the categorical approach is most evident in the diagnostic classification of personality disorders. As noted in the 2002 publication "*Research Agenda for DSM-V*" (Kupfer, First, Regier, eds.), there is widespread dissatisfaction among both clinicians and researchers with the current categorical system for personality disorders. The current system asks the practitioner to determine whether an individual's personality manifestations meet diagnostic criteria for one or more specific *DSM-IV* personality disorders (such as borderline, obsessive-compulsive, and/or paranoid personality disorder), thus leading to an array of potential problems, including but not limited to the following:

- 1) Severely ill inpatients often meet criteria for three, four, five, or even more *DSM-IV* personality disorders;
- 2) Outpatients often do not meet the criteria for *any* of the specific categories, requiring instead the use of the non-specific diagnosis, Personality Disorder Not Otherwise Specified (PDNOS);
- 3) Patients with the same diagnosis vary substantially with respect to the diagnostic criteria used to make the diagnosis, so that two patients with the same diagnosis can look very different;
- 4) The diagnostic thresholds separating normal from disordered are unstable, so that the disorder can appear to come and go over time;

5) The absence of a developing scientific base for a number of the diagnostic categories (e.g., histrionic, paranoid, schizoid, and obsessive-compulsive personality disorders) contributes to the difficulty of substantiating diagnoses in these categories.

Dimensional models of personality functioning and disorder have been studied for a number of years. In fact, during the *DSM-IV* deliberations, adoption of a dimensional model for personality disorders was considered but ultimately rejected. Among the perceived problems were the number of competing and incompatible models that had been proposed by the research community, the lack of empirical data regarding the validity of the proposed models, and questions about the clinical utility of a dimensional system.

The goal of the conference held in December 2004, therefore, was to stimulate research toward the development of a dimensional model of personality disorder that would have a strong empirical foundation with respect to: behavioral genetics, neurobiological mechanisms, childhood antecedents, cross-cultural application, continuity with the rest of the diagnostic manual, coverage of clinically relevant maladaptive personality functioning, diagnostic thresholds, and treatment implications.

Proceedings of the Conference

The conference began with a presentation by Erik Simonsen, M.D., outlining limitations of the categorical model for personality disorders (as described above).

Thomas Widiger, Ph.D., then presented historical efforts at dimensional models of personality that included the: three-factor model of Eysenck; five-factor model of Zuckerman; twenty-four traits and four dimensions of Tyrer; three-polarity model of Millon; seven factor model of Cloninger; three-factor model of Tellegen, Watson, and Clark; five-factor model of Costa and

(continued on next page)

McCrae; and the interpersonal circumplex model. Widiger called for an integration of the various alternative dimensional models, pointing out most of the models share common higher-order domains that could allow for integration into a unified four or five factor hierarchical model. Further, Widiger indicated how the existing *DSM-IV* personality disorder criteria could be integrated within this common hierarchical model.

Lee Anna Clark, Ph.D. (Iowa City, Iowa), John Oldham, M.D. (Charleston, S.C.), and Professor Charles Pull (Luxembourg), served as discussants for these two initial presentations.

W. John Livesley, M.D. (Vancouver, Canada), delivered the next presentation on the "Behavioral and Molecular Genetic Contributions to a Dimensional Classification of Personality Disorder." Livesley noted that although it may make sense for future classifications (*DSM-VI* and beyond) to incorporate a provision for encoding genotypes associated with the increased likelihood of personality disorder, there is currently very limited data supporting a relationship between genetic polymorphisms and personality traits; of these the effects are small and relatively non-specific. Livesley presented the behavioral genetic research that seeks to explicate the genetic and environmental structure underlying phenotypic variation. He concluded that it is possible to construct an etiologically-informed dimensional classification and that genetic methods can help in integrating the different dimensional schemes that have been proposed.

Peter McGuffin, M.D., Ph.D. (London, UK), and Benjamin Greenberg, M.D., Ph.D. (Providence, Rhode Island), served as discussants.

Joel Paris, M.D. (Montreal, Canada) presented on the neurobiological dimensional models of personality, specifically reviewing the models of Cloninger, Depue, and Siever. He concluded that associations between dimensional trait measures and specific neurobiological measures remain ambiguous, with the exception of a robust link between serotonin and impulsive aggression or harm avoidance. Paris postulated that our understanding of the neuroscience of emotions and behaviors is currently at too early a stage to establish associations between dimensions and biological markers; he called for future research to help further elucidate the relationship between neurobiology and emotions.

Robert Cloninger, M.D. (St. Louis, MO), and Professor Peter Tyrer (London, UK), were the discussants for this presentation.

Ivan Mervielde, Ph.D. (Gent, Belgium), presented "Childhood Antecedents and Developmental Psychopathology." He first reviewed the evidence for a dimensional presentation of childhood temperament and personality. Mervielde then proposed that four broadband dimensions capture individual differences of personality in children and adolescents: extraversion, emotional stability, agreeableness, and conscientiousness; two dimensions describe childhood psychopathology: externalizing and internalizing; and these personality and psychopathology dimensions can be related to each other using a hierarchical model.

Rebecca Shiner, Ph.D. (Hamilton, NY), served as discussant.

Dr. Juri Allik (Tartu, Estonia) presented on "Personality Dimensions Across Cultures." He reported studies examining personality

dimensions measured in a wide variety of cultures and languages. Although such data remain limited, the data support the hypothesis that covariation among personality traits is universal and extends across languages and cultures, including both Western and non-Western. Mean trait scores did vary across cultures, although cross-cultural differences accounted for only a third of the magnitude of individual differences within a culture. Allik noted that this small-magnitude cross-cultural difference suggests the possibility of achieving a reasonable scalar equivalence irrespective of language and culture.

Michael Ashton, Ph.D. (St. Catherine's, Canada), Juan Lopez-Ibor, M.D. (Madrid, Spain), and Yueqin Huang M.D., Ph.D. (Beijing, China), served as discussants.

Robert Krueger, Ph.D. (Minneapolis, MN), addressed the continuity of Axis I and Axis II disorders. Krueger began by reviewing the putative differences between Axis I and Axis II disorders, concluding that they are more similar than distinct. He hypothesized that the connection between Axis I and Axis II disorders may be provided by a focus on how each is related to the underlying structure of personality. Krueger proposes a hierarchical structure of mental disorders that integrates the psychopathology represented by Axis I disorders with personality traits. The proposed hierarchy consists of two higher-level factors (externalizing and internalizing), five mid-level dimensions (corresponding to those in the five factor model), and lower order facets.

