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Psychiatric Research Report

Three New Directors

Ting-Kai Li, M.D. NIAAA Director

Ting-Kai Li, M.D., an internationally known expert on the genetics of alcoholism, has been named director of the National Institute on Alcohol Abuse and Alcoholism. As Distinguished Professor of Medicine, Biochemistry, and Molecular Biology at Indiana University School of Medicine, he also directed the Indiana Alcohol Research Center.

"His unparalleled scholarship and proven leadership abilities will enable NIAAA to continue to capitalize on the diverse scientific opportunities in biomedical, clinical and prevention research," said NIH director Elias Zerhouni in announcing Li's appointment.

Li and colleagues have investigated gene variants coding for alcohol and aldehyde enzymes, and have pursued their relationship to alcoholism and its complications. They have also developed rodent models of alcohol preference and researched the heritability, sensitivity and repeatability of a variety of responses to ethanol in humans.

A 1959 graduate of Harvard University Medical School, Dr. Li joined the faculty of Indiana University School of Medicine in 1971 and served as Associate Dean for Research from 1986 to 2000. He is a member of the Institute of Medicine,

(see Li, continued on page 21)

James H. Scully, M.D. APA Medical Director

James H. Scully, M.D., who served as APA Deputy Medical Director for Education from 1992 to 1996, will return to APA as its new Medical Director in January 2003. He succeeds Steven M. Mirin, M.D., who has served the APA as Medical Director since 1997.

"It is critical for our patients and our profession that APA be successful," said Scully. "No other organization can represent the full spectrum of the fourth largest specialty in American medicine."

Dr. Scully brings an unusual mix of talent and experience to the Medical Director position. He is currently Professor and Chair of the Department of Neuropsychiatry, University of South Carolina (USC) School of Medicine in Columbia, South Carolina. He serves as APA's delegate to the AMA House of Delegates, as current Chair of the Residency Review Committee (RRC) for Psychiatry, and as one of eight Directors of the American Board of Psychiatry and Neurology. In addition, Scully recently served a stint as Interim Director of the South Carolina Department of Mental Health and is currently the Department's Director of Education, Training, and Research.

Scully is widely recognized for his commitment to psychiatry education. His residency training program at USC attracts medical graduates from all over the country. And as a result of his leadership, nearly 10 percent of USC's medical school graduates specialize in psychiatry, one of the highest percentages in the country. Dr. Scully was Residency Training Director at the University of Colorado before becom-

(see Scully, continued on page 21)

Thomas R. Insel, M.D. NIMH Director

Psychiatrist and neuroscientist Thomas R. Insel, M.D., has been appointed Director of the National Institute of Mental Health (NIMH). A 15-year veteran of the NIMH Intramural Research Program (IRP), he re-joins the Institute after an eight-year hiatus, first as Director of the Yerkes Regional Primate Research Center, as Professor, Department of Psychiatry, Emory University School of Medicine, and, for the past few years, as founding Director of the Center for Behavioral Neuroscience, an interdisciplinary research and education consortium of eight Atlanta area colleges and universities. Dr. Insel will oversee the $1.3 billion NIMH research budget. He begins his new appointment in mid-November.

In discussing the selection process at a September National Advisory Mental Health Council (NAMHC) meeting during which he introduced Insel, NIH Director Elias Zerhouni, M.D., said mental health research represents one of the NIH's most important missions, "way beyond anybody's grasp in terms of both national health and the future of the nation." In this context, Zerhouni cited Insel's "compelling vision" for the mental health research field. The NIH Director said that in making his selection decision he also investigated Insel's role in securing $30 million funding for the Center for Behavioral Neuroscience, which was among only five centers selected from among 283 institutions competing for the coveted National Science Foundation centers grants. "It was very telling to me that not only was he able to establish the Center on top of a primate center and run it for five years, but then got the renewal funded. That, I thought, was quite an accomplishment." Zerhouni praised Insel's

(see Insel, continued on page 21)

Also in this Issue

AADPRT

Pre-Meeting – March 5, 2003

Sponsored by NIMH, APA Committee on Research Training, and APIRE

Scholarly Activity: What is it? How to do it?

Scholarly Activity is an RRC requirement of every residency training program. It is defined as those activities which promote an environment of scholarship and inquiry within the training program. However, the task of defining what these "activities" might include and gaining knowledge on how each training program can accomplish them is a formidable task. Scholarly Activity may includes a broad range of activities from being able to critically appraise the scientific literature to participating in research that actually contributes to the literature.

The objective of this **Pre-Meeting** will be to discuss **why** scholarly activity is important to residency training and to provide some first hand experiences on **how** to pursue various scholarly activities in any given program: big or small, research or clinically based, rural or urban, private or public.

Selected Workshops:

Journal Clubs as Scholarly Activity
Evidence-Based Teaching as Scholarly Activity
Turning a Notion into Research
Evidence-Based Case Conferences
Critical Reading of the Literature
Matching Mentors with Residents
Investing Clinical Faculty in Evidence-Based Thinking
How to Write a Scientific Presentation/Paper
Basic Quantitative Methods
Learning about the IRB Process

All AADPRT members are encouraged to attend this Pre-Meeting. Members who would like to present their ideas on how they pursue scholarly activity in their own programs will be welcomed. Contact **Program Chair:** Michele T. Pato, M.D. (cmpato@aol.com) or **Co-Chair:** Carol Bernstein, M.D. (carol.bernstein@med.nyu.edu) so that these ideas can be included in the final program.

From the Committee on Research Training

Scholarly Activity–What does it have to do with Research?

Michele T. Pato, M.D., Chair

As chair of the Committee on Research Training, my columns have focused on how to pursue a research career and also, on why. Yet, such a focus seems to leave out the majority of psychiatrists who view themselves as "clinicians" not "researchers." In fact, one can often watch the light dim in the eyes of most in the audience when one begins to preach about the importance of doing research. Over the past five to ten years, however, the Accreditation Council on Graduate Medical Education (ACGME) has recognized the importance of research teaching, and today research, or what the Residency Review Committee (RRC) more generally defines as the "pursuit of Scholarly Activity," is a required component of most residency training programs.

What is this scholarly activity and how does it include the concepts and pursuit of research? Scholarly activity is, in fact, the basis of all research and something that every good physician does or should do in the pursuit of the best care for patients. Rather than setting up this false dichotomy of "The Researcher" and "The Clinician," we should view ourselves as an admixture of the two with neither ingredient totally absent.

Defining Scholarly Activity

Scholarly activity is defined in the Graduate Medical Education Directory as an environment in which inquiry and scholarship take place so that the individual can develop "new knowledge, learn to evaluate research findings and practice habits of inquiry" as part of continuing professional responsibility (Graduate Medical Education Directory, 1998, pp 273-274). Many would consider environment to refer to the physical space and equipment available to pursue inquiry and scholarship, and this is obviously an important component. However, in many ways, this is secondary to the intellectual resource provided by faculty, colleagues, and patients.

Any research pursuit has at its core a question — a hypothesis — and a plan to answer that question — an experiment. Similarly, every patient with whom we are faced poses a question: What is wrong with me? The physician then must design a plan — in essence, an experiment — to address that question, for example, a treatment trial. To come up with an adequate experiment one must know how to ask questions and how to find the answers. This is also the essence of scholarly activity, a spirit of inquiry.

Components of Scholarly Activity

To meet the requirements for scholarly activity, faculty and trainees must seek to learn and to practice the posing of questions (hypotheses), the seeking out of data to support their hypotheses, the analysis of the validity of that data, and the relevance of the data to the particular patient or situation for which the question was posed. It is these skills that are the basis of evidence-based medical practice. Thus, we can turn to the evidence-based literature to help us articulate many of the skills and activities that are part of scholarly activity and the pursuit of research.

Perhaps one of the most powerful ways to engage residents in scholarly activities is to have them pursue a research project or work alongside a mentor. In so doing, not only do they learn how to pose questions, but they actually participate in the process of discovering the answers.

For residency training directors, as well as for residents and faculty, the question becomes: How can one teach scholarly activity and then demonstrate that the skills, knowledge, and attitudes of scholarly activity have been acquired?

This, in fact, will be the subject of an all-day symposium to be held on March 5, 2003 as a pre-meeting to the annual meeting, March 6-9, of the American Association of Directors of Psychiatric Residency Training, in San Juan, Puerto Rico. Among the proposed topics will be an examination of those activities that reinforce evidence-based practice of medicine. For instance: 1) Are case conferences presented with an emphasis on posing questions about the patient and then presenting supporting literature to justify conclusions? 2) Are clinical rounds held with an emphasis on having residents seek answers from the literature for the questions raised during rounds? 3) Do faculty, in teaching both at the bedside and in the classroom, support their comments by demonstrating their own knowledge of the current literature and of evidence-based practices? 4) Are journal clubs conducted systematically to assess both the scientific merit and relevance of the findings presented?

Assessing Scholarly Activity

The process of assessment is the first step toward improving scholarly activity within a program or department. The opportunities available to do research, the mentors available for tutoring trainees, and the procedures set up to support research projects, are all measurable components of a program's scholarly activity. Core courses in basic statistical concepts and in critical reading of the medical literature are also required to fulfill the mandate of scholarly activity and to ensure that faculty and trainee alike can evaluate the validity and merit of research findings. Outcome measures can also include assessments of how often the literature and supporting data are cited by residents and faculty in oral and written presentations. Publication productivity by residents and faculty is another measure of scholarly activity within a department or program.

In conclusion, research does not exist without scholarly activity. If reading the literature critically can become a welcome routine instead of a chore, then as physicians we have the key tool for staying competent in our field and, hopefully, for maintaining enthusiasm, a spirit of inquiry, for what we do. ■

From APIRE

Following the development of ICD-10 and DSM-IV, a rapidly expanding body of scientific research evolved in neuroscience, clinical science, and in public health research and practice. In preparation for the next revision of psychiatric classification, a series of conferences on specific diagnostic issues tied to particular disorders has been conceptualized by the American Psychiatric Institute for Research and Education (APIRE), and is being undertaken as a collaborative effort with the World Health Organization (WHO) and the World Psychiatric Association (WPA). Each conference will seek to (a) stimulate empirical diagnostic research to improve the validity of psychiatric diagnosis and (b) facilitate movement toward a unified DSM/ICD.

The first of these conferences, the Yokohama Depression Symposium, was held on August 25, 2002, in association with the XII World Congress of Psychiatry meeting in Yokohama, Japan. The symposium – comprised of four sessions – was designed to review the contributions of research from multiple scientific fields and to explore the potential of integrating these research findings into a common set of diagnostic criteria. Opening remarks were presented by Juan Lopez-Ibor, President of the WPA, and by Benedetto Saraceno, Director of Mental Health for the WHO, emphasizing the priority placed upon globalization of the next effort at diagnostic classification.

Will *DSM-V* Criteria for Depression be More Research Based?

John F. Greden, M.D.
Chair, APA Council on Research

Diagnostic criteria provide efficient "shorthand" communication about medical/psychiatric disorders; they have become indispensable in communicating with colleagues, predicting course, selecting treatment, formulating prognosis, and even submitting reimbursement bills. But it should be remembered that they have a higher calling, still unachieved. *DSM* criteria ideally should reflect research breakthroughs, catalyze future research studies, foster global integration, and bring research and clinical worlds closer together.

Have our *DSM* clinical diagnostic criteria traditionally been founded upon research data? Only in general ways. Have we always talked the same language across international borders? Infrequently. Do research advances regularly find their way into criteria revisions? Not easily. Being frank, vast historical voids have existed between clinical criteria and the research literature.