Tracie Shea, Ph.D. (Providence, RI), David Watson, Ph.D. (Iowa City, Iowa), and Deborah Hasin, Ph.D. (New York, NY), were the discussants for this presentation.

Timothy Trull, Ph.D. (Columbia, MO), described two major challenges that must be addressed by dimensional models if they are to be considered viable alternatives to the categorical system: *coverage* (whether the system adequately characterizes conditions encountered in clinical practice) and *cutoffs* (whether the system adequately indicates the points at which personality pathology is sufficiently severe to warrant clinical attention). He first compared coverage of several dimensional systems by noting their relationship to *DSM-IV* personality disorder categories as well as their content validity. Trull proposed that the four higher-order dimensions these systems have in common support the possibility of integration. He then reviewed general issues for determining whether a personality disorder is present (including statistical deviance and consequent dysfunction and impairment). Evaluating several proposals for the use of dimensional models to diagnose personality disorder, Trull recommended that future research focus on how best to define clinically significant dysfunction.

Drew Westen, Ph.D. (Atlanta, GA), Paul Costa, Ph.D. (Baltimore, MD), and Carl Bell, M.D. (Chicago, IL), served as the discussants.

Roel Verheul, Ph.D. (Halsteren, Netherlands), delivered the final presentation of the two-day conference, covering the "Clinical Utility of Dimensional Models of Personality Pathology." He argued that a dimensional diagnostic system will substantially improve clinical utility, especially with respect to coverage, reliability, subtlety (level of detail and richness), and clinical decision making. Verheul notes, however, that any future dimensional model cannot entirely replace a categorical system, which will

continue to be needed for legal, medical, and administrative purposes.

Erik Simonsen (Denmark) and Theresa Wilberg (Oslo, Norway) acted as discussants.

Concluding session

The conference concluded with a discussion of various research strategies that will enrich the empirical base for making future decisions about the classification of personality disorders.

Coming up

Complete versions of the presentations summarized above are scheduled to be published in a special edition of the *Journal of Personality Disorders*. In addition, a future monograph, to be published by American Psychiatric Publishing, Inc., will include both the main presentations and the discussant responses.

NEXT CONFERENCE

Diagnostic Issues in Substance Use Disorders
February 14 -17, 2005
Co-Chairs: John Saunders, M.D.
Marc Schuckit, M.D. ■



DSM-V Timeline

- 1999-2005** Development of DSM-V Preplanning White Papers
- 2002** Publication of "A Research Agenda for DSM-V" (monograph containing six white papers)
- 2004-2005** Publication of additional DSM-V Preplanning White Papers
- 2004-2007** Review data from the 10 APA/NIH-sponsored conferences on "The Future of Psychiatric Diagnosis: Refining the Research Agenda"
- 2007*** Appointment of DSM-V Workgroups
- 2012*** Publication of DSM-V

*These dates are tentative; although these events will not occur any earlier, they could occur later.

From the Committee on Research Training



“KNOWING IS NOT ENOUGH, WE MUST APPLY”

Leonardo DaVinci

Michele T. Pato, M.D.

Chair, APA Corresponding Committee on Research Training
VA Medical College, Washington, D.C.
SUNY Upstate Medical University/Syracuse

Throughout its 15-year history, the APA Committee on Research Training (CRT) has promoted and supported medical students, residents, and junior faculty in the pursuit of research careers. A primary focus of these efforts has been the Junior Investigators Colloquium, now in its 10th year and renamed the Early Career Investigators Colloquium.

Within the past several years, the Committee's interest in training physicians with increased capabilities in conducting, understanding, and applying research has become a more prominent concern within medicine, generally, and specifically within the field of psychiatry. Various themes on these emergent issues are given voice in the Winter 2004 issue of the journal *Academic Psychiatry*, Laura W. Roberts, M.D., Editor-in-Chief.

The Winter issue focuses simultaneously on the obstacles facing women striving to build careers, especially research careers, in academic psychiatry and on the obstacles facing academic psychiatry striving to make a transition to the universe of evidence-based medicine. The journal brings together a brilliant array of articles, commentaries, and analyses that clearly reflect the areas common to both endeavors.

In the introductory editorial, **Coverdale, Roberts, and Louie** speak to the established place of four related concepts in residency training: research literacy; critical appraisal skills; evidence-based medicine; and practice-based learning. They assert that “These linked endeavors in residency training serve to affirm, anchor, and advance the scientific basis of the field of psychiatry.” Yet, we do not yet understand enough about how to teach the skills required for proficiency in these four concepts, nor do we know how to scale the barriers to integrating these initiatives into residency training. “Committing to the scientific basis of the field of psychiatry,” the authors conclude, “also entails a commitment to the enhanced rigor of our educational programs, practices, and related research endeavors.”

Fenton, James, and Insel* take this mandate further by linking the future of psychiatry to the training of physician scientists as well as research-literate clinicians. Documenting revolutionary advances in brain science over the past two decades, the authors call attention to the unchanged practice of clinical psychiatry in the same period of time. With the exclusion of continuously refined pharmaceutical inventiveness, the “stunning advances we have seen in basic neuroscience have yet to be translated into innovations in clinical care.” The urgent need, in the 21st century, to simultaneously produce physician scientists, who can transform neuro-

science advances into improved treatments, and research-literate clinicians, who can assure the delivery of science-based care, motivates a NIMH prescription for the “rethinking and reform” of psychiatric residency training.

Two concepts are central to the NIMH prescription:

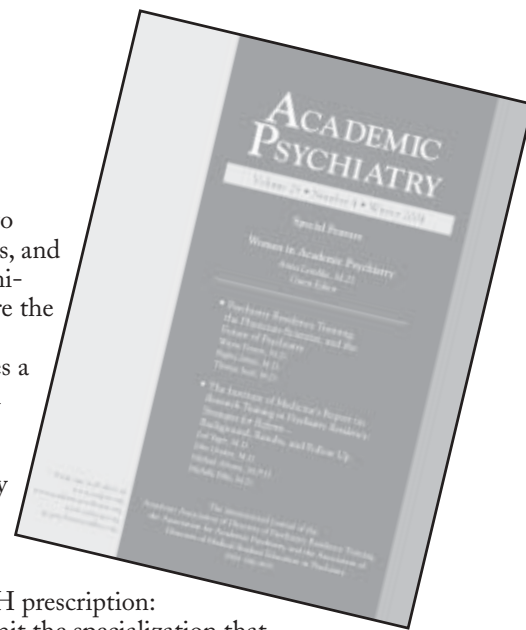
1) *flexibility*, to permit the specialization that will allow indepth training in key areas currently competing for time and resources within residency programs (such as patient-oriented research, child and adolescent, geriatric, and public sector psychiatry), and 2) *evidence-based medicine*, the principal concept upon which all residency training should be based.

These key concepts, in turn, derive from the NIMH-commissioned Institute of Medicine (IOM) report, *Research Training in Psychiatry Residency: Strategies for Reform*, described by **Yager, Greden, Abrams, and Riba**. This original article recaps the background and results of the IOM study and outlines, in compelling detail, the implementation efforts of the National Psychiatry Training Council (NPTC) formed to avert the fate of previous IOM reports and recommendations that have languished due to the absence of mandated follow up activities.

Special Feature

All of the articles in the Special Feature, “Women in Academic Psychiatry,” allow the explicit link to be made between the unfulfilled need for physician scientists and the underutilized resource represented by women psychiatrists in academia.

Anna Lembke, Guest Editor for the Special Feature on women, cites statistics to support an assertion that could turn out to be the foundation for future remedies and realignments. “The increasing number of women entering [medicine and] psychiatry has positively impacted academic psychiatry.” Yet, “the bad news,” confirmed and elaborated throughout the Special Feature, is that more women has not translated into more promotions, more full-professors, more chairs, more deans, more women funded as principal investigators. A domino effect perpetuates the dilemma,



of course, by failing to produce more female mentors and role models. Lembke makes a realistic case for the power of a female mentor on potential acolytes, presumably male as well as female students. **Bogan and Safer** also expound on the benefits of mentorship in residency training citing a study that demonstrates “a significant association between having a mentor of either sex during training and number of publications, time spent on research, and career satisfaction.” However, they continue, “it is possible that mentorship with respect to personal development and balancing family and career may be more effective from same-sex mentors or role models.”

Janet Bickel confirms the differential effect of male vs. female mentors and lends credence to the idea that the paucity of female mentoring and role modeling contributes substantially to the failure of women to progress sufficiently in academic ranks. Bickel cites evidence that in the past 15 years – 15 years – the percentage of women faculty achieving the rank of full professor has increased by only *one percent* (1%). She analyzes the contribution to this alarming statistic made by stereotypic and powerful “mental models of gender,” concluding that in order to be judged professionally competent, women must work more than twice as hard as men: “An analysis of peer review scores for postdoctoral fellowship applications revealed that female applicants had to be 2.5 times more productive than the average man to receive the same competence score.”

Deborah Hales applies these concerns more specifically to the confines of the academic research enterprise. “Evidence-based research, the mantra of modern medicine, will help transform psychiatry into a 21st century clinical science,” she asserts. And within the academic world, where the increased presence of women is remarkable primarily in terms of numbers, rather than status, “research is the currency for advancement.” Yet, warns Hales, “Questions of gender equality are even more daunting in the area of psychiatric research.” Within academia, she fears, women psychiatrists will tend to “populate the ‘clinical educator’ tracks rather than the research tenure tracks,” to the detriment of science as well as future generations of academicians.

Garfinkel et al., provide survey data to support Hales’ fears. Citing studies carried out both in the United States and Canada, the authors report that men are more likely than women to have research training, to become principle investigators on (peer-reviewed) research grants, to publish in scientific journals, and to receive pharmaceutical funding.

Each of the articles presented in this Special Feature addresses the stresses facing women who struggle to balance residency and early career with childbearing, family responsibilities, and personal time. **Silvia Olarte**, following a sample of women trying to “negotiate their multiple roles,” reported that compromise is the rule in making professional choices, resulting in the tendency to choose private practice over academia for the advantage of flexibility.

Jonathan Borus, chair of psychiatry at Brigham and Women’s/Faulkner Hospitals, describes his efforts to counter these stresses (at the departmental level) and to deal directly with the increasing numbers of residents and academic women who must negotiate the biological, social, and economic realities of their multiple roles.

Borus asserts that medicine, in general, and psychiatry, specifically, must embrace structural change to avoid the consequences of impending losses: “Organized medicine...cannot afford to lose one-half of its workforce. Similarly, academic psychiatry cannot afford to have some of its best and brightest stop focusing on the pressing problems of our field and leave academia for private practice.”

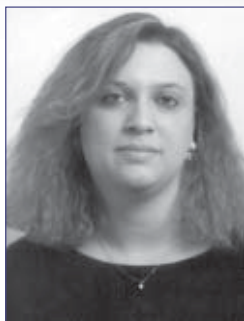
Academic institutions must not only accommodate but *value* part-time work, job sharing, pregnancy, balanced lifestyles for both male and female physicians. Implementing these goals will require new ideas for funding and structuring promotion timelines, tenure tracks, administrative and clinical responsibilities, as well as supplemental training for mid-life re-entry to academic careers. Borus cites changes to accommodate the 80-hour work week in residency training as an example of the need and the ability to change.

On the subject of ‘change,’ Janet Bickel, in her article on “Women in Academic Psychiatry,” cautions that simply studying and issuing reports on the problem does not bring about reform. “Improvements to complex systems do not occur naturally or develop out of the coping mechanisms of isolated individuals.” **Michele Pato** makes a case for bringing about change at the local level rather than waiting for policy changes at the university or national level. An analogy is made to the research process itself: “Any large experimental undertaking begins with pilot data, results from a single patient, or a single probe of a single neuron. Then the hypothesis is expanded into a small sample of subjects or a different set of cells to see if it still applies, and then the larger study is proposed.”