We are now launching the next nomenclature revision—*DSM-V*. To help understand why gaps have existed and to see whether some of the gaps can be filled, a process for planning the research agenda upon which the next *DSM* will be based was begun in September 1999. The results of that planning process, to date, have just been published by APA (*A Research Agenda for DSM-V,* 2002) and were summarized by Michael First in the Summer 2002 issue of the *Psychiatric Research Report* ("A Research Agenda for *DSM-V*: Summary of the White Papers"). The next phase in the planning process was initiated by Darrel Regier who organized The Yokohama Depression Symposium. Although the proceedings of the symposium are scheduled to be published, I was asked to report on sessions of the Symposium that lie within my sphere of expertise for the readers of the *Psychiatric Research Report (PRR)*. Following then, is my summary of those presentations that pertain to the overview, the neuroscience base, and the clinical science base for improving diagnostic criteria for depression. I am also taking the liberty of a few personal commentaries, placed in italics for "truth in advertising."

Dr. Darrel Regier began the day by summarizing the birth, growth, and development of the *Diagnostic and Statistical Manual (DSM)* and of the *International Classification of Diseases (ICD)*. Why should anyone care? Why is this relevant? Because Dr. Regier's look back coherently reveals the hurdles that have been faced with each successive revision and that will almost certainly be faced again while forging *DSM-V* and *ICD-11*.

In 1948, the World Health Organization took charge of the sixth revision of the *International Classification of Diseases (ICD-6)*, including for the first time a section for the classification of mental disorders. Only five countries, however, officially adopted the classification. The United States was not in that group, in part because many of the diagnostic terms used had etiologic implications that were at odds with the various schools of psychiatry in the U.S. By 1952, the U.S. had developed its own alternative, *DSM-I*, the parent of our current *DSM-IV*. If current psychiatric residents could find a copy of *DSM-I*, they would be reassured that we have come a long way in five decades, but they would also conclude that we have a long way to go for meaningful integration between clinical and research worlds.

By 1959, WHO had begun efforts to create a classification system of mental disorders that could represent an international consensus of concepts and terms. These efforts were not successful, however, and both *ICD-8* and *DSM-II* were published in 1968 without consensus.

DSM-II made some progress by incorporating brief definitions for each disorder. These short paragraphs, however, did not serve mental health researchers who required homogeneous groups of subjects to pursue clinical studies. The research community at Washington University School of Medicine responded to the problem by developing the St. Louis Diagnostic Criteria for Research (Feighner, Robbins, and Guze, 1972) which operationalized diagnostic criteria but relied almost totally on phenomenology. These criteria promptly became the foundation for the Research Diagnostic Criteria (RDC), developed by Robert Spitzer and colleagues, which in turn became the building block for *DSM-III* and for several subsequent diagnostic

In the article below, John F. Greden, Department of Psychiatry, Chair of the University of Michigan Medical School, Executive Director of the University of Michigan Depression Center, and an observer at the Yokohama Symposium, summarizes and reviews presentations made in two sessions of the day-long meeting: The Neuroscience Base; The Clinical Science Base. The third session of The Yokohama Depression Symposium represented The Public Health Research Base, and for this session we present defining portions of the presentations made by the four featured speakers. The final session of the Symposium, co-chaired by David Kupfer, Assen Jablensky, and Norman Sartorius, was a discussion of the wide-ranging issues presented throughout the day. In our effort to bring the critical events of the day to the field-at-large, the Symposium will be published as a single volume and is scheduled to be available through American Psychiatric Publishing Inc. (APPI) by summer 2003.

Darrel A. Regier, M.D., M.P.H.
Executive Director, APIRE

assessment instruments for research studies. The two main innovations introduced by *DSM-III* were the provision of explicit diagnostic criteria for each disorder in the classification and the introduction of a multiaxial system for recording diagnostic evaluations. The use of explicit criteria for defining specific types of mental disorders was widely adopted by the international research community and prompted a succession of international cooperative efforts.

The wheels were rolling. Clinical diagnostic criteria and research diagnostic studies were indirectly talking the same language, but gaps still existed. Key features emphasized in most research studies—etiology, neurobiological changes, and treatment response—remained absent. This almost suggested that there were no data underlying the nomenclature; hardly the case, but often the perception. *My Commentary? First, achieving a national consensus on any of these issues is never easy; a global consensus will require even more work, patience, and time. Second, preclinical, basic neuroscience, and clinical science speak different languages; integrating the three means learning new languages, a step that also requires a lot of work.*

The presentations following Dr. Regier's overview addressed recent advances that could and *should* contribute to the development of *DSM-V* and *ICD-11*.

Dr. Brian Leonard described animal models of depression focusing upon one model, the olfactory bulbectomized rat (OBR), and making the case that animal models have predictive validity, face validity,and construct validity. The OBR rat for example, shows changes in psychomotor activity, circadian shifts, elevated glucocorticoid secretory patterns, significant reductions of serotonin transporter (5HTT), as well as sleep and immune pattern alterations fairly identical to those found in human forms of depression. *Comments? Preclinical animal research has failed to produce a consensus animal model of depression, but such work has generated irreplaceable knowledge, and it is essential that we continue our efforts in this direction.*

Dr. Florian Holsboer addressed the roles of stress, corticotrophin releasing hormone (CRH), and the molecular mechanisms of antidepressant medications. He noted that all effective antidepressant medications restore stress dysregulation to some degree, and if we develop medications that act more directly and efficiently, the potential benefits could be enormous. Dr. Holsboer presented recent data supporting the view that while CRH antagonists may be ideal agents for selected types of depression, a commercial product has remained elusive. The search, however, should continue. Data were also presented to illustrate linkages among stress, depression, and genomics, noting that stress counts, but so does genotype. *My comments? Since we cannot disconnect or ignore genomics from our understanding of depression, perhaps it time for us to stop trying to do so in our nomenclature, in our academic discourse, and hopefully in DSM-V.*

Dr. Dennis Charney focused upon synergizing the various silos and suggested that any new diagnostic system should incorporate aspects from genotyping, neurobiological phenotyping, behavioral phenotyping, emotional modifiers or precipitants, and therapeutic targets and responses. These themes are pillars of the NIMH Strategic Plan for Mood Disorders. *My commentary? The impressive scientific advances in an array of fields finally make synergistic formulations more of a reality and less of a dream. But, incorporating them into a "consensus" nomenclature will NOT be politically easy. That doesn't mean we should not try.*

Dr. Ming Tsaung further emphasized the importance of genetic contributions to diagnostic criteria. Data from his group indicate that genetic factors are most important for those with severe depression and early onset. *My commentary? We would be well served to emphasize severity measures more strongly in our lifetime understanding of depression and in our nomenclature, rather than labeling each step along a likely severity spectrum with a different name (e.g., dysthymia or "double depression").*

Dr. Wayne Drevets addressed neuroimaging. While its complexities remain profound and its costs high, the proliferating data provide compelling and publicly persuasive evidence that depression is a brain disease. *My comments? Neuroimaging studies speak a universal language; they are understood visually by all and, assuming that research breakthroughs continue at the current pace, it is reasonable to conclude that such data will find their place in DSM-V. Data should rule the day, not the issue of whether imaging-assisted diagnoses are reimbursed by third-party payers.*

Dr John Mann postulated that if depression is a brain disease, its etiologies may be clarified by postmortem evaluation of brain tissue. Postmortem approaches have been immensely valuable throughout prior centuries, but my, how the science has improved! Postmortem tissue now can be studied with molecular assessments, molecular imaging, neurochemistry, and genetic assessments. In the process, the potential to enhance our understanding about pathophysiology has grown logarith-

(continued on next page)

mically. *The message? While certain research modalities such as preclinical animal models and postmortem assessments are resisted by a few, the knowledge gleaned may be life-saving for millions and for generations to come.*

In the last two presentations of this sequence, **Drs. David Schaffer and Eugene Paykel** addressed two additional aspects. Dr. Schaffer queried whether juvenile mania was newly observed or newly invented? Dr. Eugene Paykel reminded everyone that one of the ultimate conveyers of truth is outcome, and that treatment response needs to be incorporated into outcome assessments and hopefully into our nomenclature. *My commentaries? First, nomenclature controversies are not historical vestiges; each new era will introduce new controversies, hopefully solveable by data not ideology. Second, as we introduce molecular neuroscienece, genetics, and neuroimaging into our nomenclature, we should resist forming premature judgments about whether an entity exists where data are absent or inconsistent. We must also never abandon clinical descriptions proven to have value, notably treatment response and outcome.*

Conclusion. The informative sessions of this symposium forced participants to look ahead by looking backward. They fostered the recognition that while our diagnostic criteria have become more research based in the past half century, we have a long way to go. *DSM* revisions, even when driven by science, never have been easy or politically uncomplicated and will not be for *DSM-V*. Consensus is never easy, never has been, and definitely won't be in the more global world toward which we strive. Molecular, genetic, proteomic and neuroscience advances will not slow down; rather, they will occur even more rapidly with each passing year. A strategy, therefore, needs to be developed for the rapid inclusion of research-based breakthroughs into our clinical diagnostic criteria.

If these steps are to be successful, more translation and more translators are vital to build bridges between basic and clinical science—the proverbial "bench-to-bedside" and vice versa. For translators to be developed, an emphasis upon research training must become a hallmark of every medical school, post-doctoral program, and especially every psychiatry residency program. We have a lot to do.

Knowledge does heal. *And* we are accumulating a lot of it as evidenced by the presentations at this depression symposium. Now our challenges are to translate from multiple directions and multiple languages into a universally accepted and usable research-based set of diagnostic criteria. Such a step will help clinicians, investigators, and the public. Most importantly, it will help our patients—they are waiting. Let's work together to make it happen!

THE PUBLIC HEALTH RESEARCH BASE

Dr. Bedirhan Ustun reported on the impact of the Global Burden of Disease Study (GBD), published in 1996 and supported by the WHO, Harvard School of Public Health and World Bank. The longitudinal GBD Study examined 107 major diseases in a comparative framework that included factors of both mortality *and* disability. When disability was taken into account, the formerly unrecognized burden of mental disorders became undeniably evident: mental disorders ranked as high as cardiovascular and respiratory disease, surpassing all cancers combined, or even HIV. Depressive disorders, as a single diagnostic category, were the leading cause of disability world wide.

From a scientific point of view, the GBD was a meta-synthesis of diagnostic and epidemiological information, forming the basis for a conceptual "diagnostic parity" for mental disorders. It is essential, therefore, to treat the quality of diagnostic criteria for mental illnesses in par with other physical disorders in order to link the classification system with public health planning and evaluation tools such as cost-effectiveness analyses and health system performance.

Dr. Wolfgang Rutz presented evidence from European public health studies indicating that European males in countries of societal burden and stressful transition seem only half as often depressed as females, according to conventional depression diagnostic criteria, but have a much higher suicide rate than females. This, despite the well known association between suicide and depression. A link seems to exist to male problems of alexitymia, non-compliance, differences in helplessness or help-seeking behavior, a typical "atypical" phenomenology of depression, and behavioral patterns associated with a breakdown of coping ability and maladaptation. Foundations for the paradoxical evidence could possibly be found in the ethological background of human behavior in crises, in fight for survival, and in behavioral differences between the two genders. Male helplessness, depression and depressive suicide seems today under-recognized, under-treated, and not sufficiently monitored, possibly contributing to the paradox of preponderant suicidality and premature mortality.

Dr. Rutz' presentation elaborated the clinical and public health argument for rethinking diagnostic criteria for atypical typical depressive behavior, especially in males, to better reflect common underlying pathophysiological and ethological mechanisms, pathways and processes.

Dr. Shekhar Saxena spoke to the need for including a focus on prevention and promotion in a revised diagnostic and classification system. Traditionally, these systems have served clinical, research, and educational purposes; larger public health issues have not been taken into account. In the past ten years, however, significant advances have been made in the areas of prevention and promotion research, allowing for conceptual and operational links to diagnosis and classification. Early identification and intervention of several disorders is now possible based on enhanced knowledge of predisposing risk factors and early symptoms. Including information related to prevention and promotion in future classificatory systems assures that clinicians and pubic health professionals become aware of existing and newly developing preventive strategies to modify the onset, course, and outcome of disorders. Taking this step would also respond to public demands for prevention strategies and would enhance prospects for funding illness prevention and health promotion.

Dr. Valery Krasnov presented conclusions from a study designed first, to assess prevalence of affective spectrum disorders in a primary care setting and second, to assess treatment outcome with a new collaborative care model. The investigation took place from 1999 to 2001 in 11 polyclinics in several Russian cities forming five catchment areas with a total population of 9,000 persons. Diagnosis and treatment of depression were accessible and even relatively simple within the framework of the organizational model used. The

(see DSM-V Criteria, continued on page 23)

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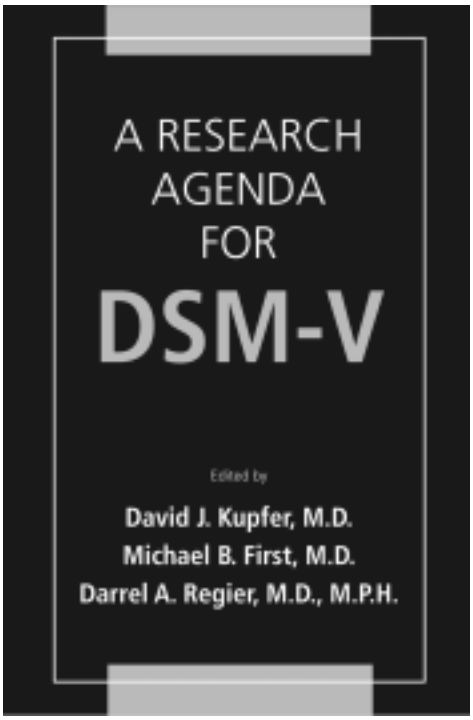


A Research Agenda for DSM-V

Edited by David J. Kupfer, M.D., Michael B. First, M.D., and Darrel A. Regier, M.D., M.P.H.

This volume represents a far-reaching attempt to stimulate research and discussion in the field in preparation for the start of the DSM-V process, still several years away, and to integrate information from a wide variety of sources and technologies.

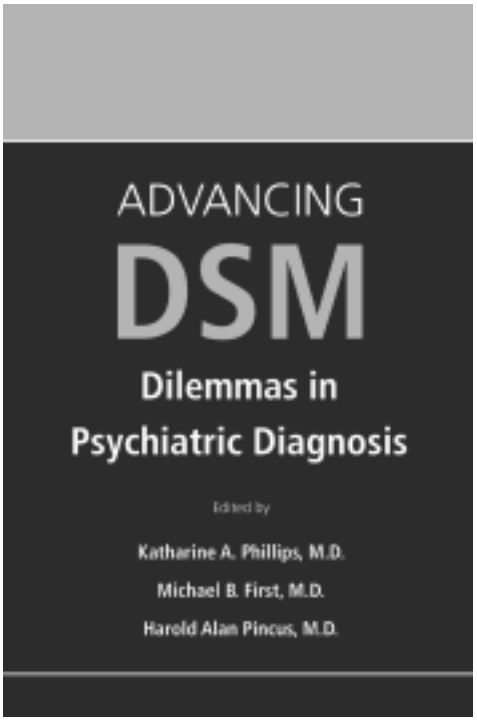
Produced as a partnership between the American Psychiatric Association and the National Institute of Mental Health, this fascinating work, reaches into the core of psychiatry, providing invaluable background and insights for all psychology and psychiatry professionals-food for thought and further research that will be relevant for years to come.

Advancing DSM: Dilemmas in Psychiatric Diagnosis

Edited by Katharine A. Phillips, M.D., Michael B. First, M.D., and Harold Alan Pincus, M.D.

In *Advancing DSM: Dilemmas in Psychiatric Diagnosis,* leading clinicians and researchers present diagnostic dilemmas from clinical practice that are intriguing, controversial, unresolved, and remarkable in their theoretical and scientific complexity. Chapters present a specific case study of a disorder or an area of diagnosis that illuminates the need for a revised diagnostic system. Chapter by chapter, *Advancing DSM* raises important, clinically relevant questions about the nature of diagnosis under the current DSM system and recommends new approaches.

DSM has been a landmark achievement for the field. By allowing reliable diagnosis, it has brought order out of chaos and fostered groundbreaking advances in research and clinical care. *Advancing DSM* will brief you on exciting changes in psychiatry today that will inform a next-generation DSM.



From the Council on Research

Presented below is the second in a series of four articles on models of research training in psychiatry residency programs. All four models were originally addressed at the NIMH-APA Workshop on Research Training for Psychiatrists, November 7, 2001.

Building Bridges
The Pittsburgh Model of Research Career Development

Holly A. Swartz, M.D. and Raymond Y. Cho, M.D., M.Sc.
Department of Psychiatry, University of Pittsburgh School of Medicine,
Western Psychiatric Institute and Clinic, Pittsburgh, PA

National concerns about the dwindling supply of physician-scientists and declining research training opportunities for psychiatrists have led to a national dialogue on new strategies to recruit and train the next generation of psychiatric researchers. In November 2001, the APA and NIMH jointly sponsored a Workshop on Research Training for Psychiatrists. This article focuses on one of the four training models presented at the Workshop, the University of Pittsburgh's approach to attracting, cultivating, and retaining junior research psychiatrists.

Contributing to the decline in psychiatry researchers, the path to a career in research is littered with a series of obstacles—including lacunae in research training opportunities, inadequate mentoring, and competing clinical demands—which threaten to derail all but the most tenacious nascent investigator. Pittsburgh's model can be understood as a series of bridges that help young investigators to overcome these obstacles, enabling them to stay on the research path throughout the early stages of their career development.

A Developmental Pathway

The Department of Psychiatry at the University of Pittsburgh is committed to providing research training opportunities across the developmental trajectory of early career psychiatrists. From undergraduate and medical school opportunities to the first year of residency through the junior faculty level, a variety of flexible research training experiences attract potential researchers at all stages of early career development. We will briefly describe the current training programs at the residency level and above, review the general principles of all research training programs at Western Psychiatric Institute and Clinic (WPIC), and then discuss in more detail the Junior Faculty Scholar Program.

Residency: The residency research track is open to all psychiatry residents at the University of Pittsburgh School of Medicine. Approximately half of the participants commit to the program at the beginning of their residencies and the other half join later. Entry into the research track is relatively informal (e.g., there is no separate match for this track), involving brief written statements of interest along with interviews with director of the track, Ronald Dahl, M.D., and Executive Vice Chair of the Department, Harold Pincus, M.D. The program is moderately structured, consisting of monthly meetings and an increasing percentage of time spent on research activities as training progresses. Because of the heavier clinical service and educational requirements of the PGY-1 and PGY-2 years, research-related activities during these initial years are usually limited to setting up research opportunities that are pursued more vigorously during the PGY-3 and 4 years. Up to half of the PGY-3 year and the full PGY-4 year can be dedicated to research related activities. In addition to engaging in research projects, participants have used this time to partake of various other research-related pursuits such as formal course work and starting concurrent graduate degree programs.

Members of the research track meet on a regular basis, congregating monthly to engage in informal discussions about topics such as mentorship (an important and recurring topic), funding, and conference attendance. In these dinner meetings, which alternate between Dr. Pincus's home and WPIC, participants update each other on their progress and discuss frustrating encounters related to research and training. Co-residents and course leaders offer informational and peer support, helping trainees develop problem-solving strategies as needed. In addition, specific benchmarks for self-assessment are provided to trainees to help them evaluate their progress. Although there have been ongoing discussions of further formalizing the requirements of the research track, these meetings have provided a venue to maintain *de facto* standards simply by keeping participants apace with each other.

Post-Residency/Fellowships: In the spirit of providing bridges to a research career across the developmental continuum, the Department of Psychiatry administers several Institutional Research Training grants (T32) for M.D., Ph.D., and M.D./Ph.D. post-graduate trainees. These two-year fellowship programs recruit recent graduates interested in topics such as child psychiatry, late-life mood disorders, and psychiatric epidemiology. Some graduates of the residency research track enter these fellowship programs and others enter with little or no prior research experience. The fellowships support a full-time commitment to research, enabling fellows to conduct small research projects and submit grant applications. The program is organized around the Survival Skills Seminar, a weekly meeting of fellows and senior faculty course leaders, designed to teach fellows essential skills necessary for a research career. Using a peer-review process modeled after an NIMH study section, the Survival Skills Seminar helps fellows hone their grant writing skills and learn to work more effectively with mentors. The Seminar also covers topics such as research ethics, curriculum vitae preparation, and multidisciplinary collaboration.

Junior Faculty: A survey conducted by Pincus et al. found that the median time between the end of research training and receipt of the first extramural grant was

three years. Bridging this critical time period, the Junior Faculty Scholars (JFS) Program (Mental Health Education Grant, R25 MH60473, Reynolds, P.I. and Pilkonis, Co-P.I.), is designed to help junior faculty transition to the status of independent investigator. A novel approach to address the high rates of attrition from the research trajectory during the first years of a faculty appointment, the JFS Program to date has enrolled 17 trainees, 11 of whom (65%) have successfully garnered an initial career development award (K01, K08 or K23). The JFS Program provides partial salary support (25%) for up to eight faculty members selected for two-year appointments, supporting junior faculty with a broad range of research interests. Some scholars find additional sources of salary support, ideally freeing 50 percent of their time for research-related activities. The program specifically recruits individuals committed to eight identified priority research areas: neuroscience and neuroimaging, genetics, treatment outcome research, health services research, developmental psychopathology, geriatrics, the relationship between mental and physical health, epidemiology and population-based studies. A statistician is available to JFS participants to provide support for the establishment of databases, strategies for data management, as well as data analyses and reports.

All JFS participants convene weekly for a seminar loosely modeled on the Survival Skills Seminar offered to research fellows. As mature learners, junior faculty scholars use a problem-based learning approach to tackling issues such as grantsmanship, balancing career and personal life, mentoring problems, and academic promotions. In addition, a didactic program focuses on providing participants with multidisciplinary, scientific literacy (i.e., neuroimaging, genetics, large-scale clinical trials) so that graduates will be able to engage in scientific dialogues that transcend narrow areas of expertise. The program also provides a small amount of funding for pilot studies that can be used to generate data essential to the submission of an initial career development award.

General Principles of Research Training

***Mentoring, mentoring, mentoring*:** Only partly in jest, WPIC educators assert that the top three research training priorities are mentoring, mentoring, and mentoring. In each of the training programs, course leaders provide systematic advice on selecting an appropriate mentor and nurturing the mentoring relationship. In the earliest stages, a research candidate is encouraged to meet with several senior faculty scientists to evaluate mutuality of research interests and goodness of the interpersonal fit. As the research training progresses, "meta-mentoring" (*i.e.*, several senior faculty meeting regularly with young investigators to discuss mentoring issues) helps research trainees optimize the mentoring relationship and manage potential difficulties. On an administrative level, the Department systematically selects faculty with strong mentoring skills and interests. In addition, mentoring is formally "incentivized" by incorporating mentoring activities into routine faculty performance evaluations and bonus compensation opportunities.

***Flexibility*:** The Department of Psychiatry stresses the importance of flexibility both within individual programs and across the programmatic research training enterprise. Although some residents are committed to research careers from the outset, others become interested later in their training. The flow of opportunities across the developmental trajectories enables individuals to "join up," without regard to level of training. For those who commit to the process from the outset, participation in the full sequence of training programs enables participants to expand their research skills as they advance through the early part of their careers.

***Colleagues/Peers*:** The size and scope of WPIC research and training activities assures an impressive critical mass of colleagues at each developmental stage. Building on these natural opportunities for collegial interactions, research trainees at WPIC participate in problem-based learning exercises that focus on peer review of draft research proposals, manuscripts, etc. Using a process that is modeled on NIMH study sections, trainees are encouraged to critique one another's work which hones scholarship and exposes the group to a range of scientific topics. Peer consultation on rough drafts is far less threatening than formal scientific review and enables even hesitant trainees to solicit input at the earliest stages of grant and manuscript development. In addition, peer support decreases potential feelings of isolation experienced by many junior investigators and provides exposure to potential future collaborators from other disciplines and labs.