Just such a local effort, implemented in the residency program at Thomas Jefferson University, is described in a Letter that concludes the Winter 2004 issue of *Academic Psychiatry*. A required research rotation (one day per week for seven weeks) for PGY-3 residents resulted in four of the five residents who completed the rotation electing to continue their research projects as an elective in the fourth year of training. The program captures Pato’s concept of pilot programs at the local level, thus implementing the Leonardo DaVinci imperative quoted as the title to this article: “*Knowing is not enough, We must apply!*” ■

* National Institute of Mental Health

Building Research Careers



The “K Years”

Don't Miss Out on the Fun

Melissa P. DelBello, M.D.
Department of Psychiatry
University of Cincinnati College of Medicine

In previous issues of this newsletter* we discussed the K (career development) award application process. Perhaps, hearing what life is like once you have been granted a K award will motivate some junior faculty interested in a research career to apply. Typically, a K award is granted for 4 or 5 years, the “K years.” These “K years” are unique in that they provide an opportunity to learn, be productive, and enjoy research without the burden of worrying about salary support. There are certain do’s and don’ts that I have found helpful to get the most out of these years.

DO set limits.

DON'T get overwhelmed with administrative, clinical and teaching duties.

It is very easy to get pulled in many different directions as a junior faculty member at an academic institution. There are medical students and residents to teach, committees that always need “energetic” junior faculty to serve on them, and administrative and clinical obligations that need to be fulfilled. Although some amount of clinical, teaching, and committee work is important to advance your academic career, if you don't learn to set limits these responsibilities can monopolize your time. How then does one go about setting limits?

When approached about becoming a member of a local, regional, or national committee, it is very useful to talk to an existing committee member about the required time commitment before agreeing to participate. Once you have agreed to participate, it is often too late to renege. Offer to become an *adjunct* committee member, which allows you to participate in the cause but requires less time.

Teaching medical students and resident classes is important but initially requires a lot of preparation time. However, as you teach the material more frequently, the preparation time becomes shorter which helps to minimize the time commitment. While developing new material, therefore, agree to only one commitment at a time.

In psychiatry, there are too many patients and not enough psychiatrists. It can be very difficult, therefore, to set limits on time spent in clinical activities, since that is why most of us went to medical school in the first place. It is very helpful to have a mentor who is

willing to support your limit setting. Alternatively, your K award can be useful for this purpose. For instance, it is much easier to say that your mentor or the government (which is paying your salary through the K award) will not support your participation in another committee, allow you to take on more clinical time, or spend any more time teaching, than it is to say you don't have any more time. One strategy to maximize the time spent with administrative duties is to combine efforts: teach medical students and residents while they rotate with you during your clinical time, this way you can kill two birds with one stone.

DO set research priorities.

DON'T let others convince you of what your priorities should be.

Eager early career researchers commonly become interested in many research questions, which can quickly lead to losing focus. It is also common for senior investigators to entice K awardees to participate in their research efforts. A balance between establishing successful collaborations and staying focused on your research interests is optimal. Although it is easy to obsess about the specific details of a particular research project, examine the “bigger picture” by setting weekly, monthly, and yearly research goals; this can be a helpful strategy to maintain an overall perspective on *your* research priorities. An occasional glance at the career and research plans of your K award may also stimulate your ability to refocus. Similarly, although it is tempting to write chapters or reviews, this requires a large time commitment and distracts from reaching your research goals.

DO set goals.

DON'T set unobtainable goals.

One approach to maintaining focus and juggling the many demands of your K years is to set short-term and long-term research and professional goals. The annual progress report for your K award helps to set yearly goals, but it is also important to set realistic short-term goals to avoid becoming discouraged and frustrated with your academic career when you don't meet unrealistic deadlines. Submitting a manuscript every two weeks may be an overly optimistic goal, but setting a realistic manuscript deadline and then meeting that deadline only encourages further productivity.

*see PRR Fall 2003, www.psych.org/research/dor/prr/index.cfm

Balancing coursework, patient care, research, and teaching obligations can be difficult. By setting short-term and long-term goals in each of these areas you can maximize your time and minimize your effort. If you set clear goals during your K years, you will also learn to set limits.

DO enjoy your work.

DON'T stay in an unhappy situation.

While it is important to maintain your focus and organize your time during the K years, it is also a great time to explore new opportunities. Explore and develop new but related research and academic interests. This is a unique opportunity to get paid to take classes and to learn useful tools for your career, such as research design, statistics, and ethics. Take advantage of this opportunity. Unfortunately, I have encountered several colleagues who, unhappy with their current work situation, have stayed on aimlessly drifting

through their K years and struggling in their post-K years. In order to be maximally productive during your K years, it is essential to enjoy the work and have productive collaborations with colleagues. There are many job opportunities for junior faculty in academic psychiatry, so don't waste your time in an unhappy situation.

Concluding your K years

Unfortunately, all good things must come to an end, and we must ultimately ask, "Is there life after a K award?" The answer is both "yes" and "no." I have seen careers develop in both ways. There are those who submit three successful RO1 applications in the first post-K year, and then there are those who pursue alternative career paths.

In either case, the "K years" are a luxury. Use them to learn, be productive, establish collaborations, *and* to have fun. ■

At the Annual Meeting...

Dr. DelBello will present at the following scientific sessions in Atlanta

■ **Bipolar Disorder From Adolescence to Adulthood**

Industry-Supported Symposium

Saturday, May 21, 6 – 9 p.m.

■ **Psychopathology of Children at Risk for Bipolar Disorder**

New Research Young Investigator Poster Session

Monday, May 23, 9 – 10:30 a.m.

■ **Pharmacological Treatment Options for Children and Adolescents With Bipolar Disorder Symposium**

Monday, May 23, 2 – 5 p.m.

■ **Obstetrical Complications in Children at High Risk for Bipolar Disorder**

New Research Poster

Tuesday, May 24, 3 – 5 p.m.

■ **Quetiapine Efficacy in Bipolar Adolescents With Depressive Symptoms**

New Research Poster

Tuesday, May 24, 3 – 5 p.m.

■ **Pediatric and Adult Bipolar Patients: Neuroimaging and Pharmacological Differences Symposium**

Wednesday, May 25, 2 – 5 p.m.

SOCIETY of BIOLOGICAL PSYCHIATRY

60TH Annual Convention & Scientific Program

Pathogenesis and Prevention of Major Mental Disorders

May 19th – 21st, 2005



Sheraton Atlanta Hotel
Atlanta, Georgia

Freshest Data Sessions

The Freshest Data Session will provide an opportunity to submit an abstract for oral presentation of cutting-edge data on Friday, May 20, 2005. Submit abstracts beginning February 14, 2005. Abstract deadline is March 14, 2005.