***Research Opportunities/Collaborations*:** Participation in a structured training program confers upon its participants a stamp of legitimacy that facilitates collaboration with other investigators, both within the University and at a national level. Program leaders help match trainees to potential mentors and encourage even timid individuals to avail themselves of the opportunity to meet with faculty researchers (including visiting scholars from other institutions who are invited to give grand rounds or other academic presentations). In addition, the Department of Psychiatry actively recruits researchers from other disciplines (medicine, social work, pediatrics), encouraging collaborations that cross traditional lines and ideologies.

***Infrastructure*:** In addition to mentoring and research skill-building, junior investigators need access to a research infrastructure that supports their research endeavors. All training programs provide at least partial salary support to free the trainee from a portion of their clinical responsibilities. The JFS Program includes salary support for a statistician who is available for consultation and assistance with statistical analyses. Several mechanisms within the University of Pittsburgh offer seed money grants to generate pilot data for extramural grant applications, including the child (P30 MH66371, Brent, P.I), midlife (P30 MH30915, Kupfer, P.I.), and late-life (P30 MH52247, Reynolds, P.I.) Specialized Mental Health Intervention Research Centers. These large center grants also provide key research infrastructure such as data management and administrative support for affiliated junior investigators. Finally, an internal review committee rigorously reviews all grant applications prior to submission to external agencies, enhancing the quality of the applications.

A Personal Perspective (H.A.S.)

As summarized above, the JFS Program, funded by an R25 grant from NIMH, is designed to help junior faculty transition to the status of independent investigator. When the program began in 1999, I was among the first "class" of junior faculty to receive salary support through this mechanism. I entered the program with defined research interests and an established relationship with a senior scientist mentor. However, I lacked many of the fundamental skills that I would need to embark on a career in research. In fact, I doubted my

(see From the Council, continued on page 22)

Residents' and Fellows' Corner

Academic Tool Development for Psychiatry Residents: Writing and Time Management

Robert McCullum-Smith, M.D., Ph.D.
University of Michigan Medical School

Beginning with this issue of the PRR and continuing through 2003, the Residents' and Fellows' Corner will be authored by Robert McCullumsmith. Dr. McCullumsmith has agreed to take on this task, occasionally in collaboration with residents he supervises, in addition to his responsibilities as lecturer in the Department of Psychiatry, research investigator in the Mental Health Research Institute, and co-parent of four young children. We welcome Rob to the PRR staff. At the same time we congratulate Melissa DelBello, M.D., former custodian of this Corner, in her role as author of a new column focusing on junior faculty/investigator issues. The column, to be initiated in the Winter 2003 issue of the newsletter, will begin with Part II of Melissa's report on "Writing a 'K' Award" (PRR, Summer 2002).

When I began residency there seemed to be a never-ending stream of interesting patients, many of these cases about which there was little of direct relevance in the scientific or clinical literature. Of course, there was also an attending physician on each case, who would invariably suggest, "We should write this up." In fact, during my internship and second year of residency, I think I had five such offers. I judiciously (or so I thought) chose two of these cases to work on. The most interesting was a case of either secondary parkinsonism (per psychiatry) or catatonia (per neurology); the difficulty of making a diagnosis thus providing a challenging and interesting topic for a case report and a review of the relevant literature.

Work on this case report carried over into the third year, when I had a 50/50 division of my research and clinical time. During this period of my training I had to reformat my CV for a grant application and realized that I had perhaps used a format that was insufficient for the grant application. Specifically, I had not indicated which of my publications were peer-reviewed and which were not. This led to a series of short but eye opening exchanges with my mentor about where to put my energy when writing and publishing papers. This article summarizes these discussions and some of the guidelines I developed to help focus my time and efforts in a way to optimize my chances for advancement to the next level of an academic research career.

Some activities carry forward into your career – some don't

At the time, my goal was to finish the research track residency program at the University of Michigan School of Medicine, and then look for an academic psychiatry position where I could spend most of my time doing research. I had little to no appreciation for the workings of things like tenure clocks or appointment and promotion committees. It was revealing to learn that to successfully compete for an academic research position, I would be held to specific standards, including the type, variety, and impact of my publications. These standards may differ depending on the type of pathway or track of a particular academic job. At the University of Michigan, there are three academic tracks: clinical, instructional, and research scientist. Many factors other than publications go into decisions to hire or promote instructional, research scientist, or clinical track faculty—grant funding, teaching, and administrative roles—but publishing papers during residency is one area where your efforts will carry forward into your career. Nobody may remember how many times you have presented a case at grand rounds or how well you taught medical students on the inpatient unit. For example, I applied for a travel award that specifically excluded grand rounds under the teaching experience section of the application. A solid record of publishing peer-reviewed articles that center around a common theme, however, is somewhat more noticeable.

As my third year of residency started, I set aside three weeks to work on the case report of the interesting patient with the equivocal diagnosis. I looked through the *American Journal of Psychiatry*, the *Archives of General Psychiatry*, and other journals with high impact ratings. Impact ratings are an estimate of the importance of articles published in a specific journal based upon the average number of times articles in the journal are referenced (see the following link for details: http://www.isinet.com/isi/hot/essays/journalcitationreports/7.html). It quickly became apparent that the journals with the highest impact ratings in psychiatry rarely, if ever, publish single case reports, even with a well-written review of the literature.

I was told I could send my case report, without a literature review, as a letter to the editor. But this falls into a gray area: Are they peer-reviewed? Do they count as publications? It depends largely on whom you ask. Anyway, after three weeks of writing, I had a pretty good manuscript, but I had a lot more to do since I had taken on reviewing several different aspects of the relevant literature. I had included akinetic mutism, conversion disorder, and locked-in syndrome in the differential and I wanted to properly examine these topics. At this point, I had generated some data in the lab, enough to begin writing a paper. I had a decision to make. Should I throw myself completely into the so-called "data" paper, or continue work on the case report? My time was limited to a 50 percent effort in the lab, and much of this went to performing experiments.

With an eye toward the future, I asked around, talked to my mentor, and gathered information about what would be best for my career. Most of the advice was clear: given a choice between a data-based paper and a case report, the data-based paper would do more for me. It would likely be in a higher profile (and higher impact) journal; it would without question be considered peer-reviewed and be tucked into the now titled "Peer-Reviewed Publications" category of my CV; and it would begin to establish a theme or identity for my career in academic psychiatry. The bottom line was that nobody who would be reviewing my papers or grants in the future would notice a case report of parkinsonism secondary to a CSF shunt revision compared to a paper with data that supports a hypothesis of altered glutamatergic neurotransmission in schizophrenia. Thus, I developed Rule Number One: Only write peer-reviewed data papers.

Such a rule does not necessarily apply to all academic tracks. Non-data-based chapters and review articles are very important for advancement in the clinical track at the University of Michigan. Further, such publications are highly appropriate for residents who are not on a research trajectory but may be interested in learning a topic in depth while contributing to the literature. There is nothing better than a well-written review article to help sift and sort through a difficult topic, and few people have time to read all the relevant primary sources.

When (and when not) to write a book chapter

Later that fall, I promptly broke rule number one. Work on the data paper bogged down, and my mentor asked me to help write a book chapter. I said yes, and enthusiastically threw myself into the same review article mode I had been in the summer before, but this time under the cover of my mentor's approval. Many review articles written for publication in a journal are formally peer-reviewed and often held to higher standards than data papers. Book chapters, however, are "edited." This usually means that the editor of the book is happy to have received the chapter in time to include it in the book. While book chapters are occasionally peer-reviewed, the reality is that chapters are not usually reviewed as rigorously as other papers. In fact, many institutions require that book chapters go under a separate heading on your CV. Our chapter was lightly peer-reviewed and was somewhat related to schizophrenia, making a good rationalization of my efforts possible. But the question remains, should a resident looking for a career in research write non-peer-reviewed articles?

I would say that it depends on whether or not it makes sense for the individual resident. If a person has many peer-reviewed articles and is asked to write a chapter related to his or her work, there is an opportunity to demonstrate to the field the ability to synthesize large amounts of information in the context of an underlying paradigm or hypothesis. On the other hand, if several book chapters are all you have written, the question can be raised as to whether or not you have the ability to succeed in a research career that requires publishing data-based papers and writing grant applications based on these publications.

It is important to recognize that as a resident you will not always have a pile of tabulated, completely analyzed, coherent data to turn into a paper. Often these downtimes are at the beginning of a research project. This is the time to read articles and generate both an electronic bibliographic database as well as an intellectual database of the relevant literature. These periods of time, when you have no data in hand, are best filled with writing review articles or book chapters.

Later in my third year, I began to get e-mails from one of the co-authors of the case report. He was very interested in finishing the manuscript and suggested I should just finish it and send it off. His advice was to work on it a little bit every day, an hour here or there, until finished. This seemed to be good advice, and given the frequency at which it was offered, I had great difficulty ignoring it. While in the lab generating data, I tried to spend my free half-hours here and there working on my data papers. This seemed to help my productivity, and I developed the habit of always having some type of writing to work on. Whether it is a grant application, a travel award essay, a data paper, a book chapter, a review article or even a letter of recommendation for a student, I always try to be writing every day. I carry partially written copies of papers anywhere there might be downtime, so I can edit and make corrections. So this is Rule Number Two: Always be writing something.

Some exceptions to the rules

So why am I writing this article? I asked a colleague to read a draft of this article, and she pointed out the implicit paradox of my advice—by writing this article I am clearly breaking rule number one. I guess I would say that this is where the exceptions come in. It is important as your career moves along to develop a presence in your field and to provide some service, however small or large, to support psychiatric research. This may be in the form of book chapters or commentary on research training. However, the primary reason for writing this article is that I enjoy it. For me, all writing cannot be about glutamate transporter expression in schizophrenia or differential effects of antipsychotics on signaling pathways. I need some outlet for what I call "fun" writing. This is writing outside that required by my career, that is not scrutinized by statistical reviewers, and writing that I strongly believe makes me a better science writer. Rule Number Three is simply to occasionally write something because you enjoy it.

Two years later, the case report is still on my desk. It is in line behind the three or four data papers that I need to write first. I have politely, but firmly, stated my priorities to the co-authors when they have inquired. I reread the current draft a few weeks ago. It does not need much more—perhaps two to three days of solid work prior to submission. Maybe sometime around the Christmas holidays ..... ■

Legislative Forum

Lizbet Boroughs, M.S.P.H., Associate Director,
Division of Government Relations

❖ *FY 2003 Appropriations Status*

The **Senate** Appropriations Committee passed the massive $136.7 billion FY 2003 Labor-HHS-Education Appropriations bill (S. 2766) on July 23, placing the bill on the Senate Legislative Calendar for further action. The Committee's version of the bill surpasses the Administration's initial request by $5.8 billion, a seven percent increase over current year totals.

NIH. The Committee bill includes a $3.7 billion, 13.8 percent, increase for the National Institutes of Health (NIH), bringing the recommended FY 2003 budget for NIH up to $27 billion and completing the five-year bipartisan effort to double the NIH budget.

For **NIMH**, the Senate bill recommends an 8.3 percent increase of $103 million. This is $8 million less than the Administration's request and falls far short of the overall NIH increase, 13.8 percent. As Congress moves forward on the FY 2003 Labor-HHS appropriations bill, APA will press for a final version that includes a NIMH increase at least equal to the overall NIH boost.

NIDA. The Senate Committee has proposed an $80 million increase in the budget for FY03, matching the Administration's request. While this number falls short of the $142 million increase sought by the APA, it will mean a nine percent rise from the FY02 budget of $888.1 million, if passed as proposed by the Senate Committee.

NIAAA. APA's proposed $71 million increase in funding for FY03, from a FY02 total of $384.2 million, is undershot by both the Administration and the Senate committee proposals. Both have consented to slate requests for FY03 at an increase of $34 million, which will result in a 8.8 percent increase over last year's actual budget.

CMHS. The Senate Labor-HHS-Education Appropriations bill proposes to increase overall funding for the Center for Mental Health Services (CMHS) by $12 million in FY 2003, an increase that includes the President's request for a $7 million increase in support for PATH (Projects for Assistance in Transition from Homelessness).

For the PRNS programs (Programs of Regional and National Significance), the Senate bill rejects the Administration's proposals to cut the PRNS account by $7.5 million. PRNS funds are controlled by CMHS, in direct contrast to state-managed formula grant programs such as the Mental Health Block Grant program and the PATH program.

Other provisions contained in the Senate bill for CMHS: $5 million to continue a new senior citizen program at CMHS; a $1 million increase recommended by the Administration for the CMHS Jail Diversion program bringing to $5 million the program's total allocation; a $10 million increase in services for children experiencing PTSD.

The **House** bill (H.R. 5320) was referred to the House Committee on Appropriations on September 4. No further action was taken on the bill as of September 30.

❖ *Mental Health Parity*

APA Research Director Darrel A. Regier, M.D., M.P.H., testified on Insurance Coverage of Mental Health Benefits in hearings held on July 23rd before the U.S. House of Representatives, Committee on Energy and Commerce, Subcommittee on Health. Regier stated, on behalf of APA, that diagnosis and treatment of mental illness has become the fastest accelerating and the most exciting frontier in the biological sciences.

"We understand how the brain works and how mental disorders affect the brain better than at any time in our nationís history. Yet the ability for Americans to secure medically necessary care for their mental illnesses is largely negated by open, legal, and blatant insurance discrimination. It is difficult to comprehend how those opposed to parity can continue to sanction the disenfranchisement of patients with one type of medical condition - mental disorders - from the same rights as patients for all other medical or surgical care."

Parity opponents are now focusing their objection on the diagnostic criteria for mental disorders found in the APA's *Diagnostic and Statistical Manual, Fourth Edition (DSM-IV)*, arguing that the *DSM-IV* criteria are too broad. "These allegations are simply unfounded. The carefully crafted language in both the House and Senate parity bills fully protects the ability of health plans to determine if the treatment meets the requirement for clinically significant distress or disability," said Dr.Regier. "The DSM issue is a canard intended to distract Congress from the real issue: blatant discrimination against a single group of patients who for no fault of their own need treatment for mental illness."

Mental illnesses are costly to the economy and to American businesses. "According to the *Report of the Surgeon General on Mental Health* (1999), the lack of parity coverage for mental illness treatment costs businesses over $70 billion every year in absenteeism, lost productivity, increased use of sick and disability leave, substance abuse and higher use of non psychiatric medical services."

"Expanding mental health parity would level the health care coverage playing field to require fair access to equitable mental health treatment, which will

lessen health care costs in the long run," said Dr. Regier. "There is a moral imperative for ending discrimination against patients seeking treatment for mental illness. Parity is a health policy issue, not a partisan political issue."

❖ *Workforce Shortage*

Representatives Patrick Kennedy (D-RI) and Ileana Ros-Lehtinen (R-FL) have introduced legislation to address the national shortage of child and adolescent psychiatrists. The Child Mental Health Professional Expansion Act, H.R. 5078, proposes educational incentives to encourage individuals to enter children's mental health professions. Reps. Kennedy and Ros-Lehtinen are enlisting co-sponsors for the legislation.

If passed, the legislation would extend Medicare graduate medical education (GME) support to child psychiatry training programs, and it would also create a loan forgiveness program for use by child and adolescent psychiatrists.

The bill requires the Health Resources and Services Administration (HRSA) to conduct a study on the distribution and need for child mental health professionals. Less than 20 percent of the estimated 14 million children and adolescents who suffer from a mental illness receive treatment *(Report of the Surgeon General's Conference on Children's Mental Health, 2001)*. The Child Mental Health Professional Expansion Act would remove one of the barriers to adequate treatment, the lack of available child and adolescent psychiatrists. ■

PROGRAMS	FY 02 FINAL	FY 03 ADMIN REQUEST	FY 03 APA REQUEST	SENATE COMMITTEE 7/16/02	HOUSE
CMHS					
CMHS Total	$832.1m	$832.1m (0)	$1200.11m (+$368.01)	$844m (+$12m)	Pending
Block Grant	$433.0m	$433.0m (0)	$671.15m (+$238.15)	$433.0m (0)	Mark-up
Children's MH	$96.7m	$96.7m (0)	$140.00m (+$43.31)	$96.7m (0)	
PATH	$39.9m	$46.9m (+7m)	$46.9m (+$7.00)	$46.9m (+$7m)	
Protection & Advocacy	$32.5m	$32.5m (0)	$37.18m (+$4.68)	$35.5m (+$3m)	
PRNS	$230.0m	$223.1m (-$7m)	$304.88m (+$74.87)	$232.0m (+2m)	
NIH					
NIMH	$1,248.0m	$1,359.0m (+111m)	$1,447.7m (+$199m)	$1,351.0m (+$103m)	
NIDA	$888.1m	$968.11m (+$80m)	$1,030.2m (+$142m)	$968.11m (+$80m)	
NIAAA	$384.2m	$418.24m (+$34m)	$455.55m (+$71m)	$418.24m (+$34m)	

News and Notes

Negative Research Results

Technology and innovative thought have partnered in *The Journal of Negative Results in Biomedicine*. This new publication, an online medical journal, is focused on airing unexpected outcomes of rigorously conducted research. The brain child of Harvard cell biologist Bjorn Olsen, Ph.D., the journal is intended to serve as a forum to reward strong research even if the work challenges established conventions producing unexpected, controversial, or provocative results. Olsen is convinced of the merit in publishing research anomalies, noting that "Those negative results can be extremely valuable information….Without those published results, there's no evidence that someone has gone down that path and uncovered nothing." Olsen hopes that with the help of the new online journal the dead ends of negative results research will give way to an open road.

Olsen acknowledges that disclosing such work will not be met with resounding approval. He expects, for example, that pharmaceutical firms who seek to downplay the negative results of drug trials will be especially resistant to this new line of thought. The hope is that as these firms become more invested in the research effort, they will come to embrace all results which manifest through proper and competent research.

The online-only journal is published through the UK-based Biomed Central (www.biomedcentral.com) and can be accessed at www.jnrbm.com.

NIH Agenda

Explanation, translation, and accountability will be priorities during the tenure of newly-appointed NIH Director, Elias Zerhouni, M.D. During his first address to the NIH Director's Advisory Committee, Zerhouni referred to pressure from Congress and from the administration to see to it that research funds are expended properly and responsibly. The standard for agency performance has been set high, and Zerhouni will endeavor to ensure that performance measures are established. "There is a huge cry out there for accountability and transparency," Zerhouni stated, referring to the issues that will dominate the current administration. Opening the lines of communication to better explain how funding is allocated begins with a thorough understanding of what biomedical science intends to accomplish. Zerhouni expects that this "fundamental discourse" will pave the way to increased awareness of the need for research.

Changing Climate of Academic R&D

A recent study by the National Science Foundation (NSF) indicates that over the past three decades academic research and development has begun to rely more heavily on state, industry, and academic institutions, and less significantly on federal support. The 30-year trend shows that the federal share of academic R&D support has dropped from 68% in 1972, to 58% in 2000. Given this 10% decline in federal funding, academic institutions have picked up the slack by increasing their share of the composite funding from 12% in 1972, to 20% in 2000. While it still does not represent the largest component of R&D funding, institutional support was the fastest growing source over the 30-year period, rising from 3% in 1972, to 7% in 2000.

The NSF analysis also targeted specific fields of study, including engineering, biology and medicine. Federal support fell simultaneously for these fields. NSF notes that the decline in the federal share for medical sciences occurred during a period that included the initial years of the NIH doubling effort, indicating that non-federal sources of medical science R&D managed to increase funding faster than the federal government despite expansion of the NIH budget.

IACUC Approval

Research institutions with PHS Animal Welfare Assurances will now be able to submit verification of approval from their Institutional Animal Care and Use Committee (IACUC) after NIH peer review is complete, as long as it is provided before the award is made. Prior to this rule change, verification was required before peer review. The policy change was announced by NIH in an August 7, *Federal Register* Notice, and was effective beginning September 1, 2002. This policy is applicable to all research with live vertebrates supported by PHS. The modification is intended to "enhance flexibility of institutions and reduce burdens on applicants and IACUCs."

NIH Young Investigator Awards Decline

At its annual meeting in early September, the Association of Independent Research Institutes (AIRI) presented data on NIH extramural grantees. The study, spanning the years between 1980 and 2001, indicates that researchers under the age of 35 have experienced an 18.8% decline in support from NIH. The decline in funding to these junior researchers directly correlates to the increase of support for investigators over the age of 55. Changing demographic trends, institutional regulations limiting grant submissions to tenured faculty, and funding of larger, more complex projects are all factors thought to be responsible for the 10.7% increase in support to more senior investigators over the past 21 years.

The NIH Office of Extramural Research (OER) contributed additional interpretations of the findings: the database (CRISP) used in the AIRI study currently contains only the names of principal investigators who are likely to be more senior than co-investigators who are not yet included in the database; increased funding of large, multi-institutional research projects may favor senior investigators.

Mental Health and Mass Violence

A national conference report released on September 5, 2002 addresses existing data and research needs on a broad range of issues concerning early mental health interventions following exposure to mass violence. The report is entitled *Mental Health and Mass Violence: Evidence-Based Early Psychological Intervention for Victims/Survivors of Mass Violence. A Workshop to Reach Consensus on Best Practices*, and was developed by five organizations: NIMH, the American Red Cross, and the Departments of Defense, Justice, and Veterans Affairs. The report is targeted to those who

deliver interventions to emotionally distressed persons following mass violence, to those who research these issues, and to employers who want to help workers who have experienced emotional trauma. Prepared by 58 mental health researchers and clinicians from the U.S. and five other countries, the report details what is effective, what is not, and what questions require further research. Included is an outline of a sample training program for an early intervention workforce.

ACNP–ECNP Exchange Program

The American College of Neuropsychopharmacology (ACNP) and the European College of Neuropsychopharmacology (ECNP) have agreed to a three-year trial program of exchanging fellows to attend the annual meeting of each organization. The first three fellows to represent the ECNP will attend the ACNP meeting in Puerto Rico in December 2002. The ECNP will select three young individuals who receive Poster Awards at the ECNP meeting in Barcelona, October 5 – 9, 2002; the ACNP will waive the meeting registration fee, invite the fellows to present posters and to attend the special programs for travel awardees. To represent the ACNP at the 2003 ECNP meeting, the ACNP Education and Training Committee will select fellows from winners of the ACNP Travel Awards. For further information about the program, contact Louise Gallant at the ACNP offices, lgallant@acnp.org.

Council on Bioethics Report

The President's Council on Bioethics has issued its first report, *Human Cloning and Human Dignity, an Ethical Inquiry.* The document summarizes the council's six-month study of Somatic Cell Nuclear Transplantation (SCNT). According to the report, the council members agreed to support a legislative ban on cloning for reproduction but were divided on the issue of a moratorium on cloning for biomedical research.

A ten-member majority supported a four-year moratorium on human SCNT in favor of more animal research, more discussion of the ethical issues, and more time to set up the regulatory processes that all members supported. The minority, seven council members, supported eventual establishment of an oversight and regulatory system, with interim approval of continued research on stem cells and tissues derived from human cloned embryos.

The majority position was opposed by members of the Coalition for the Advancement of Medical Research, including Maxine Singer of the Carnegie Institution of Washington, Richard Klausner, and Gerald Fischbach, both former directors of NIH institutes. A petition circulated by the Coalition charged that an entire generation of biomedical researchers would be lost as a result of the four-year moratorium. The Council's report is available on line at www.bioethics.gov.