Registration Materials and Resources

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- Registration Form
- Program (Preliminary)
- Poster Instructions
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APA Practice Guideline for the Treatment of Patients With Acute Stress Disorder and Posttraumatic Stress Disorder

Robert Kunkle, M.A.
Senior Program Manager
Practice Guidelines
American Psychiatric Association

Future Research Needs

Practice Guideline for the Treatment of Patients With Acute Stress Disorder and Posttraumatic Stress Disorder was published in November 2004 as the latest in the APA practice guideline series. A listing of current and forthcoming guidelines can be found on the APA practice guidelines Web page.¹ The page includes links to the complete text of 12 guidelines now available as well as to additional tools such as quick reference guides and interactive CME programs that offer Category 1 credit accepted by the APA and the AMA.

What are practice guidelines?

The term *practice guideline* refers to a set of patient care strategies developed to assist physicians in making clinical decisions. Each guideline in the APA series is developed according to AMA and IOM criteria by an expert work group comprised of clinicians, researchers, and academicians. The work group uses an explicit methodology to review and document evidence available for the guideline topic, which is usually a *DSM* diagnostic category. Conclusions from this review form the basis for treatment recommendations that, in turn, undergo broad, iterative review by additional experts, allied organizations, all APA components, and any APA member on request. A practice guideline thus integrates research data with clinical consensus. The APA Assembly and the Board of Trustees formally endorse each guideline prior to publication. A detailed description of the APA development process is available on the APA practice guidelines Web page.

Guideline structure

The format for APA guidelines published after the year 2000 consists of three parts: Part A, initially published as a supplement to the *American Journal of Psychiatry*, contains essential treatment recommendations; Part B provides background information as well as a robust review and synthesis of the evidence that informs Part A; Part C summarizes areas for which more research data are needed to guide clinical decisions. Part A of the Acute Stress Disorder (ASD) and Posttraumatic Stress Disorder (PTSD) guideline was published as a supplement to the November 2004 *American Journal of Psychiatry* (Volume 161, Number 11). The complete guideline is available online and will be included in the next compendium of practice guidelines to be published by American Psychiatric Publishing, Inc. (APPI) in May 2006.

Future research needs for ASD and PTSD

Treatment of ASD and PTSD has assumed increasing significance in the context of current world events. For psychiatrists, understanding and amplifying the evidence base for such treatment has become equally important. Thus, we are pleased to reprint in the PRR Part C, Future Research Needs, of the ASD/PTSD guideline. Over the years, as APA's practice guidelines have become more detailed and comprehensive, so too has Part C. Once just a bulleted list, the Future Research Needs section of recent guidelines has become a resource unto itself.

Research needs for ASD and PTSD were identified during the guideline development process as clinical questions arose for which sufficient relevant data did not exist and where additional evidence was needed to guide clinical decisions.

Equally significant, this section points to issues that confound the translation of research findings into clinical practice settings, emphasizing the important role that real world variables, such as comorbidity, treatment availability, patient preference, provider capabilities, and managed care, among others, bring to the therapeutic situation. Caveats such as durability of therapeutic gains and adherence to treatment planning are also addressed in this final section of the practice guideline.

Robert J. Ursano, M.D., chair of the work group that developed this guideline, comments, "There is a substantial need for research on ASD and PTSD, including [studies on] treatment, epidemiology, and comorbidities. The contribution of PTSD as a comorbid disorder in serious mental illness is only now beginning to be understood. PTSD may become the first mental disorder that we are able to prevent. Its unique status as both an acute form and a chronic form with substantial morbidity makes it also a good model for the close relationship of psychiatry with all of medicine. Our patients and our understanding of their illnesses across a wide range will be aided by better treatments of these two disorders."

The work group chaired by Ursano included Carl Bell, M.D.; Spencer Eth, M.D.; Matthew Friedman, M.D., Ph.D.; Ann Norwood, M.D.; Betty Pfefferbaum, M.D., J.D.; Robert S. Pynoos, M.D.; and Douglas F. Zatzick, M.D. David M. Benedek, M.D., served as consultant to the work group. Laura J. Fochtman, M.D., is APA Practice Guidelines Medical Editor, and John S. McIntyre, M.D., is chair of the Steering Committee on Practice Guidelines. ■

[¹ www.psych.org/psych_pract]

Practice Guideline for the Treatment of Patients With Acute Stress Disorder and Posttraumatic Stress Disorder

Part C: Future Research Needs

Research over the past decade has led to considerable advances in our understanding of the epidemiology of the acute and long-term neurobiological and psychological changes that occur after highly stressful experiences.

Research has also identified a variety of treatment approaches for pathological responses to traumatic events, including ASD and PTSD. Although much has been accomplished, future study is required to expand current understanding and inform future assessment, prevention, and treatment strategies.

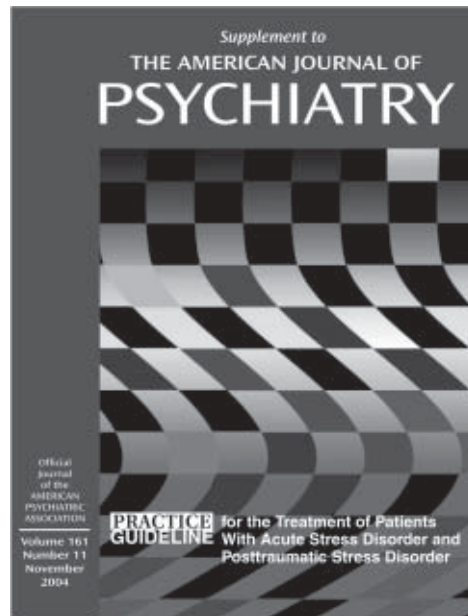
The following future research needs are not presented in any effort to prioritize, nor are they intended to be exhaustive. They serve to illustrate the fact that our understanding of the range of human response to traumatic stress is in its infancy and only beginning to evolve.

• Early interventions/posttrauma treatment

In early intervention (in the hours or days after a traumatic event), the aim is to reduce immediate distress, but ideally it might also be to prevent the development of ASD or PTSD. However, relatively little is known about prevention. Small, controlled studies of psychotherapy suggest efficacy (135, 136, 448), as do the studies of early case-management interventions (131–134). In addition, a few small controlled studies suggest that early pharmacological interventions may reduce development of posttraumatic symptoms (137, 172, 433). However, larger controlled trials and long-term followup studies are needed to fully address the efficacy and effectiveness of psychotherapeutic, psychopharmacological, psychoeducational, and supportive interventions in reducing initial distress and later development of ASD or PTSD, as well as in improving social and occupational functioning.

• Identification of risk factors for development of ASD or PTSD

Given the wide variability of human response to traumatic events, future intervention strategies would be aided by a greater understanding of the extent to which ASD or other diagnoses or factors are associated with subsequent development of PTSD. Elucidation of markers or risk factors (e.g., biological or genetic markers, psychological traits, other life experiences, or ethnocultural variables) that specifically relate to the development or severity of ASD or PTSD after initial or subsequent exposures to potentially traumatic events would be valuable (179, 449, 450). Neurobiological markers are being identified, for example, that are associated with reduced susceptibility to developing disorders after exposure (or exposures) to potentially traumatic events (451).



Further study of markers for both vulnerability and resilience may help explain variability in the development of ASD or PTSD within populations exposed to similar traumatic events and may contribute to a better understanding of the natural history of these conditions. Better identification of at-risk populations within groups similarly exposed may also guide future preventive and acute intervention strategies. In addition to the independent effects of specific markers or risk factors, interactions among identified biological, psychological, and social factors may further alter the likelihood of developing ASD or PTSD and also merit additional study.

• Subthreshold and complex PTSD

Persons may develop significant symptoms in one or more of the three ASD or PTSD symptom clusters but not meet the full diagnostic criteria for ASD or PTSD (452–454). These individuals may be significantly impaired (452, 455), raising questions about the appropriateness of current threshold criteria for PTSD. Similar questions may be raised about the current DSM-IV-TR criterion that to be considered traumatic, a person's response to an event must include "intense fear, helplessness, or horror," since this criterion excludes many persons who report feeling numb or who demonstrate dissociative responses (19). Further study is needed to determine whether such individuals, who might otherwise qualify for these diagnoses, would benefit from treatment.

Randomized, controlled trials of therapy and medications have focused on reducing readily identifiable core symptoms that are outlined in the current diagnostic criteria for PTSD; these symptoms lend themselves to quantification with available severity scales. Clinicians recognize that PTSD and ASD are associated with changes in belief systems, view of self, and ability to trust others, as well as related changes in social, occupational, and interpersonal functioning that may affect patients' lives to a far greater extent than more readily quantifiable core clinical features. The extent to which these issues, rather than the more easily recognized or reliably reported reexperiencing phenomena or hyperarousal, represent the more disabling aspects of the illnesses also bears further investigation. Another question for further study is whether these often-observed changes represent symptoms that should be included in refined diagnostic criteria for PTSD or should signify a separate diagnostic entity (e.g., occurring perhaps as a consequence of earlier or repeated exposure to trauma). More difficult to assess is the extent to which deterioration in spheres of functioning is mitigated by currently available treatments and which approaches may be most effective for addressing the illnesses' effects on functioning.

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Whether or not traumatic grief and complicated bereavement should be recognized as separate diagnostic entities, response to loss is often a focus for persons seeking treatment (303, 456). Since traumatic loss is common, further study of potential treatments for prolonged or disabling grief is warranted.

• Medication treatments and psychotherapies

For the most part, studies of psychotherapy and medication treatment for ASD and PTSD have been small and of relatively brief duration. While larger, well-controlled studies of SSRIs have been conducted, similar studies are lacking and are needed for virtually all other available medication treatments. Newer medications such as tiagabine (457) have been pilot tested but will also require larger-scale controlled studies to establish efficacy.

Benzodiazepines are a widely used and effective treatment for other psychiatric disorders, including anxiety disorders. Although they may improve sleep in ASD or PTSD, some evidence suggests that benzodiazepines also may increase the likelihood of developing PTSD (157, 438). Given the widespread use and prescription of these medications in emergency settings, well-controlled studies are needed in patients with ASD and PTSD.

Studies of pharmacological treatments are also needed to provide evidence on step-wise or algorithmic approaches to treatment choice and to define the role of adjunctive medications in patients with partial responses to first-line agents. Pharmacokinetic or pharmacodynamic properties of medications within subclasses have yet to be studied with regard to their effect on efficacy in treatment of PTSD, nor have the effects of ethnic or cultural considerations on treatment response been clearly delineated.

At the neurobiological level, the mechanisms by which specific medications alter putative disease processes remain unclear. Studies of the neurobiological effects of specific interventions may provide clues to the pathophysiology of these disorders and suggest other avenues of treatment.

Cognitive and behavioral therapies—particularly as early interventions—have demonstrated efficacy largely in victims of sexual assault, interpersonal violence, and industrial or vehicular accidents. Replication of these studies in combat veterans or other victims of mass violence is also important. Preliminary findings with innovative psychotherapies (368, 413, 415–417) require further study in larger controlled trials. Manualizing both emerging and traditional psychotherapies is one approach that may promote more rigorous study. Given the widespread use of psychodynamic psychotherapy, it is particularly important to encourage controlled studies to examine the techniques used and their efficacy.

In the clinical setting, psychotherapeutic approaches are most often used in combination with one another. Regardless of theoretical orientation, clinicians use elements of psychodynamic therapy, supportive therapy, cognitive behavior therapy, or other approaches incorporating various degrees of imaginal or in vivo exposure. Identification of the effective subcomponents of various cognitive and behavior therapies and eye movement

desensitization and reprocessing (EMDR) in the research setting has not been accomplished, and even less is known about effective subcomponents of these therapies in typical clinical populations. Investigations of combinations of various psychotherapies are few (177, 397, 458). Effectiveness trials that assess whether efficacious psychotherapeutic and psychopharmacological interventions can be adapted beneficially to typical clinical settings are similarly necessary (25).

• Treatment of specific symptoms or clinical concerns

Given mixed results with benzodiazepines and the prominence of sleep disturbance in traumatized individuals (459–461), it is critical to identify medications or therapies that can target nightmares and insomnia without increasing the patient's likelihood of developing other symptoms (426, 462). Further study may also help to identify particular interventions that reduce other specific symptoms in patients with ASD or PTSD, such as self-injurious, deliberately self-harmful, or suicidal behaviors (277). The role of active involvement of family members and community supports in enhancing adherence—as has been applied to other severe mental disorders—requires further exploration (84). There are few studies of the potential of family or couples therapy for reducing symptoms or dysfunction in PTSD (372). The effect of other treatments on reducing functional impairment is another broad area that requires further investigation.