NRC and Biomedical Education

A September 10 report from the National Research Council, *BIO2010: Undergraduate Education to Prepare Biomedical Research Scientists*, scrutinizes the status quo in biomedical education. The request is for undergraduate institutions to teach science as it is now conducted, but with increased emphasis on its interdisciplinary nature. At many colleges and universities, biology students take additional courses in mathematics and physical sciences, but these subjects are not integrated in the biology classroom, leaving students lacking in the key connections between scientific disciplines.

The report suggests materials and approaches that teachers may use to address the idea of interdisciplinary learning in the sciences. Adaptable modules and interactive computer systems developed by companies such as BioQUEST, allow students to simulate costly experiments and thereby to see integration of the disciplines at work. Interdisciplinary lecture and seminar courses are considered a good jumping-off point to demonstrate how the sciences overlap. The report also suggests ideas for new labs in physics, engineering, chemistry, and genomics, following a "crawl, walk, run" model for learning. This approach allows students to mature from step-by-step instructions to guidelines and examples, to ultimately seeking independent research opportunities.

BIO2010 strongly encourages developing opportunities for independent research, advising that the one-on-one mentoring relationship between student and faculty member in an area of specific interest fosters critical thinking and the ability to draw connections among disciplines.

E-Grants to Replace the Federal Commons

E-Grants, a government-wide electronic grant application system, is expected to be launched on October 1, 2003. The deployment of this system will effectively replace the Federal Commons as the electronic grant portal. Resulting from E-Government initiatives to improve access to government services via the internet, E-Grants is supported by 11 department and agency partners, and managed by the Department of Health and Human Services (DHHS).

Those who have navigated the Federal Commons system will notice similarities between it and the new E-Grant system. The benefit of the new system is that it will significantly reduce the amount of internet browsing one must accomplish to source information. Integration of the systems is the aim, and the hoped-for result is what the E-Grants Program Management Office (PMO) refers to as a "one-stop electronic grant portal where potential grant recipients will receive full service electronic grant administration." Centralization of the system will allow patrons to communicate at a single point of entry which acts as a broker between the various agencies.

E-Grants' Business Partner Network (BPN) will be the one-time "central registration point" for all grant applicants and will also maintain organizational profiles of agencies so that multiple registration and maintenance with multiple agencies will not be required. The E-Grants system ultimately will be a single source for access to funding opportunities posted by research-funding departments and agencies. ■

Research Training Opportunities

■ **SPONSOR: AstraZeneca and APIRE**

■ **POSITION: Young Minds in Psychiatry Awards**

DESCRIPTION: Four unrestricted career development awards in the amount of $45,000 each, will be awarded to recognize and promote promising work of young physicians (35 years of age or under) working in the field of psychiatry. Two awards will be made to promising physicians from the United States, and two awards will be made to promising physicians from countries outside the United States. U.S. applicants must be members of the APA; international applicants do not need to be members of the APA in order to apply. The Young Minds in Psychiatry Awards will cover a range of activities, including research, educational efforts, travel, salary support and materials, for work performed in two substantive categories: (1) Bipolar Disorder, and (2) Schizophrenia. Applications must demonstrate: evidence of academic promise; how the award will advance the applicant's career; innovative or original concepts, approaches or methods of developing applicant's career. Proposals should be no longer than three pages, including references, printed in type not smaller than 10-point type, with 1-inch (2.5 cm) margins on all sides and one full space between lines.

DEADLINE: November 20, 2002

CONTACT: For additional information, applications, and instructions, Ernesto Guerra, Research Training Director, APA, toll-free 1-800-852-1390, e-mail: eguerra@psych.org, Web site: www.psych.org/res_res/youngminds_announce.cfm.

■ **SPONSOR: APA, Committee on Research Training and APIRE**

■ **POSITION: Research Colloquium for Junior Investigators**

DESCRIPTION: The Committee on Research Training requests nominations for participants in the annual APA Research Colloquium for Junior Investigators to be held on May 18, 2003 in conjunction with the APA Annual Meeting in San Francisco. The purpose of the Colloquium is to provide guidance and mentorship to senior residents, fellows, or junior faculty in the early phases of their research careers, and to those who have interest and potential in developing research careers. Colloquium participants will have the opportunity to present research and to obtain feedback about past, present, and future research interests from mentors in small group settings, as well as to obtain general information about research career development and grantsmanship. A $1,000 stipend is provided to participants. The all-day workshop will focus on these three substantive areas: 1) Anxiety and Stress Related Disorders, 2) Clinical Trials, and 3) Epidemiologic and Health Services Research.

DEADLINE: November 15, 2002

CONTACT: Ernesto Guerra, toll-free: 1-800-852-1390, e-mail: eguerra@psych.org, Web site: www.psych.org/res_res/index.cfm.

■ **SPONSOR: American Psychiatric Institute for Research and Education (APIRE)**

■ **POSITION: Program for Minority Research Training in Psychiatry (PMRTP)**

DESCRIPTION: This NIMH-funded program supports minority medical students and psychiatric residents for an elective or summer experience in a research environment. Funds are provided for stipends, tuition, travel, and training-related expenses. Stipends are also available for one- or two-year post-residency fellowships. Training takes place at research-oriented departments of psychiatry in major U.S. medical schools and other appropriate sites nationwide. A research mentor at the training site oversees the research training experience.

DEADLINE: December 1 for residents seeking a year or more of training and for post-residency fellows. April 1 for medical students who are planning a summer research training experience. For other elective experiences students should apply at least three months before the start date of the proposed research training.

CONTACT: Ernesto Guerra, Research Training Director, APIRE, 1400 K Street, NW, Washington, DC 20005. Tollfree 1-800- 852-1390, fax: (202) 789-1874, e-mail: eguerra@psych.org, Web site: www.psych.org.

■ **POSITION: Program for Minority Research Training in Psychiatry (PMRTP)**

DESCRIPTION: The American Psychiatric Institute for Research and Education and the Program for Minority Research Training in Psychiatry request applications from residents at the PGY-4 (and some PGY-3) level that may be interested in developing a research career. Selected postresidency fellows receive stipends for a one-year renewable fellowship; stipends range from $42,648 to $44,616 for residents and up to $48,852 for postresidency fellows. In addition, fellows receive travel support to attend the APA Annual meeting and other scientific meetings to present their research findings. Some tuition support is also available. Underrepresented minorities are encouraged to apply.

DEADLINE: December 1, 2002

CONTACT: Ernesto Guerra, toll-free 1-800-852-1390, e-mail: eguerra@psych.org, Web site: www.psych.org/res_res/pmrtp5302.cfm.

■ **SPONSOR: APIRE and Janssen Pharmaceutica**

■ **POSITION: Research Fellowship in Severe Mental Illness**

DESCRIPTION: The American Psychiatric Institute for Research and Education (APIRE) and Janssen Pharmaceutica are co-sponsoring a fellowship program for promising PGY-1, PGY-2, and PGY-3 psychiatric residents with interest in clinical and health services research on

severe mental illness: schizophrenia, bipolar illness, or other forms of severe mental illness. Fifteen scholars are selected and each receives $5,000 during the second year of the fellowship to assist in research career development.

DEADLINE: January 15, 2003, for submission of applications.

CONTACT: Ernesto Guerra, Research Training Director, APIRE, toll-free 1-800-852-1390, e-mail: eguerra@psych.org, Web site: www.psych.org/res_res/janssen61101.cfm.

■ **SPONSOR: Columbia University**

■ **POSITION: Research Fellow**

DESCRIPTION: This is a two to three year NIMH-supported post-residency training program for psychiatrists starting July 1, 2003. Location is in one of the clinical research divisions of Columbia University's Department of Psychiatry, at the New York State Psychiatric Institute, Creedmoor Psychiatric Center, or Presbyterian Hospital. Fellows participate in ongoing clinical research projects and learn research skills by working closely with a senior member of the research faculty. Many areas of clinical research are represented: affective and anxiety disorders, schizophrenia, eating disorders, nosology, psychopharmacology, etc. Trainees are selected on the basis of their interest and potential in becoming full time academic researchers in psychiatry. Fellowship stipends begin at $52,000 through the combination of New York State and NIMH funds.

DEADLINE: December 15, 2002

■ **POSITION: Research Fellowships in Geriatric Psychiatry**

DESCRIPTION: This is a two to three year NIMH-sponsored program to prepare promising M.D.s and Ph.D.s for careers as independent clinical investigators. Training includes work with a mentor and courses in statistics, research design, translational research, ethics and grant writing. Positions available for July 1, 2003. Applicants may send a resume or request applications.

DEADLINE: December 15, 2002

CONTACT: Steven P. Roose, M.D., New York State Psychiatric Institute, 1051 Riverside Drive, Unit 98, New York, NY 10032. (212) 543-5749, fax: (212) 543-5607, e-mail: spr2@Columbia.edu. Columbia University is an AA/EEO employer especially interested in recruiting minorities and women.

■ **POSITION: Postdoctoral Research Fellowship in TMS**

DESCRIPTION: Federally funded postdoctoral fellowship available immediately (start date flexible) at the Columbia University Magnetic Brain Stimulation Lab. The fellow will receive extensive hands-on training in transcranial magnetic stimulation (TMS). The lab is equipped with state-of-the-art magnetic stimulators capable of performing single pulse, paired pulse, repetitive stimulation, and magnetic seizure therapy (MST) in humans and in animal models. Access to functional neuroimaging is available, as well as access to a full spectrum of clinical psychiatric populations. The fellow may participate in a range of clinical and preclinical studies using TMS as a probe of brain function and as a putative treatment for psychiatric disorders. The initial project will employ TMS in combination with functional MRI to study working memory networks affected by sleep deprivation. Clinical training in psychiatry, neurology, or radiology would be desirable. Please send CV and list of references to contact below.

DEADLINE: Open, ongoing recruitment

CONTACT: Holly Lisanby, M.D., Department of Biological Psychiatry, New York State Psychiatric Institute, 1051 Riverside Drive, Unit 126, New York, NY 10032. (212) 543-5568, fax: (212) 543-6056, e-mail: shl24@columbia.edu.

■ **SPONSOR: Mental Health Clinical Research Center, University of Iowa**

■ **POSITION: Postdoctoral Fellowships in Clinical Neuroscience**

DESCRIPTION: Applications are being accepted for a 1- to 3-year NIMH-funded fellowship program in the neurobiology of major psychotic disorders. The fellowship is designed for either: 1) psychiatrists who have recently completed residency or are beginning their fourth year of residency and/or; 2) recent Ph.D.s in psychology (clinical or experimental), neuroscience, biostatistics, biomedical engineering, or related fields. Major areas of activity include brain imaging (MRI, fMRI, & PET), biostatistics, cognitive neuroscience, neuroanatomy & neuropathology, neuropharmacology, & molecular genetics. The primary focus of the Clinical Research Center is on schizophrenia and related psychotic disorders.

U.S. citizenship or permanent visa status required. Applicants from underrepresented groups and from all ethnic backgrounds are encouraged to apply. For more information about the Mental Health Clinical Research Center, visit http://iowa-mhcrc.psychiatry.uiowa.edu/.

DEADLINE: Applications available now for positions beginning July 1, 2003.

CONTACT: For application write to Nancy C. Andreasen, M.D., Ph.D., Director, MHCRC, 2911 JPP, 200 Hawkins Drive, Iowa City, IA, 52242-1057. (319) 356-1545 or e-mail Vicki Foubert at vicki-foubert@uiowa.edu. The University of Iowa is an Equal Opportunity/Affirmative Action Employer.