• Generalization of research trials to clinical populations

As for most disorders, the generalizability of medication trials and therapy studies for the treatment of ASD and PTSD is frequently limited by high levels of subject exclusion because of comorbidity, high subject dropout rates, and relatively short durations of follow-up periods (277). Consequently, the robust treatment responses observed in research settings may not always be seen in typical patients treated in clinical practice. Longer-term follow-up studies must also be conducted to determine whether initial gains made in therapy or with medication are long-lasting and whether maintenance treatment is necessary. More studies are needed to clarify potential adverse effects of treatment and patient factors that reduce adherence to specific regimens (463). Effectiveness trials are also necessary to assess whether efficacious therapeutic and/or psychopharmacological interventions for ASD or PTSD can produce meaningful and lasting changes in patients who typically present in community settings. The importance of PTSD as a comorbid disorder in serious and persistent mental disorders such as schizophrenia or bipolar disorder highlights a particular need for study of PTSD treatment in these patient groups.



The fact that stressful life events may cause emotional and behavioral effects has long been recognized. Psychiatrists concerned themselves with the consequences of traumatic experience decades before the diagnoses of ASD and PTSD were specifically identified. Clinical experience, descriptive literature, and case study guided treatment of persons suffering from the effects of traumatic exposure long before randomized, controlled trials were conceptualized or became a standard for evaluating new evidence. Disregarding clinical experience accumulated before these advances in

research design would be as imprudent as believing that research conducted under current standards has adequately demonstrated the full range of effective treatment. Standards for gathering and evaluating new evidence are evolving and should inform the development of future guidelines for assessing and treating mental disorders that arise in the aftermath of exposure to traumatic events.

Coding System for References

The following coding system is used to indicate the nature of supporting evidence in the references:

[A] *Randomized double-blind clinical trial.* A study of an intervention in which subjects are prospectively followed over time; there are treatment and control groups; subjects are randomly assigned to the two groups; both the subjects and the investigators are blind to the assignments.

[A-] *Randomized clinical trial.* Same as above but not double-blind.

[B] *Clinical trial.* A prospective study in which an intervention is made and the results of that intervention are tracked longitudinally; study does not meet standards for a randomized clinical trial.

[C] *Cohort or longitudinal study.* A study in which subjects are prospectively followed over time without any specific intervention.

[D] *Control study.* A study in which a group of patients and a group of control subjects are identified in the present and information about them is pursued retrospectively or backward in time.

[E] *Review with secondary data analysis.* A structured analytic review of existing data, e.g., a meta-analysis or a decision analysis.

[F] *Review.* A qualitative review and discussion of previously published literature without a quantitative synthesis of the data.

[G] *Other.* Textbooks, expert opinion, case reports, and other reports not included above.

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News and Notes

Clinical-Translational Research Position

The Department of Psychiatry at the University of California, San Francisco, invites applications for a Clinical/Translational Researcher in *Depression and/or Anxiety Disorders*. The incumbent will play a key role in the development and expansion of funded research programs in the Depression Center. The incumbent will also supervise and serve as a role model for clinical research track psychiatry residents. Candidates must have a California medical license and be board certified or eligible in psychiatry by the start of their appointment. The appointment will be in the Assistant-Associate Professor In Residence series beginning on or after July 1, 2005.

Please submit CV and three letters of reference by **April 15, 2005**, to Victor Reus, M.D., Chair, UCSF Department of Psychiatry, 401 Parnassus Avenue, San Francisco, California, 94143-0984 (norak@lppi.ucsf.edu). UCSF is an affirmative action/equal opportunity employer.

ACNP Julius Axelrod Mentorship Award

The American College of Neuropsychopharmacology (ACNP) presents the Julius Axelrod Mentorship Award to an ACNP member who has made an outstanding contribution to neuropsychopharmacology by mentoring and developing young scientists into leaders in the field. The Award consists of a monetary award and a plaque to be given during the President's Plenary Session. Any scientist may nominate an ACNP member for this award.

Submissions should include: a nominating letter, no more than three pages in length, describing the candidate's contributions to those mentored; a representative list of people who have been mentored by the candidate, their job titles and contributions to the field; letters of support from no more than three people who have been mentored by the candidate; and the candidate's curriculum vitae.

Send eight (8) copies of each submission to the ACNP Executive Office before **May 20, 2005**. Indicate *title of the award* on submission envelope as well as on all materials submitted. [ACNP Executive Office, Honorific Awards, 545 Mainstream Blvd., Suite 110, Nashville, TN 37228]

ACNP Joel Elkes Research Award

The American College of Neuropsychopharmacology (ACNP) presents the Joel Elkes Research Award to a young scientist (45 years or younger) in recognition of an outstanding **clinical/translational** contribution to neuropsychopharmacology. The contribution may be based on a single discovery or a cumulative body of work. Of particular interest are contributions that further understanding of self-regulatory processes as they affect mental function and behavior in disease and well-being. The Award consists of an expense paid trip to the ACNP Annual Meeting, December 11-15, 2005, in Waikoloa, Hawaii, a monetary award, and a plaque to be given at the ACNP Annual Meeting during the President's Plenary.

Submissions: *One* nominating letter (no more than three pages) describing the contribution(s) of the candidate and the significance of the contribution(s); a curriculum vitae; no more than three papers representing the contribution upon which the Award would be based. Candidates must not be U.S. citizens or members of ACNP.

Send eight (8) copies of each submission to the ACNP Executive Office before **May 20, 2005**. Indicate *title of the award* on submission envelope as well as on all materials submitted. [ACNP Executive Office, Honorific Awards, 545 Mainstream Blvd., Suite 110, Nashville, TN 37228]

ACNP Daniel H. Efron Research Award

The American College of Neuropsychopharmacology (ACNP) presents the Efron Award for outstanding **basic/translational** research contributions

to neuropsychopharmacology. The contributions may be preclinical or work that emphasizes the interface between basic and clinical research. The selection of the awardee is based on the quality of the contribution, and its impact in advancing neuropsychopharmacology. Candidates must be 45 years of age or younger. The Efron Research Award consists of an expense paid trip to the ACNP Annual Meeting in Waikoloa, Hawaii, December 11-15, 2005, a monetary award, and a plaque to be given at the ACNP Annual Meeting during the President's Plenary.