■ **SPONSOR: Neuropsychiatric Institute & Hospital, UCLA**

■ **POSITION: Research Training in the Psychobiology of the Major Psychiatric Disorders**

DESCRIPTION: This NIMH-funded program prepares postdoctoral fellows for research careers in psychiatry and biobehavioral sciences, with particular emphasis on research approaches to clinical problems. Instruction in the principles of research methodology and technique are stressed. The program for each trainee consists mainly of active participation in research work under faculty preceptorship, allowing the trainee to acquire practical as well as theoretical proficiency in a variety of laboratory and statistical techniques, and firsthand experience with problems of experimental design and research strategy. This is supplemented by a curriculum of seminars and workshops in which trainees and faculty participate as a group. Flexible programs that are suited to unique interests and needs may be arranged. Research projects may involve basic laboratory studies as well as clinical studies of patients

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with psychiatric and medical syndromes. Departmental laboratory facilities are available for human and animal studies in psychopharmacology, psychoneuroimmunology, behavioral genetics, clinical neurophysiology, brain imaging, neurochemistry, cellular neurophysiology, and neuropsychology. In addition, specialty clinical programs in alcoholism and the addictions, aging, mood disorders, schizophrenia, and other illnesses provide ample opportunity for clinical research and collaboration. The research training faculty is composed primarily of psychiatrists and clinical and experimental psychologists, and the program maintains close working ties with the Departments of Neurology, Genetics, Pediatrics, Medicine, Psychology, Radiology, and others at UCLA.

DEADLINE: Open.

CONTACT: Submit a brief statement of background and interests, a two-page description of a potential research project, CV, and three letters of recommendation to Andrew Leuchter, M.D., Director, Division of Adult Psychiatry, UCLA Department of Psychiatry and Biobehavioral Sciences, 760 Westwood Plaza, Room 37-452, Los Angeles, CA 90024. Information can be faxed to (310) 825-7642 or e-mailed to fellow@qeeg.npi.ucla.edu.

■ **SPONSOR: University of Massachusetts Medical School**

■ **POSITION: Psychopharmacology Fellowship**

DESCRIPTION: The Psychopharmacology Program at the University of Massachusetts Medical School (40 miles west of Boston) offers a full-time, one-year PGY-5 fellowship position in psychopharmacology beginning July 1, 2003. The recipient will participate in clinical research in affective and psychotic disorders, have an individual project under the supervision of Dr. Anthony Rothschild, and will also participate in ongoing psychopharmacology research projects in the Department of Psychiatry. The Fellow will: have protected research time and opportunities to travel; present at meetings; and train in psychopharmacologic evaluation, treatment, and consultation both in outpatient and inpatient settings. Candidates must have completed an approved residency in psychiatry.

DEADLINE: Open

CONTACT: Please send CV and two letters of recommendation to Anthony J. Rothschild, M.D., Professor and Director of Clinical Research, Department of Psychiatry, University of Massachusetts Medical School, 361 Plantation Street, Worcester, MA 01605. (508) 856-1027, fax: (508) 856-4854, e-mail: rothscha@ummhc.org.

■ **SPONSOR: University of Pittsburgh**

■ **POSITION: Postdoctoral Research Fellowship in Psychiatry/Mental Health Services Research**

DESCRIPTION: The University of Pittsburgh Department of Psychiatry and the University of Pittsburgh Medical Center Health System's Western Psychiatric Institute and Clinic is offering a 2-year postdoctoral research fellowship opportunity for M.D.s or Ph.D.s with an interest in mental health services research.

The combined resources of the Medical Center Health System and the Department of Psychiatry provide a remarkably enriched academic environment that has been uniquely successful in fostering research career development.

The fellowship opportunity is designed to provide methodological skills acquisition in addition to research experience with an established investigator in one of three (child, mid-life, late-life) mental health intervention research centers. Research emphasis includes comorbidity of psychiatric disorders and general medical disorders, the effect of mental disorders on health services utilization, epidemiology of mental disorders in primary care, and the design and adaptation of intervention strategies for particular settings (e.g. primary care, pediatrics, community and ob/gyn), and populations (e.g. women, underserved).

There will be opportunities for fellows to collaborate with the RAND-University of Pittsburgh Health Institute. The Institute is a joint effort between RAND Health and the School of Medicine and Health Sciences at the University of Pittsburgh. The work of the Institute focuses on traditional aspects of health services research such as financing, organization, quality and access. In addition, postdoctoral fellows can take advantage of established collaborations between the University's Center for Research on Health Care in the Department of General Internal Medicine, the University's Graduate School of Public Health, and the hospitals of the UPMC Health System. The Department is also home to the Robert Wood Johnson Foundation's national program on depression in primary care.

DEADLINE: Open

CONTACT: Harold Alan Pincus, M.D., Professor and Executive Vice Chair, Western Psychiatric Institute and Clinic, 3811 O'Hara St., Pittsburgh, PA 15213. Fax: (412) 624-8015, e-mail: pincusha@msx.upmc.edu

■ **SPONSOR: Yale University School of Medicine**

■ **POSITION: Clinical Neuroscience Research Training**

DESCRIPTION: The Department of Psychiatry offers a unique opportunity for PGY-4 residents and PGY-4 fellows interested in cutting-edge clinical neuroscience research. Emphasis is on the biologic basis of neuropsychiatric disorders. Trainees are encouraged to develop their own research studies in one or more of the following areas: novel psychopharmacology, brain imaging research (PET, SPECT, 1H-MRS, fMRI), pharmacologic challenge paradigms, and genetics of psychiatric disorders. Neuroscience faculty have extensive expertise in the areas of schizophrenia, mood disorders, substance abuse (alcohol, cocaine, nicotine) and women's reproductive behavioral health research. Faculty closely mentor trainees to enhance research training and promote trainees' career development.

DEADLINE: Open

CONTACT: Interested applicants should send their curriculum vitae to Robert Malison, M.D., Director, Neuroscience Research Training Program, Yale University Department of Psychiatry, Clinical Neuroscience Research Unit, Connecticut Mental Health Center, 34 Park Street, New Haven, CT 06519, or send an e-mail requesting more information to robert.malison@yale.edu. ■

Research Funding Opportunities

■ **SPONSOR: National Science Foundation (NSF)**

■ **SUBJECT: Cognitive Neuroscience**

DESCRIPTION: In January 2002, the NSF announced a new emphasis in the area of cognitive neuroscience. The program is intended to spur the development of novel techniques and models directed toward enabling basic scientific understanding of a broad range of issues involving brain, cognition, and behavior. The emphasis at NSF will be placed on projects that integrate perspectives across disciplines and integrate data from a variety of techniques, e.g., neuroimaging, physiological recording, stimulation methods, cognitive and behavioral methods, genetic analysis, molecular modeling, and computational modeling.

DEADLINE: January 15 and July 15 of each year beginning in 2003

CONTACT: Lawrence M. Parsons, (703) 292-7249, fax: (703) 292-9068, e-mail: lparsons@nsf.gov, Web site: www.nsf.gov.

■ **National Institute on Alcohol Abuse and Alcoholism (NIAAA)**

■ **SUBJECT: Alcohol Treatment, Services, and Prevention Studies of High Priority to Providers**

DESCRIPTION: While significant research on alcohol treatment, services, and prevention, has accumulated over recent years, the alcohol treatment and prevention fields have also witnessed a troubling gap in communication between those who conduct alcohol research and those who provide services. One factor contributing to this gap is the sentiment that topics of pressing interest to providers are not addressed in proposed and funded research projects. This program announcement is intended to address that problem by directing attention to research topics that providers have suggested as having a high priority. The specific topics covered in this program announcement (PA-02-167) include: clinical outcomes under managed care, robustness of outcomes to applied conditions, case management, tools for improved services delivery, treatment of individuals with co-occurring mental disorders, treatment for other special populations, improved prevention practices, behavior and management of providers, linkages to other medical and social services, and studies of treatment policy decisions.

DEADLINES: February 1, June 1, October 1

CONTACTS: Mike Hilton, Ph.D., Division of Clinical and Prevention Research, NIAAA, (301) 443-8753, fax: (301) 443-8774, e-mail: mhilton@willco.niaaa.nih.gov.

■ **SPONSOR: National Institute on Drug Abuse (NIDA)**

■ **SUBJECT: Chronic Stress in Relation to Drug Abuse and Addiction**

DESCRIPTION: The National Institute on Drug Abuse encourages research on adaptive changes within the brain brought about by chronic stress or repeated stressors and their functional relevance to drug use, abuse, and addictive processes. The relationship between drugs of abuse such as cocaine and heroin, activation of the hypothalamo-pituitary-adrenal (HPA) axis, and neural substrates subserving cognitive or behavioral processes under conditions of chronic stress is complex. Studies of these relationships, however, may provide clues as to how drugs of abuse can produce persistent changes in the brain that in turn modulate behavioral processes, including drug-seeking and drug-taking behaviors. This is a one-time solicitation (RFA DA-03-004) with an intended commitment of approximately $2.5 million expected to fund approximately 7 to 12 grants.

DEADLINES: Letter of Intent, November 19, 2002

Application, December 19, 2002

CONTACTS: Nancy Pilotte, Ph.D., for preclinical research issues, (301) 443-6975, e-mail: npilotte@mail.nih.gov; Minda Lynch, Ph.D., for human laboratory-based research, (301) 445-1322, e-mail: mlynch1@nida.gov.

■ **National Institute of Mental Health (NIMH)**

■ **SUBJECT: Summer Institute for Family Researchers**

DESCRIPTION: The NIMH is sponsoring the 2003 Summer Institute for Family Researchers to be held in Santa Ana Pueblo, New Mexico, from June 26 – 29, 2003. This year's theme is *Intervention as Science.* The institute accepts a limited number of both junior and senior researchers as participants, and particularly encourages minority family researchers to participate. Important new developments in theory, research design, methods, and analysis in the field of family research will be the focus of the meeting. Both structured presentations and informal intellectual exchange among participants and presenters are features of the institute.

DEADLINE: Applications are due by March 28, 2003.

CONTACT: Dee Frisque, Pennsylvania State University, (814) 863-7108, e-mail: dmr10@psu.edu.

■ **SPONSOR: National Institute of Mental Health (NIMH)**

■ **SUBJECT: Dissemination and Implementation Research in Mental Health**

DESCRIPTION: The National Institute of Mental Health invites grant applications for research that will build knowledge on methods, structures, and processes to disseminate and implement mental health information and treatments into practice settings. Dissemination and implementation research is designed to bridge the gap between clinical research and everyday practice. Recent literature has underscored the importance of understanding the many factors that affect whether the practice community will use a given intervention. Invited research on dissemination will

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address how information about mental health care interventions is created, packaged, transmitted, and interpreted among a variety of important stakeholder groups. Research on these topics will address the level to which mental health interventions can fit within real-world mental health service systems. The goal of the program announcement is to encourage mental health researchers to work with interdisciplinary scientists and practice stakeholders to develop conceptualizations for dissemination and implementation that are applicable across diverse practice settings, and to design studies that will accurately assess the outcomes of these efforts.

This program announcement will use the NIH research project grant (RO1), small grant (RO3), and exploratory-developmental grant (R21) award mechanisms.

DEADLINES: February 1, June 1, October 1,

CONTACTS: David A. Chambers, Ph.D., Division of Services and Intervention Research, NIMH, (301) 443-3747, fax: (301) 443-4045, e-mail: dchamber@mail.nih.gov.

■ **SPONSOR: NIMH and NIDA**

SUBJECT: Translational Grants - Borderline Personality Disorder (BPD)

DESCRIPTION: The NIMH and NIDA invite exploratory-developmental R21 applications for new, innovative translations of basic science theories, methods and findings to clinical research concerning borderline personality disorder, its features, and its relationship to co-occurring disorders. Applicants for the R21 grants should be committed to pursuing the proposed line of research subsequently through RO1 and other appropriate grant mechanisms with benefit of the data developed through the exploratory-developmental work. Areas of basic science for possible translation include modern psychometrics and measurement theory, basic behavioral science, social science and neuroscience. This effort seeks to involve more researchers and *particularly early career* investigators in translational research related to BPD. Collaborations of basic and clinical scientists are encouraged, and collaborating scientists need not be at the same institution. Consistent with the need to develop a cadre of translational researchers, the proposed project must include provision for an advanced graduate student, a postdoc, or an early career researcher to receive additional training in the basic science area from which the translation is to be drawn *and similarly,* to receive training in the clinical science involved in the research. Various training modalities may be utilized, including coursework, directed readings, tutorials, and visits to labs of other scientists, as well as active involvement in the proposed research. Preliminary data is neither expected nor required for an R21 proposal. Refer to RFA MH-03-001.