Submissions should include: a nominating letter (no more than three pages) describing the candidate's contribution(s) and the significance of the contribution(s); a curriculum vitae; and, no more than three papers representing career contributions or specific works.

Send eight (8) copies of each submission to the ACNP Executive Office before **May 20, 2005**. Indicate *title of the award* on submission envelope as well as on all materials submitted. [ACNP Executive Office, Honorific Awards, 545 Mainstream Blvd., Suite 110, Nashville, TN 37228]

New NARSAD Research Award

The National Alliance for Research on Schizophrenia and Depression (NARSAD) has established a major new schizophrenia research award to stimulate further research on the causes and treatment of schizophrenia. The **Staglin Family Music Festival NARSAD Schizophrenia Research Award** was announced in 2004; the first award is slated to be made July 2005. This new award will be supported through funds raised by the Music Festival for Mental Health, an annual event held in the Napa Valley at the Staglin Family Vineyard. One award of \$250,000 will be made each year to a young investigator (no more than 45 years of age) to help establish or maintain a program of research. The award will cover research costs, rather than salary, and may be used over a period of up to three years.

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Candidates must have M.D. and/or Ph.D. degree or an equivalent doctoral-level degree as well as postdoctoral training in a scientific field that can be applied to the study of schizophrenia. Candidates should be in the early stages of an independent scientific career and hold an appointment at the assistant or associate professor level. The award will have an annual application receipt date in December of each year (December 2, 2005). The NARSAD Web site (www.narsad.org) displays complete information on the application process.

An esteemed five-member committee of the NARSAD Scientific Council serves as the review panel for this award: Huda Akil (University of Michigan), Samuel Barondes (University of California, San Francisco), Eric Nestler (University of Texas, Southwestern Medical School), Solomon Snyder (Johns Hopkins University), and Daniel Weinberger (NIMH), who serves as Chair.

2005 NARSAD Independent Investigator Award

The Independent Investigator Award provides opportunities of up to \$50,000 per year for two years. The award is intended to facilitate innovative research of particular relevance for schizophrenia, major affective disorders, or other serious mental illnesses. Candidates must be scientists at the associate professor level with national, competitive grant support as Principal Investigator. Basic and/or clinical investigators are supported. Applications for the 2005 award are due by March 4, 2005; application materials are available on the NARSAD Web site (www.narsad.org).

RWJ Clinical Scholars Program

The Robert Wood Johnson Clinical Scholars Program provides an outstanding two-year opportunity for young psychiatrists seeking post-residency research training. The goal of the RWJ Clinical Scholars Program is to augment physicians' clinical training by providing new skills and perspectives underlying health services research. The program's newest iteration also emphasizes community-based research and leadership training.

The program is structured around four participating universities – University of California, Los Angeles, School of Medicine; University of Michigan Medical School; University of Pennsylvania School of Medicine; Yale University School of

Medicine. Although each program varies in design and emphasis, each institution offers a core structure that introduces Scholars to the basic disciplines and methods used in health care research, providing graduate-level study and research as part of a university-based postresidency training program that can lead to additional academic degrees. Stipends at the four training sites currently range from \$45,000 to \$50,000 per year.

A National Program Office, at Stanford University, provides technical assistance, direction, and development of the core curriculum for the RWJ Clinical Scholars program. The program emphasizes its commitment to racial, ethnic, gender and disciplinary diversity; applications from candidates with diverse backgrounds are encouraged.

Though the program is designated for two years, competitive selection for a third year is offered in order to enhance research productivity. The program selects participants a full year in advance; participants selected in July 2005 will begin the program in July 2006. Thus even first- and second-year residents should explore the program and begin to think about the application process. See the National Program Office Web site, <http://rwjcsf.stanford.edu>.

Judson Daland Prize

The Judson Daland Prize for **Outstanding Achievement in Clinical Investigations** is awarded by the American Philosophical Society in recognition of outstanding achievement in *patient-oriented* research. Nominees for the \$20,000 prize must have done their work in a U.S. institution, however, must not necessarily be U.S. citizens. Candidates should be no more than 15 years beyond receipt of the M.D. degree. Nominations must be submitted by the chair of a clinical department of a medical school or hospital and should include: an abstract of the work to be honored, a CV with bibliography, a 50-word summary of the nominee's major achievements, and a letter stating the patient-oriented nature of the investigation. Three additional letters of support, no more than one from the nominee's institution, should be sent separately to the Society. Nominations must be received by March 15. See further nominating instructions on the Society Web site: www.amphilsoc.org.

APPA Meeting in NYC

The Annual Meeting of the American Psychopathological Association (APPA) will be held in New York City at the Crowne Plaza Hotel, March 3 – 5. This year's program, *Toward Prevention and Early Intervention of Major Mental Disorders*, will address a number of key issues ranging from DNA molecules to government policy. The Presidential Address will be given by Ming T. Tsuang, M.D., Ph.D.: "Toward the Prevention of Schizophrenia, Early Detection and Intervention." Dr. Tsuang was the recipient of the 2003 American Psychiatric Association Award for Research in Psychiatry. For scientific program details, visit www.appassn.org.

New Research Report

In November 2004, the National Academies issued a report on *Facilitating Interdisciplinary Research*, the recommendations of a study sponsored by the National Academies Keck Futures Initiative. The Futures Initiative was launched in 2003 to stimulate new modes of scientific inquiry and break down the conceptual and institutional barriers to interdisciplinary research. Nancy C. Andreasen, M.D., Ph.D., served as co-chair of the study committee that researched and wrote the new report. Dr. Andreasen is the Editor-in-Chief of the *American Journal of Psychiatry*. Recommendations in the report target academic institutions, funding organizations, journal editors, professional societies, and graduate as well as undergraduate students. "The report identifies steps that individuals and institutions can take to more effectively conduct, facilitate, and evaluate interdisciplinary research programs and projects," summarizes Andreasen. To read the report online or to obtain copies, visit the Web site of the National Academies Press: www.nap.edu. ■



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Anthony F. Lehman, M.D.

Evidence-Based Treatment for Persons with Schizophrenia



APA Award for Research in Psychiatry

Herbert Y. Meltzer, M.D.

Algorithms for Treatment of Schizophrenia

and

Dilip V. Jeste, M.D.

Title to be announced



Psychiatric Research Report (PRR)

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