DEADLINE: Letter of Intent, January 13, 2003; Application, February 12, 2003

CONTACT: James Breiling, Ph.D., Division of Mental Disorders, Behavioral Research and AIDS, **NIMH**, (301) 443-3527, fax: (301) 443-4611, e-mail: jbreilin@mail.nih.gov. Cecelia McNamara, Ph.D., Division of Treatment Research, **NIDA**, (301) 402-1488, fax: (301) 443-6814, e-mail: cmcnamar@mail.nih.gov.

■ **SPONSOR: NINDS, NIDA, and NIDCD**

SUBJECT: Collaborative Neurological Sciences (CNS) Award

DESCRIPTION: The National Institute of Neurological Disorders and Stroke, the National Institute of Drug Abuse, and the National Institute on Deafness and Other Communication Disorders combine efforts to expand neuroscience research opportunities for faculty, students, and fellows at minority institutions. The purpose of the CNS Award is to encourage collaborations between scientists at minority institutions and NIH grantees (or those with equivalent grant support) from leading research laboratories in the conduct of neuroscience research.Funding from the CNS Award should lead to joint research efforts and publications, shared research instrumentation and resources, exchange of research techniques, and other scientific activities to enhance the research capabilities of applicants at minority institutions to successfully compete for independent research funding during the performance period of the award. An application may include proposals for basic, clinical, and/or translational neuroscience research.

The program announcement will use the S11, Minority Biomedical Research Support Thematic Project Grant funding mechanism. The S11 mechanism is intended to promote increased faculty and interdepartmental collaboration. Applicants may request a project period of up to five years and a direct cost budget of up to $200,000, which may include up to $75,000 for the collaborator. Program Announcement PAR-02-130.

DEADLINE: February 1, June 1, October 1

CONTACT: Gayathri Jeyarasasingam, Ph.D., Office of Minority Health and Research, **NINDS**, (301) 496-3102, fax: (301) 594-5929, e-mail: gj62v@nih.gov. Jean Craft Comolli, Center of AIDS and Other Medical Consequences of Drug Abuse, **NIDA**, (301) 402-0630, fax: (301) 594-6566, e-mail: jc282a@nih.gov. Daniel Sklare, Ph.D., Division of Extramural Research, **NIDCD**, (301) 496-1804, fax: (301) 402-6251, e-mail: daniel_sklare@nih.gov. ■

Li
(continued from page 1)

National Academy of Sciences, and editor of the journal *Alcoholism: Clinical and Experimental Research.*

The author of more than 400 journal articles and book chapters, Li has been a major participant in two NIAAA-supported research consortia: the Collaborative Study on the Genetics of Alcoholism; the Integrative Neuroscience Initiative on Alcoholism.

"Great progress has been made over the last two decades in our scientific knowledge base of genetics, neurobiology, and the behavioral and other aspects of alcohol abuse and alcoholism," said Li. "I am confident that by diligently expanding the boundaries of our knowledge we will continue to improve ways of preventing and treating these important public health problems."

Dr. Li replaces Raynard Kington, M.D., Ph.D., who served as acting director following the retirement in January of Enoch Gordis, M.D., who had been NIAAA director since 1986. ■

Scully
(continued from page 1)

ing vice chair for education at that institution, and during his term as APA Deputy Medical Director he held simultaneous appointments as clinical professor of psychiatry at Georgetown University School of Medicine, at George Washington University Department of Psychiatry, and at the Uniformed Services University of the Health Sciences.

The author of numerous articles on issues in psychiatric education, Dr. Scully is editor of the influential textbook *Psychiatry* (Lippincott, Williams & Wilkins, Fourth Edition, April 2001). He is on the editorial boards of the journals *American Family Physician* and *Medical Update for Psychiatrists.*

On behalf of the Division of Research, the Council on Research, and the American Psychiatric Institute for Research and Education, the PRR welcomes Dr. James Scully as the next APA Medical Director. ■

Insel
(continued from page 1)

ability to "build teams" and to "bring logic to fields of research." But, confided Zerhouni, it was the "body language of the people [at Emory] who work with [Insel] that convinced me he would be an outstanding leader for the NIMH."

After earning both undergraduate and medical degrees from Boston University, Insel served an internship at Berkshire Medical Center, Pittsfield, Massachusetts, and a psychiatry residency at the Langley Porter Neuropsychiatric Institute, University of California at San Francisco. He joined the NIMH (IRP) in 1979 as a clinical associate. Working in the NIH Clinical Center, he ran an inpatient unit and helped to pioneer research on Obsessive-Compulsive Disorder (OCD), initiating some of the first treatment trials for OCD using serotonin reuptake inhibitors.

"As time went on, I became much more interested in mechanism," Insel explained at the NAMHC meeting. "How do genes affect cells, and how do cells affect systems, and then how do systems end up creating behavior that's either normal or abnormal." In a major career shift, he moved in the mid-1980s from the Clinical Center to the NIH Animal Center in rural Poolesville, Maryland, to develop a new laboratory. "It was basically a program focused on what we now call social neuroscience," explained Insel, "trying to identify the genes, cells, molecules and systems that are important for social information processing, social attachment, for parental behavior, for some of these very complex aspects of behavior." Insel's laboratory has demonstrated the importance of the neuropeptides oxytocin and vasopressin in maternal behavior, pair bond formation, and aggression. For example, discoveries emerged from his lab about the neural basis of monogamy in certain species of voles. "One of the eternal grateful feelings I'll have is having had that opportunity with the program to change directions, to get new training, and work with spectacular colleagues and to do things that had never been done before," Insel said.

Moving in 1994 to Emory and directing Yerkes "was in some ways a third career for me," he added, "because I became very involved at that point in administration and in building scientific programs, often far-a-field." He spent much of his five years at Yerkes developing what has become one of the nation's leading centers for HIV vaccines. The first such large center ever funded in the life sciences by NSF, the Center for Behavioral Neuroscience focuses on the neurobiology of social behavior, with a special commitment to recruiting underrepresented minorities as students and faculty. Insel has continued his research on social attachment and behavior, and under an NIMH grant, has been involved in the development of an autism research center.

Insel promised to share his "vision" for what he hopes to accomplish at NIMH at the winter meeting of the National Advisory Mental Health Council, after he has had a chance to listen to the views of NIMH program staff and to other constituencies in the field. ■

New NIDA Journal

Science & Practice Perspectives is a new peer-reviewed NIDA publication for drug abuse researchers and treatment providers. Launched in July 2002, and to be published twice a year, the journal seeks to promote a practical, creative dialogue between scientists and service providers. The exchange of information is expected to help clinicians make the most of their programs and treatment outcomes while helping researchers construct new hypotheses and design studies with greater relevance to the needs of providers and patients. No-cost subscriptions may be ordered online: www.drugabuse.gov. ■

From the Council
(continued from page 9)

capacity to write a fundable grant and identified myself as a clinician rather than a researcher. As someone who was likely to stumble over the obstacles in my career path, the JFS program provided me with a bridge from clinical work to research at a critical juncture in my professional development. Through the JFS Program, I learned about the NIMH funding machinery, established a timeline for writing a career development application, subjected my proposal to internal peer review, and received encouragement when I needed it the most. I submitted an application for a Mentored Patient-Oriented Research Career Development Award (K23) on February 1, 2001 and received notice that it would be funded in January, 2002.

As I reflect on the role of the JFS Program in the development of my research career, I can identify several components of the process that I found especially helpful. From a practical standpoint, protected research time enabled me to collect and analyze pilot data and then write the grant application. Access to a statistician was critically important as I attempted to understand the data I collected and to write the methods section of the grant. The program directors (Charles F. Reynolds III, M.D., and Paul A. Pilkonis, Ph.D.) were invaluable resources for finding answers to research questions, both mundane (Are "pink sheets" really pink?) and profound (How do you balance your academic career with your personal life?).

Weekly seminars, modeled on the fellowships' Survival Skills Seminar, are an essential part of the JFS experience. As a problem-based seminar, the content of individual sessions reflects the interests and needs of participating trainees. For me, some of the most helpful discussions involved the NIH review process. At the beginning, I did not even know the questions I should ask. Therefore, it was invaluable for me to learn that there were differences between a K23 and K01 award and that it is advisable to contact the NIMH program officer before submitting a grant (I first had to ask, "What is a program officer?"). Generous colleagues offered to share with the group their previously submitted applications and "pink sheets," enabling the rest of us to learn from their successes and failures. When more complicated problems arose (What do you do if you think your grant has been assigned to the wrong review committee? What if your priority score is on the margin of being fundable?), we turned to Drs. Reynolds and Pilkonis for guidance and advice. In addition, because we each presented our work to the group on a rotating schedule I had helpful "deadlines" that encouraged me to stick to the timeline that I had established for myself. Incisive feedback from course leaders and peers strengthened early iterations of my application and helped me refine my hypotheses—even though the process was sometimes psychologically grueling.

Weekly group meetings also provided me with invaluable exposure to other scientific disciplines. The JFS-sponsored formal mini-courses on topics such as neuroimaging and epidemiology were educational and interesting. However, it was through the process of reviewing the work of other JFS colleagues that I came to appreciate more fully the complex issues facing cognitive scientists, behavioral medicine scientists, and health economists. In addition to increasing my awareness of research projects across the Department, this process built a foundation for future collaboration and consultation with other JFS colleagues. In fact, I frequently contact former JFS "classmates" to ask their advice on topics outside my area of expertise (i.e., What instrument should I use to assess childhood depression in a low income population? Can you recommend a developmental psychologist to consult on my project?). We often discussed mentoring issues during our weekly JFS meetings, and I was able to think critically about the attributes that make (or break) a mentoring relationship. Although I am lucky enough to enjoy a relatively frictionless relationship with my mentor, I am hopeful that these discussions will enable me to be a better mentor to others in the years ahead.

Finally, the JFS Program played an important psychological role in my transition to the role of a research psychiatrist. The program was, for me, the first formal statement and recognition of my research careers goals. In addition to providing me with skills, structure, and support, it gave me research "credentials" within the Department which in turn opened doors for invitations to research symposia, speaking opportunities, and research collaborations. In retrospect, the process of participating in weekly meetings with other researchers, declaring my research interests, and preparing a grant submission to NIMH helped to consolidate my professional identity and move me back into the research pipeline. I also think that as a female physician, the chance to participate in this program later in my career (i.e., at the junior faculty level) was especially important. It rescued me from the fate of some female colleagues who, like myself, opted out of the academic track for a few years in order to have children—but then, unlike me, never had the opportunity to return.

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model was based on a working relationship between the general practitioner, the consulting psychiatrist, and the nurse. Within this arrangement a substantial reduction of symptoms and positive treatment response rates were found in over 90 percent of the cases that were diagnosed and treated. These results were perhaps due to the moderate expression of symptoms and the lack of complications found in primary care settings as compared to cases and treatments in traditional psychiatric institutions.

Results indicated rare cases of "pure" anxiety or "pure" depression in the polyclinic population. Dynamic ratios and transitions between the two disorders are more a part of clinical reality. The concept of separate depression and anxiety disorders accompanied by comorbidity is thus in conflict with the concept of a unified single disorder spectrum that considers anxious-depressive affective disorder as a cohesive entity. Operational criteria for separate disorders do not offer a solution for diagnostic dilemmas; in contrast, a dynamic hierarchy and multiple interrelationships between depression and anxiety should be taken into account in the development of future psychiatric diagnostic systems. Future research should also be aimed at establishing the relationships between specific physical disorders and the stages of affective disorder. ■

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